STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910384	03/02/2017
NAME OF PROVIDER OR SUPPLIER **ROYAL CARE A.C.L.F., INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **5081 DUNN ROAD** **FORT PIERCE, FL 34981**	

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

0000 - Initial Comments

A Complaint Investigation, CCR #2017000005, was conducted on at Royal Care A.C.L.F. Inc., license #7462. The facility had deficiencies at the time of the investigation.

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on interviews and record review, the facility failed to ensure unlicensed staff who assist residents with self-administration of medications applied required standards when doing so by:
1. Allowing an unlicensed staff member to administer via syringe to 2 of 2 residents receiving injections (Residents #7 and #8).
2. Allowing unlicensed staff to share medication assistance tasks for the same resident and same dose.
This has the potential to affect all 9 of the current residents, all of who receive assistance with self-administration of medications.

The findings included:

Review of the facility's medication systems conducted on , with the Administrator and Employee B present, revealed the following:

1. During the entrance conference conducted at 9:05 AM, Employee B, the Administrator's Designee and the facility's lead Caregiver and Medication Technician (MT), was asked and stated she administers via syringe to Residents #7 and #8. The Administrator was present at the time.

Review of Resident #7's records revealed she was admitted to the facility on . Her AHCA Form 1823 (medical examination) documented she requires assistance with self-administration of medications. The medical examination included an order for " 10 ML, inject 70 [units , daily]". There was no medication observation record (MOR) available for review; see citation issued herein at A0054. On at 1:05 PM, a bottle of 10 millimeters (ML) was observed centrally-stored in the facility's kitchen refrigerator (photographic evidence obtained). In an interview conducted at 10:22 AM, Resident #7 stated she performs her own glucometer tests and Staff B brings her in a syringe and she injects herself.

Review of Resident #8's records revealed she was admitted to the facility on . The facility had not yet obtained her AHCA Form 1823 (medical examination). There was no medication list or written Health Care Provider (HCP) medication orders available for review. There was no MOR available for review; see citation issued herein at A0054. Observation of her current medication supplies

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910384	03/02/2017
NAME OF PROVIDER OR SUPPLIER **ROYAL CARE A.C.L.F., INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **5081 DUNN ROAD** **FORT PIERCE, FL 34981**	

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

conducted at 1:10 PM with Employee B present, revealed a centrally-stored bottle labeled with Resident #8's name and " 10 ML, inject 70 units , every morning and every evening" (photographic evidence obtained).

In an interview conducted at 11:02 AM, Staff C, a Caregiver and MT hired , was asked and stated she will handle medication tasks as needed but Staff B handles most of the medication tasks; Staff B handles all of the tasks. In an interview conducted at 1:53 PM, Staff A, a Caregiver and MT also hired , was asked and provided the following information. She sometimes conducts the medication tasks. Staff B handles all -related tasks. She doesn't know where the is stored.

This was discussed with the Administrator and Staff B on at 2:25 PM, they acknowledged Medication Technician standards of practice do not include the preparation of syringes for injections.

2. In an interview conducted at 1:01 PM with the Administrator present, Staff B was asked and provided the following information. When assisting residents with self-administration of medications, she:
A. Reviews the resident's MOR for what to give.
B. Pulls the doses from the medications containers.
C. Puts the individual resident's medications in a small plastic cup labeled with the resident's name.
D. Hands the cup of medications to another MT to give to the resident.
E. Initials the resident's MOR.

In an interview conducted at 11:02 AM, Staff C confirmed she assists with medication tasks and stated Staff B "updates the residents' medication records". In an interview conducted at 1:53 PM, Staff A confirmed she assists with medication tasks and stated Staff B "does all the charting". Review of several randomly selected MOR's over multiple months revealed only Staff B's initials on the MOR's.

This was discussed with the Administrator and Employee B on at 2:25 PM; they acknowledged MT's cannot share medication tasks for the same resident and same dose. They further acknowledged Medication Technician standards of practice also include:
A. Taking the medication, in a properly labeled container from where it is stored, and bringing it to the resident.
B. In the presence of the resident, read the label, open the container, remove the prescribed amount of medication and close the container.
C. Keeping a record of when a resident receives assistance with self-administration under this section.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910384	03/02/2017
NAME OF PROVIDER OR SUPPLIER **ROYAL CARE A.C.L.F., INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **5081 DUNN ROAD** **FORT PIERCE, FL 34981**	

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

D. HCP-ordered medications to be given "as needed" require specific instructions that preclude independent judgment on the part of the unlicensed staff member, and are given at the specific request of a competent resident.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interviews, the facility failed to maintain daily medication observation records (MOR's) for 2 of 3 sampled Residents (#7 and #8), and did not provide individual medication order entries on the MOR for each medication received by the Resident (#10), for 1 of 3 sampled residents.

The findings included:

Medication systems and resident record review conducted , with the Administrator and Employee B present, revealed the following:

1. Review of Resident #7's records documented she was admitted to the facility on . Her AHCA Form 1823 (medical examination) documented she requires assistance with self-administration of medications. Review of the medication orders documented on her medical examination and observation of her current medications supplies revealed the following medications were centrally-stored:
A. 40 milligrams (MG) daily
B. 80 MG daily
C. 20 MG daily
D. 25 MG twice daily
E. 10 MG daily
F. 10 MG daily
G. 10 milliequivalents (MEQ)

Further review of her records revealed no documentation of required medication observation records (MOR's) for 2016 and 2017 showing the resident's name, known , the resident's HCP name and telephone number; the name, strength and directions for use for each medication; and a chart for recording each dose is taken, missed, refused or other pertinent information related to individual doses. A MOR dated 2017 was completely blank.

On at 1:33 PM, an interview was conducted with Employee B, the Administrator's Designee

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910384	03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL CARE A.C.L.F., INC.	**5081 DUNN ROAD FORT PIERCE, FL 34981**

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

and the facility's lead Caregiver and Medication Technician. She was asked and stated she assists with Resident #7's medications daily. She stated had not kept MOR's for Resident #7 since her admission (2 months earlier) and confirmed there was no other related documentation available for review. The Administrator was present at the time of interview.

2. Review of Resident #8's records documented she was admitted to the facility on . The facility had not yet obtained her AHCA Form 1823 (medical examination). There was no documentation such as a medication list or written Health Care Provider (HCP) medication orders available for review. Observation of her current medications supplies conducted at 1:10 PM with Employee B present, revealed the following medications were centrally stored for Resident #8:

A. 10 milliliters (ML) inject 70 units , every morning and evening
B. 10 MG daily
C. 40 MG daily
D. 5 MG twice daily
E. 80 MG daily
F. ER 20 MEQ daily
G. 300 MG three times daily
H. 25 MG daily
I. 40 MG daily
J. 40 MG daily
K. 0.1 MG every 6 hours as needed for , greater than 160

Further review of her records revealed no evidence of the required monthly MOR for the months of , and 2017. On at 9:52 AM with the Administrator present, Employee B was asked and stated Resident #8 requires assistance with self-administration of medications and she assists with Resident #8's medications on a daily basis. She stated had not kept MOR's for Resident #7 since her admission (1 week earlier), and there was no other related documentation available for review.

3. Review of Resident #10's records documented she was admitted to the facility on . Her AHCA Form 1823 (medical examination) documented her diagnoses included , . A written Health Care Provider (HCP) order called for "[discontinue] . 20 mg ... 1 tab [by mouth daily] in am". Setraline and are anti-depressant medications.

Review of her 2016 medication observation record (MOR) revealed an entry dated calling for " 50 MG take 1 tablet every day". However, the entry was crossed out and " 30 mg" was written at the bottom of the entry. The words "1 tablet every day" were underlined. The MOR was initialed daily from through to indicate the resident

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910384	03/02/2017
NAME OF PROVIDER OR SUPPLIER **ROYAL CARE A.C.L.F., INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **5081 DUNN ROAD** **FORT PIERCE, FL 34981**	

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

received the medication on those days. A "dot" appears above the entry for .

The MOR was not clear as to when one medication ended and the other began. In an interview conducted at 2:25 PM with the Administrator present, Employee B stated she thought she could use the same entry on the MOR for two separate medication orders.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observations, interviews and record reviews, the facility failed to properly secure centrally stored medications for 2 of 3 sampled Residents (#7 and #8) who receive assistance with self-administration of medications; and, failed to ensure scheduled medications were not expired.

The findings included:

Medication systems and resident record review conducted revealed the following:

1. Resident #7 was admitted on . Her AHCA Form 1823 (medical examination) documented she requires assistance with self-administration of medications. It included the following prescribed medications: 10 millimeters (ML), inject 70 units , daily; , 10 milligrams (MG) daily; 10 MG daily; and, ER 10 milequivalents (MEQ) daily. The following concerns were noted:

A. On at 1:05 PM, the was observed stored in the kitchen refrigerator that did not lock. The kitchen had two open entrances. The was not secured either within a locked box inside the refrigerator, a locked refrigerator, or in a refrigerator in a locked . The Administrator and Employee were present at the time of observation.

B. Labels on 3 medication containers were observed with expiration dates as follows: , , expired ; , expired ; and , , expired (photographic evidence obtained).

An interview was conducted at 1:35 PM with Employee B, the Administrator's Designee and the facility's lead Caregiver and Medication Technician. She was asked and stated she assists Resident #7 with self-administration of medication, and she thinks the family added new pills to an old bottle. The Administrator was present at the times of observation and interview.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910384	03/02/2017
NAME OF PROVIDER OR SUPPLIER **ROYAL CARE A.C.L.F., INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **5081 DUNN ROAD** **FORT PIERCE, FL 34981**	

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

2. Resident #8 was admitted on . An initial medical examination had not yet been performed. In an interview conducted at 9:52 AM, the Administrator and Employee B stated Resident #8 requires assistance with self-administration of medications. Employee stated she assists Resident #8 with her medications.

One of Resident #8's medications was ML, inject 70 units , every morning and evening. It was centrally stored. On at 1:05 PM, with the Administrator and Employee B present, the was observed stored in the kitchen refrigerator that had no lock. The kitchen had two open entrances. The was not secured either within a locked box inside the refrigerator, a locked refrigerator, or in a refrigerator in a locked .

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interviews, the facility failed to ensure staff members who provide direct care to residents, received required training related to residents rights in an assisted living facility for 2 of 3 sampled Staff (A and B).

The findings included:

Personnel record review conducted with the Administrator and Staff B present, revealed the following:

1. Staff A was hired on and works as a Caregiver and Medication Technician (CG/MT). Further review of her record revealed no documentation showing she received the required 1 hour of training in Resident Rights in an Assisted Living Facility. In an interview conducted at 1:53 PM, Staff A confirmed she provides direct care for the residents.

2. Staff B started when the facility opened on . She is the Administrator's Designee and the facility's lead CG/MT. Review of her record revealed no documentation showing she received the required 1 hour of training in Resident Rights in an Assisted Living Facility. In an interview conducted at 9:00 AM, Staff B confirmed she provides direct care for the residents.

This was discussed with the Administrator and Staff B, on at 4:37 PM. He confirmed both Staff A and Staff B provide direct care to the residents.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910384	03/02/2017
NAME OF PROVIDER OR SUPPLIER **ROYAL CARE A.C.L.F., INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **5081 DUNN ROAD** **FORT PIERCE, FL 34981**	

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

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on record review and interviews, the facility failed to ensure unlicensed staff who provide residents assistance with self-administration of medications received required training, for 1 of 3 sampled Staff (A).

The findings included:

Review of Staff A's personnel records revealed she was hired on and works as a Caregiver and Medication Technician. There was no documentation showing she received the required 2 hours of annual training in Assistance with Self-Administered Medication and Medication Management provided by a either a licensed Registered Nurse or licensed Pharmacist. Further review of Staff A's records revealed a related certificate of training dated , 13 months earlier.

This concern was discussed with the Administrator and Staff B on at 4:37 PM. They confirmed Staff A provides residents assistance with self-administration of medications.

Class III

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

Based on record review and interviews, the facility failed to maintain current employment status records in the Care Provider Background Screening Clearinghouse as required for 1 of 3 sampled Staff (C).

The findings included:

Review of the facility's Clearinghouse records and personnel records conducted revealed Staff C, a Caregiver and Medication Technician, was hired . Her name, hire date, and other required information was not listed in the facility's Clearinghouse records. Her information was not entered in the Clearinghouse records within 10 days of hire. Staff C was observed during the survey providing direct care to residents. She was interviewed on at 11:02 AM and confirmed she was hired several years prior and works as a Caregiver and Medication Technician.

These concerns were discussed with the Administrator and Staff B on at 4:37 PM. They confirmed Staff C provides direct care to the facility's residents.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910384	**03/02/2017**
NAME OF PROVIDER OR SUPPLIER **ROYAL CARE A.C.L.F., INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **5081 DUNN ROAD** **FORT PIERCE, FL 34981**	

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

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