| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11967442** | **03/16/2017** |
| NAME OF PROVIDER OR SUPPLIER<br>**GOLD CHOICE ORMOND BEACH** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**1410 HAND AVENUE**<br>**ORMOND BEACH, FL 32174** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

**0000 Initial Comments**

On , 2017 through , 2017 a biennial relicensure survey in conjunction with 2 complaint surveys (CCR 2017000602, 2017000956) was conducted at Gold Choice Assisted Living Facility (License #11475). Deficient practice was identified during the surveys

**0008 Admissions - Health Assessment**

Based on record reviews and staff interviews, the facility failed to obtain a Florida Health Assessment Form (1823) within 60 days before admission or 30 days following admission for 1 Resident (Resident #3) out of 3 resident records sampled.

The findings include:

A record review for Resident # 3 revealed a date of admission of . A review of the Florida Health Assessment form was completed and signed by the physician on .

Instructions for the 1823 form mandates that the form must be completed by a licensed health care provider by means of a face to face assessment of the resident, and it is regulated that the assessment be done by a licensed physician, licensed nurse practicioner, or licensed physician assistant.

An interview with Employee J, Licensed Practical Nurse (LPN) on at 3:20 PM confirmed the 1823 for Resident #3 was dated and should have been redone.

On the facility provided a new 1823 for Resident #3 that was dated .

An interview with Employee J, LPN, on at 9:04 AM was asked who filled out the 1823 form and she replied "I did and then the physician signed off on it." Employee J was then asked for the facility to provide verification the physician came into the facility on and completed a face to face with the resident to verify the accuracy of the information provided on the 1823. The facility was not able to provide the information to this surveyor before exit of the facility on at 4:15 PM.

CLASS III

**0025 Resident Care - Supervision**

Based on record reviews and staff interviews, the facility failed to maintain a general awareness of the

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residents whereabouts for 1 Resident (Resident #14) and to contact residents physician and health care surrogate with a significant change and to maintain a written record of those changes which required medical attention for Resident's #2 and #7 out of 4 resident records sampled.

The findings include:

A record review for Resident # 14 revealed a date of admission of . An 1823 signed by the physician and dated reveals under physical or sensory limitations "At risk for wandering or for daughter attempting to take her out of the facility, ambulates independently." (photographic evidence obtained)

A review was conducted of the facility Adverse Incident log which revealed the resident wandered away from the facility on .

An interview with Employee J on at 10:45 AM confirmed she was not aware that Resident #14 was listed as a risk for wandering and should have been admitted into the facility's secured unit.

2) A record review was conducted of Resident # 7 revealed a date of admission of , with the daughter listed as the responsible party for the resident. Resident #7 was listed as receiving multiple treatments for a skin .

A review of the facility nursing progress notes revealed the resident's family was never contacted in regards to the changes with the resident's skin, medications, or treatments she received.

An interview with the family member for Resident #7 on at 3:45 PM confirmed the facility rarely calls her with changes in her moms condition. She stated that back in she was told her mom and had . One day while visiting her mother ( Resident #7) she observed a staff member applying Premetharin cream to her mother. She asked why her mother was receiving the ointment and the staff member told her it was due to her having . The daughter confirmed she was never contacted by the facility to inform her that her mother had .

During an interview with Employee J, an LPN, on at 11:10 AM, she was asked why the family wasn't called to make them aware that Resident #7 was diagnosed with . Employee J replied, " Resident #7 is her own responsible party so we wouldn't call the family." Employee J then reviewed the Resident Demographic sheet along with the signed Power of Attorney form in the chart, and confirmed her daughter should have been contacted with any changes to the resident.

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On at 12:53 PM, Employee J was asked how the staff know who to call in case of emergency or change in care for a resident. She stated "All the medication carts have packets which list who to call for each resident." Employee J was then asked to obtain the packet from the medication cart for Resident #7 and she was not able to find it. She stated that it was being updated and was not on the cart on this time.

3) A record review was conducted for Resident #2 which revealed the resident was to receive Kayexolate 15 grams (gm) on and repeat lab work for her level on .

A review of the Resident #2's Medication Observation Record (MOR) revealed an order for Kayexolate 15 gm to be given on , but was not given (photographic evidence obtained)

An interview with the Resident Care Director (RCD) on at 12:35 PM confirmed Resident #2 never received the Kayexolate or lab work as ordered on . She stated "I have a call into her Dr. and trying to find out what he wants done." The RCD was asked if Resident #2 ever received the Kayexolate medication, and she said confirmed it was never given. it's right here as she proceeded to show this surveyor a bottle of Kayexolate labeled for Resident #2 on the desk.

4) An observation was conducted on at 10:15 AM of Resident #2 being assisted with her morning medications. The resident told the Resident Care Director (RCD) at that time she was having pain and with . The RCD informed Resident #2 that she was aware and she would let her physician know.

A record review was conducted for Resident #2 on and no evidence could be found the physician was notified of the residents and pain with .

During an interview with the RCD on at 3:10 PM, she stated she faxed the physician on . She was asked to provide evidence she notified the physician on the same day, but by the end of the survey she could not provide evidence of the physician being notified before , a day after the symptoms were reported.

CLASS III

**0032 Resident Care - Elopement Standards**

Based on record review and staff interview, the facility failed to conduct and document elopement drills for residents and staff as pursuant to Sections 429.41(1)(a)3. and 429.41(1)(A), F.S. affecting all of the

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74 residents on the current census.

The findings include:

The Administrator was asked on at 9:30 AM (upon entering thefacility for survey) for the facility Policy and Procedures on elopement, as well as evidence of elopement drills being conducted twice a year with all staff in attendance.

An interview with the Administrator on at 3:00 PM confirmed he did not have evidence the facility conducted elopement drill twice a year with all staff in attendance.

CLASS III

**0078 Staffing Standards - Staff**

Based on staff interview and employee personnel file review, the facility failed to ensure 5 of 5 sampled employees (Employee A, B, C, D and E) provided a statement from a health care provider as evidence the employee did not show signs or symptoms of a communicable .

The findings include:

Record review of the personnel file for Employee A (hired ), Employee B (hired ), Employee C (hired ), Employee D (hired , and Employee E (hired ) found no evidence the employees had a statement from a healthcare provider documentation the employees were free from communicable .

The findings were confirmed during an interview with the Administrator on at 3:38 PM. He stated the facility changed their procedure from doing physicals to a review and did not add the communicable statement.

Class III

**0081 Training - Staff In-Service**

Based on record review and staff interview, the facility failed to ensure 1 of 5 sampled employees

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(Employee A) received a minimum of 1 hour in-service training within 30 days of employment that covered resident rights in an Assisted Living Facility.

The findings include:

A record review of the personnel file for Employee A (hired . . . . ) found no evidence she received training in resident rights.

The findings were confirmed during an interview with the Community Relations Director on at 10:39 AM. She stated she could not locate evidence Employee A received resident rights training in Employee A's personnel file and would continue to look. Evidence of the training was not provided by the exit conference at 4:15 PM on . . . . . .

Class III

**0083 Training - First Aid and**

Based on record review and staff interview, the facility failed to ensure one staff member with current First Aid was working at the facility at all times. (Employee C, K and L)

The findings include:

A record review of the personnel file for Employee C (hired . . . . . ) found no evidence she received training in First Aid.

During an interview with the Community Relations Director on . . . . . at 10:40 AM, she stated that the facility had nurses working on all shifts with the exception of the 3:00 PM- 11:00 PM night shift.

Record review of the employee schedule found Employee C was schedule to work nights with one other employee. The Community Relations Director was asked to provide evidence that the two other employees (Employee K and L) that work the night shift with Employee C on . . . , . . . , through was trained in First Aid.

The findings were confirmed during an interview with the Community Relations Director on . . . . . at 3:05 PM. She stated she did not have evidence of First Aid training for Employee C and Employee L.

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Class III

**0093 Food Service - Dietary Standards**

Based on observation, record reviews and staff interviews, the facility failed to post a planned and dated weekly menu viewable for all residents and to have a 3 day supply of non-perishable food on hand at all times. In addition the facility failed to have a supply of eating ware sufficient for all residents affecting all 74 resident currently residing at the facility.

The findings include:

An observation was conducted on at 10:05 AM during the initial tour of the menu posted in the hallway by the dining . It was listed as Week 4 out of a 4 week cycle of menus. There were dates listed at the top of the menu but the dates & were not found.(photographic evidence obtained)

An interview with the Employee E, on at 11:55 AM confirmed the posted weekly menu was not current and she was using Week #2 instead of Week #4.

An interview with the Administrator on at 12:05 PM confirmed the menu was not accurate and would get it changed out.

2) An observation was conducted on at 3:05 PM of the facility emergency food supply. The facility did not have enough food on hand in the event of an emergency adequate enough for the 74 residents currently living in the facility.

An interview with Employee E, on at 3:07 PM stated "We used all our emergency food during the hurricane back in and I haven't had time to re-stock it yet."

3) An observation was conducted of the noon meal on with approximately 44 residents in attendance. Employee G was observed serving the last half of the dining , in paper bowls.

An interview with Employee G, on at 12:25 PM was asked why the resident were being serviced soup in paper bowls and she said the facility did not have enough supplies for dinnerware so

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they have to get paper. She was asked how long this has been happening, and she said for about a month.

An observation was conducted of the noon meal on . . . . at 11:35 AM in the Secured Unit Dining 8 residents were eating with plastic utensils.

An interview with Employee E, on at 11:40 AM confirmed the facility was short on bowls and silverware and she needed to order some.

CLASS III