STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942886	**04/18/2017**
NAME OF PROVIDER OR SUPPLIER **COUNTRYSIDE HAVEN**	STREET ADDRESS, CITY, STATE, ZIP CODE **6960 CR 95** **PALM HARBOR, FL 34684**	

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

0000 - Initial Comments

Assisted Living Facility

On , , 2017, a change of ownership (CHOW) provisional licensure survey for the period of to was conducted at Countryside Haven. Deficient practice was identified at the time of the visit.

(License # 5305)

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, interview, and record review, the facility failed to coordinate and ensure the provision of additional care and services needed for one hospice resident (#6) of one sampled hospice residents.

Findings included:

During an observation conducted on at 10:00am, it was discovered that Resident #6 was on continuous and sitting in a recliner chair at the foot of her bed in a reclined position. The tubing and nasal cannula was in her lap. Staff F placed the nasal cannula back in her nose. Staff F stated, "she is unable to manage the (referring to turning the on/off and titrating to the correct liters) and placing the nasal cannula on; the facility's Med Techs do this when she is up in the dining ; we try to get her up every day for supper in the dining ."

An interview conducted on at 11:05am with the Hospice Nurse, revealed that Resident #6 is on continuous "she uses an concentrator at the bedside and a portable tank for the dining ; a hospice nurse comes three times a week; no, she is too weak to manage it herself." At 11:20am the Administrator stated, "There are no nurses on staff here."

A record review conducted on , revealed that there was no interdisciplinary care plan, which specifies care and services provided by Hospice and those provided by the facility and agreed upon by Resident #6 and/or responsible party. The Hospice Nurse was able to provide a copy of a generalized Hospice care plan (photographic evidence obtained) related to diagnosis and but not for specific

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care and services provided by the facility and those provided by Hospice. At 02:30pm, the Administrator stated, "this is all we have for her care plan."

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, interview, and record review, the facility failed to:

1. Ensure a safe, hazard free living environment and the coordination of care and services by a third provider for 1 Hospice Resident (#6) of 1 Hospice sampled resident; and,
2. Ensure and respect resident privacy for three Residents (#1, #2, and #3) of three sampled residents.

Findings included:

1. An observation on at 11:05am revealed the unsafe storage of portable in Resident #6's . The closet contained nine small full portable tanks in a secure holder, one freestanding tank leaning against the tanks in the holder, and on other freestanding tanks. A wicker basket with a clothes hamper with clothes in it sitting on top of the nine tanks in the holder (photographic evidence obtained). At 02:40pm the Administrator stated, "I don't know much about storage." The Administrator was unable to produce a facility policy and procedure for safe storage and stated, "We don't have one."

Resident #6 was sitting in recliner chair at the foot of the bed with per nasal cannula; storage with 2 free standing tanks with 1 canister leaning and clothes baskets with clothes on top of 9 portable tanks in secure holder - stored in closet. (photographic evidence obtained).

A record review conducted on revealed that there was no interdisciplinary care plan, which specifies care and services provided by Hospice and those provided by the facility and agreed upon by Resident #6 and/or responsible party. The Hospice Nurse was able to provide a copy of a generalized Hospice care plan (photographic evidence obtained) related to diagnosis and but not for specific care and services provided by the facility and those provided by Hospice. At 11:20am the Administrator stated, "There are no nurses on staff here; and, at 02:30pm stated, "This is all we have for her care plan."

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2. During an observation of the noon medication (med) pass on :
- At 12:00pm, Staff F walked away from med cart leaving Resident #1's picture and medical information open on the computer screen for the Electronic Medication Observation Record (EMOR).
- At 12:05pm, Staff F walked out of the dining Resident #1's picture and medical information open on the computer screen for the EMOR
- At 12:09pm, Staff F walked away from the med cart leaving Resident #2's picture and medical information open on the computer screen for the EMOR.
- At 12:15pm, Staff F walked away from the med cart leaving Resident #3's picture and medical information open on the computer screen for the EMOR.

At 12:20pm, Staff F stated, "this is how we pass meds."

An interview conducted on at 02:37pm confirmed that resident information should be protected as the Administrator stated, "The med tech should have hit the back button to close the file before walking away."

Class III

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

Based on observation, interview and record review, the facility failed provide proper assistance with self-administration of portable detailed in Section 429.256(4), F.S. for one hospice resident (Resident #6) of one hospice resident sampled.

Findings included:

During an observation conducted on at 10:00am, it was discovered that Resident #6, on continuous , was sitting in a recliner chair at the foot of her bed in a reclined position. The tubing and nasal cannula was in her lap. Staff F placed the nasal cannula back in her nose. Staff F stated, "she is unable to manage the (referring to turning the on/off and titrating to the correct liters) and placing the nasal cannula on; the facility's med techs do this when she is up in the dining ; we try to get her up every day for supper in the dining ."

An interview conducted on at 11:05am with the Hospice Nurse revealed that Resident #6 is

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on continuous and stated that "she uses an concentrator at the bedside and a portable tank for the dining ; a hospice nurse comes three times a week; no, she is too weak to manage it herself." At 11:20am the Administrator stated, "There are no nurses on staff here."

A record review conducted on revealed that there was no interdisciplinary care plan, which specifies care and services provided by Hospice and those provided by the facility and agreed upon by Resident #6 and/or responsible party. At 02:40pm the Administrator stated, "She can take it (referring to the nasal cannula) off but she cannot replace it herself."

Class III

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

Based on observation and interview, the facility failed to maintain secured storage of medication (med) during a med pass, placing all residents at risk for potentially serious outcomes by accessing meds that are not their own prescribed meds.

Findings included:

During an observation of the noon med pass on :
- At 12:00pm, Staff F turned her back to the unlocked med cart to take Resident #1's medication to them.
- At 12:05pm, Staff F walked out of the dining (away and out-of-sight) of the unlocked med cart.
- At 12:09pm, Staff F turned her back to the unlocked med cart to take Resident #2's medication to them.
- At 12:15pm, Staff F turned her back to the unlocked med cart to take Resident #3's medication to them.

At 12:20pm, Staff F stated, "this is how we pass meds."

An interview conducted on at 02:35pm confirmed that the med cart should be locked when out-of-sight as the Administrator stated, "the med cart should be locked if it is out of sight."

Class III