STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968664	R 04/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M H TENDER CARE	**29 PRINCE JOHN LN** **PALM COAST, FL 32164**

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

0000 Initial Comments

A second follow-up to the complaint investigation (CCR #2016008838) was conducted at MH Tender Care on , 2017. MH Tender Care had deficiencies at the time of the investigation.

0008 Admissions - Health Assessment

Based on observation, resident record reviews, and staff interview, the facility failed to obtain a completed AHCA 1823 (Resident Health Assessment) from a licensed health care practitioner for 6 of 6 sampled residents (Residents #2, #3, #4, #5, #7 and #8).

The findings included:

1. A record review for Resident #2 found a Resident Health Assessment dated . The examining practitioner failed to list a medical diagnosis or history for this resident. Section 3, which is required to be completed by the administrator to list the services provided to the resident by the facility was left blank. Photographic evidence was obtained.

2. Record review for Resident #3 revealed an AHCA 1823 dated and signed by the examining practitioner on . The section listing physical and sensory limitations was left blank. The section asking for evaluation of the resident's and behavioral status was blank. Photographic evidence was obtained.

3. Record review for Resident #4 revealed an AHCA 1823 dated . The examining practitioner's license number was illegible. There was no telephone number or address of the examiner listed. Section 3, which is required to be completed by the administrator to list the services provided to the resident by the facility, was missing entirely. Photographic evidence was obtained.

4. Record review for Resident #5 revealed an AHCA 1823 that was not dated, but had been signed by a physician. The physician failed to list any physical or sensory limitations, nursing, treatment or service requirements, or special precautions, if any. He also failed to indicate if Resident #5 required 24-hour nursing or care. Photographic evidence was obtained.

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5. Record review for Resident #7 revealed an AHCA 1823 signed by the examining practitioner on . The sections on the assessment asking to list physical or sensory limitations or special precautions was blank There was no prescribed diet order. Section 3, which is required to be completed by the administrator to list the services provided to the resident by the facility. was missing entirely. Photographic evidence was obtained.

6. Record review for Resident #8 revealed an AHCA 1823 signed by the physician on . Section 3, which is required to be completed by the administrator to list the services provided to the resident by the facility. was blank. Photographic evidence was obtained.

7. An interview was conducted with Employee A (caregiver) at 1:08 pm on . She reviewed the health assessments and confirmed the missing documentation for Residents #2, #3, #4, #5, #7 and #8, and stated she would notify the Administrator. She confirmed she was not a nurse, and that Resident #2 required her medications administered directly into her mouth. She did not know a licensed nurse was required to administer medications.

This was previously cited in the original complaint survey on , and again at the follow-up survey conducted on .

Class III

0025 Resident Care - Supervision

Based on observation and interview with staff, the facility failed to offer appropriate personal supervision for 1 of 1 resident considered at risk for wandering (Resident #3), out of a total of 6 sampled residents.

The findings included:

An unannounced follow-up survey was conducted at 12:15 pm on . Employee A, Caregiver, came to the front door; however, she was unable to unlock the door to permit this surveyor entry. Employee A was observed to walk away from the door and across the kitchen, She returned with a set

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of keys. Using the keys, she was able to unlock the front door's deadbolt from the inside.

An observation of the interior panel of the front door at this time revealed the deadbolt lock required a key to lock or unlock it.

An interview was conducted with Employee A at 1:15 pm on . When asked about the front door lock, she stated none of the resident had keys to the front door. She said she kept the keys on her person. Employee A said she kept the deadbolt locked because Resident #3 could "get away" if the front door was not locked. Employee A acknowledged the key lock was not an appropriate substitution for supervision for Resident #3.

This surveyor exited the facility at 1:25 pm, and returned to the facility at 2:00 pm on . Employee A came to answer the door, but was unable to unlock it. She was observed to walk away, walk across the kitchen, and return with the keys. Using the keys, she unlocked the deadbolt, and opened the door.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation and interviews with staff, the facility failed to ensure the right to a safe living environment in the event of an emergency requiring evacuation for 6 of 6 residents (Residents #2, #3, #4, #5 and #7) by utilizing a key-operated front door lock to prevent 1 of 6 sampled residents (Resident #3) from exiting the facility unsupervised.

The findings included:

An unannounced follow-up survey was conducted at 12:15 pm on . Employee A, Caregiver, came to the front door; however, she was unable to unlock the door to permit this surveyor entry. Through the window next to the door, she was observed to walk across the kitchen, and return with a set of keys. Using the keys, she was able to unlock the door's deadbolt lock.

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An observation of the interior panel of the front door at this time revealed the deadbolt lock required a key to lock or unlock it.

An interview was conducted with Employee A at 1:15 pm on . When asked about the front door lock, she stated none of the residents had keys to the front door. She said she kept the keys on her person. Employee A said she kept the deadbolt locked because Resident #3 could "get away" if the front door was not locked. Employee A acknowledged that in the event of an emergency, the residents would not be able to safely exit the building through front door should she become , .

This surveyor exited the facility at 1:25 pm, and returned to the facility at 2:00 pm on . Employee A came to answer the door, but was unable to unlock it. She was observed to walk away, walk across the kitchen, and return with the keys. Using the keys, she unlocked the deadbolt door and opened the door.

Class III

0053 Medication - Administration

Based on observation, resident record review, and staff interview, the facility failed to ensure a staff member licensed to administer medications was available to administer medications in accordance with a health care provider ' s order to 1 of 1 sampled residents identified as requiring medications administered (Resident #2), out of a total of 6 sampled residents whose health assessments were reviewed.

The findings included:

An observation of Resident #2 was conducted at 12:15 pm on . She was seated in a wheelchair, and was being fed by Employee A, Caregiver. At no time, did the resident attempt to feed herself.

A record review for Resident #2 revealed an AHCA 1823 (Resident Health Assessment) signed by a physician on . Resident #2's medical diagnoses were not listed on the form; however, the examiner did note that this patient could be disoriented to time and situation. Under the section asking

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what nursing/treatment/ , , services were required for Resident #2, the physician noted "Needs medication administration". Page 4 of the assessment listed the following medications for Resident #2: , (an anti-depressant), , , (a medication used to reduce the risk of and), , (treats high ,), (anti-depressant) and (helps prevent). Section B on page 4 of the assessment asked if the individual needed help with taking her medication. The examining practitioner marked the box that Resident #2 needed her medications administered.

An interview was conducted with Employee A at 1:08 pm on . She confirmed she gave Resident #2 her medication by placing it directly into her mouth. She did not realize a nurse was required for medication administration, and she confirmed she was not a nurse.

Class III

0077 Staffing Standards - Administrators

Based on resident and facility record reviews, and staff interview, the Administrator failed to exact supervision and operational direction over the facility including the management of all staff and the provision of appropriate care to all residents as required by Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. The Administrator repeatedly failed to obtain completed AHCA 1823s (Resident Health Assessment) from a licensed health care practitioner for 6 of 6 sampled residents (Residents #2, #3, #4, #5, #7 and #8). The Administrator repeatedly failed to maintain an accurate and up-to-date admission and discharge log that reflected the daily facility census, .

The findings included:

1. A record review for Resident #2 found a Resident Health Assessment dated . The examining practitioner failed to list a medical diagnosis or history for this resident. The section asking what level of assistance Resident #2 required for the self-administration of her medication stated she required her medications to be administered. Section 3, which is required to be completed by the administrator to list the services provided to the resident by the facility was left blank. Photographic evidence was obtained.

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Record review for Resident #3 revealed an AHCA 1823 dated and signed by the examining practitioner on . The section listing physical and sensory limitations was left blank. The section asking for evaluation of the resident's and behavioral status was blank. Photographic evidence was obtained.

Record review for Resident #4 revealed an AHCA 1823 dated . The examining practitioner's license number was illegible. There was no telephone number or address of the examiner listed. Section 3, which is required to be completed by the administrator to list the services provided to the resident by the facility. was missing entirely. Photographic evidence was obtained.

Record review for Resident #5 revealed an AHCA 1823 that was not dated, but had been signed by a physician. The physician failed to list any physical or sensory limitations, nursing, treatment or service requirements, or special precautions, if any. He also failed to indicate if Resident #5 required 24-hour nursing or care. Photographic evidence was obtained.

Record review for Resident #7 revealed an AHCA 1823 signed by the examining practitioner on . The sections on the assessment asking to list physical or sensory limitations or special precautions was blank There was no prescribed diet order. Section 3, which is required to be completed by the administrator to list the services provided to the resident by the facility. was missing entirely. Photographic evidence was obtained.

Record review for Resident #8 revealed an AHCA 1823 signed by the physician on . Section 3, which is required to be completed by the administrator to list the services provided to the resident by the facility. was blank. Photographic evidence was obtained.

An interview was conducted with Employee A (caregiver) at 1:08 pm on . She reviewed the health assessments and confirmed the missing documentation for Residents #2, #3, #4, #5, #7 and #8, and stated she would notify the Administrator. She confirmed she was not a nurse, and that Resident #2 required her medications administered directly into her mouth. She did not know a licensed nurse was required to administer medications.

2. An interview was conducted with Employee A, caregiver, at 12:15 pm on . She stated there

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were 6 residents in the facility at the time of survey (Residents #2, #3, #4, #5, #7 and #8). Resident #6 had been discharged since the last survey, and Resident #7 had been newly admitted.

Review of the admission/discharge log revealed it had not been updated to reflect the discharge of Resident #6. He was still listed as currently residing in the facility. Resident #7, who was admitted to the facility on , was not listed on the log at all. A 3rd resident still listed on the log as residing in the facility (Resident #9) interview with Employee A at 12:55 pm. Photographic evidence was obtained.

An interview was conducted with Employee A at 1:08 pm on . She reviewed the admission and discharge log, and confirmed it was not up-to-date, and was not an accurate reflection of who currently resided in the facility. She stated she would notify the Administrator.

These findings were previously cited in the original complaint survey on , and again at the follow-up survey conducted on .

Class III

0160 Records - Facility

Based on observation, facility record review and staff interview, the facility failed to maintain an accurate and up-to-date admission and discharge log that reflected the date of admission, the facility or place from which the resident was admitted, date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged for 2 residents who had been discharged from the facility (Residents #6 and #9), and for 1 recently admitted resident (Resident #7).

The findings included:

An interview was conducted with Employee A, caregiver, at 12:15 pm on . She stated there were 6 residents in the facility at the time of survey (Residents #2, #3, #4, #5, #7 and #8). Resident #6 had been discharged since the last survey, and Resident #7 had been newly admitted.

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Review of the admission/discharge log revealed it had not been updated to reflect the discharge of Resident #6. He was still listed as currently residing in the facility. Resident #7, who was admitted to the facility on , was not listed on the log at all. A 3rd resident still listed on the log as residing in the facility (Resident #9) interview with Employee A at 12:55 pm. Photographic evidence was obtained.

An interview was conducted with Employee A at 1:08 pm on . She reviewed the admission and discharge log, and confirmed it was not up-to-date, and was not an accurate reflection of who currently resided in the facility. She stated she would notify the Administrator.

This was previously cited in the original complaint survey on , and again at the follow-up survey conducted on .

Class III