STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966934	**03/20/2017**
NAME OF PROVIDER OR SUPPLIER **WHITE FLOWERS**	STREET ADDRESS, CITY, STATE, ZIP CODE **801 ARDENLEIGH DRIVE** **ORLANDO, FL 32828**	

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

0000 - Initial Comments

The re-licensure survey was conducted on . White Flowers Assisted Living, license #11036, had deficiencies at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview, the facility failed to maintain written documentation regarding a significant change for 2 of 2 sampled residents. (#2 & #6)

Findings:

1. Review of the medications for resident #2 revealed a medication that was filled on with a 90-day supply and still had a significant amount of medication left in the vial. , 20mg, take one tablet by mouth every day was in the med supply for resident #2. The MOR indicated to give at bedtime. The vial had more than 50% of the medication remaining in the bottle, which was filled over 9 months prior.

Review of the Medication Observation Records for resident #2 from , 2016 through 2017 revealed that she has refused the medication most of the time.

Review of the progress/nursing noted in the record did not find any documentation that the physician was notified of the resident's refusal to take the medicine.

In an interview with Staff A on at 9:30AM, she stated the resident said it upset her stomach and she did not want to take it so late at night. Staff A said she had not asked the doctor if the timing could be changed.

In an interview with the assistant to the administrator on at 1:30PM, he said the doctor was aware, but confirmed there were no notes to show.

2. Review of the record for resident #6, admitted on , revealed a new Health Assessment dated . There were no progress/nursing notes documenting any recent or hospitalizations.

In an interview with resident #6's son on at 1:45PM, he stated his mother had recently returned from rehab. She had a in , her left hip, and was now receiving Hospice care.

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In an interview with the assistant to the administrator on at 3:30PM, he confirmed there were no notes regarding the or hospitalization.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on resident record review and interview, the facility failed to ensure that weight records and Power of Attorney (POA) documentation were maintained in the resident's record for 1 of 2 sampled residents (#6).

Findings:

Review of the record for resident #6 did not revealed documentation of weights obtained every 6 months while in the facility. Resident #6 was admitted on . The resident receives assistance with Activities of Daily Living (ADLs). No weights were recorded for , or 2016.

In an interview with the assistant to the administrator on at 3:30 PM, he stated that they must not have written them down.

Review of the contract for resident #6 revealed that her son signed it. There was no documentation to show that he was her legal Power of Attorney in the record.

In an interview with the assistant to the administrator on at 1:30 PM, he stated that the son said he would bring a copy but never had.

In a phone interview with resident #6's son on at 1:50 PM, the son stated he did not have a POA and never did.

Class III

0189 - ADCCs in ALF - FS 429.905 (2); 58A-6.013 (2-3) FAC

Based on observation and interviews, the facility was noted to have beds for 9 residents in the facility, which is licensed for a maximum capacity of 6 residents.

Findings:

During a tour of the facility on at 8:20AM, it was observed that there were 9 beds in the facility.

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

The facility was licensed for a maximum of 6 residents.

During the tour, Staff A said there were 7 residents and 2 day care clients. She then corrected herself to say there were 6 residents and 3 day care clients, but one of the day care clients was sleeping in a bed at that time since she arrived so early that morning.

Throughout the course of the visit, 5 residents and 3 day care clients were observed. One resident was out of the country on vacation with her family. All of the residents and day care clients ate their breakfast and lunch at the dining table. They were all dressed appropriately for the day.

In an interview with the assistant to the administrator on at 10:00AM, he confirmed there were 9 beds in the facility. When he was informed he could not have beds for day care clients, he stated the Agency told him he had to have beds for his day care people. He thought it was better for them to have a place to rest in the middle of the day.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on Observation, Record Review and Interview, the facility failed to register and maintain the employment status of employees within the Agency's Background Screening Clearinghouse for 2 of 3 sampled staff employees (B & C).

Findings:

Review of the Agency's Background Screening Clearinghouse revealed Staff B, hired , and Staff C, hired , were not listed on the roster.

In an interview with the assistant administrator on at 3:45 PM, he confirmed that the roster was not accurate.

Unclassified