STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968026	**05/19/2017**
NAME OF PROVIDER OR SUPPLIER **LESLY LEISURE LIVING III**	STREET ADDRESS, CITY, STATE, ZIP CODE **8080 NW 51ST STREET** **LAUDERHILL, FL 33351**	

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

0000 - Initial Comments

An unannounced standard biennial re-licensure survey was conducted on at Lesly's Leisure Living III, License # 12018. The facility had deficiencies found at the time of the visit

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

Based on observation and interview, Employee #A failed to utilize proper hand hygiene between residents while providing assistance with self administration of medications. This was evidenced by employee failure to sanitize her hands between residents for 3 of 3 sampled residents (Resident #2, #3 and #6) during medication assistance.

The findings include:

In an observation of medication pass on beginning at 8:54 AM Employee #A was observed assisting Residents #2, #3 and #6 with their medications. Employee # A was not observed to wash or sanitize her hands prior to collecting the prescribed medications for each resident and failed to sanitized her hands between each of the resident's medication assistance. Employee # A was observed touching the residents' clothes, soiled breakfast dishes and hands between assistance.

In an interview with Employee #A on at 10:30 AM, she acknowledged she failed to sanitize her hands between each resident.

In an interview with the Administrator on at 2:00 PM she stated that proper hand hygiene should be performed by staff who conduct assistance with self administration of medications.

Class III

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

Based on observation, interview and record review the facility failed to ensure staff (Employee # A) followed appropriate procedures with assistance with self-administration of medications. This was evidenced by Employee #A's failure to read the medication label to Residents # 2 and #3 during their morning assistance with self administration of medications.

The findings include:

In an observation of medication pass on from 8:54 AM to 9:05 AM, Employee # A was assisting Residents #2 and #3 with self-administration of medications. Resident # 2 received

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, 0.5 mg, 20 mg, 50 mg and 10 mg and Resident #3 received , 100 mg, Meloxican 7.5 mg , , DR 50 mg, , 25 mg, XR 25 mg, , 81 mg, 25 mg , , , , /HCTZ -5/6.25 mg and . Employee #A did not read the medication labels or tell the residents which medications there were taking. She simply handed a cup with the medications to the resident to swallow.

In an interview with Employee #A on at 10:30AM she stated that she was trained to read aloud the prescription labels to the resident prior to assisting with self administration of medications. She stated that she forgot to follow the procedure.

During the exit interview on at 2:00 PM the Administrator and Assistant Administrator acknowledged the deficiencies. The Administrator stated Employee #A must have been nervous and forgot the proper procedure when assisting residents with self admnistration of medications.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to ensure 1 of 3 employees (Employee# A) had a current health statement indicating freedom of ( ) signed by the health care provider on an annual basis.

The findings include:

Record review was conducted on of Employee #A's personnel file which indicated the home health aide did not have a current annual health care provider statement documenting that the employee was free of signs and symptoms of . The record indicated the last examination was conducted on .

In an interview with Employee #A on at 12:30 PM she stated that she had not visited the health care provider for the required annual testing.

In an interview with the Administrator on at 2:00 PM she stated that arrangements would be made immediately to complete the required testing for Employee #A.

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0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on interview and record review, the facility failed to ensure that all staff who are in the facility alone were trained in First Aid and ( ).This was evidenced by no written documentation of required training for first aid for 1 of 3 sampled employees, (Employee #A) and expired training for - , , ( ) for 1 of 3 sampled employees, (Employee #A).

The findings include:

Review of the facility , 2017 staffing schedule indicated that Employee's #A, #B and #C where schedule to be on duty alone at the facility at times. Employee #A was assigned to work 7 AM-7 PM, Employee #B was assigned to work 7 PM-7 AM and Employee #C was assigned to work the 24 hour shift on the weekends.

Record review of Employee #A's personnel file indicated no documentation of the completion of the first aid training requirement. The file indicated that Employee #A had completed a training course in , valid thru . In an interview with Employee #A on at 12:30 PM she stated that she had not completed the required update training or the first aid course.

In an interview with the Administrator on at 2:00 PM she stated that Employees #A, #B and #C are assigned to work at the facility by themselves at times and they required current and first aid training. She stated that she was unaware that Employee #A's file did not contain any documentation of the required first aid training. Additionally she stated that she was unaware that Employee #A had not completed the required update training. She stated that she would immediately schedule the employee for the required trainings.

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 employees providing assistance with self administration of medications have completed the required annual training. This was evidence by the failure to maintain documentation of annual medication training for 1 of 3 sampled employees, (Employee #A) who provided assistance with medications at the facility.

The finding include:

In an observation of medication pass on starting at 8:56 AM, Employee #A was observed to

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provide assistance with self administration of medications for 3 of 6 residents currently living at the facility.

Review of the facility , 2017 staffing schedule indicated that Employee #A was scheduled daily to work at the facility alone from 7 AM to 7 PM.

Review of Employee #A's personnel file on revealed a certificate indicating that Employee #A last received the required medication training on .

In an interview with Employee #A on at 10:30 AM she stated that she had not completed the required annual medication training. Employee #A stated that she is routinely alone at the facility and was responsible to provide medications to the residents.

In an interview with the Administrator on at 12:30 PM she stated that she was unaware that Employee #A had not completed the required medication training update. She stated that she would schedule the employee to attend the required training and would be available to perform the medication pass herself until Employee #A has completed the training.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review the facility failed to file an incident report within 1 business day after the occurrence of an adverse incident for 1 of 1 sampled residents (Resident #5) related to an allegation of .

The findings include:

In a phone interview with Resident #5's legal representative (POA) and long time friend on at 10:30 AM, she stated that Resident #5 had lived with her until , 2017 when he was admitted to the facility due to a decline in his mental status and she was no longer able to care for the resident in her home. She stated that the resident had visual and hearing , which created , for the resident. She stated that Resident #5 was alert and oriented and called her multiple times a day from his personal cell phone. She stated that she visited the resident frequently and went out on day trips/outings with him. The POA stated that she became aware of an "incident" involving Resident #5 and Employee #D that had occurred sometime in 2017 from his family member. The representative stated that she was not present at the time of the incident but was informed that Resident #5 had been speaking on his personal cell phone to a family member when Employee #D leaned into the resident, since he was

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hard of hearing, to instruct the resident on some matter and Resident #5 kicked the caregiver. His action caused Employee #D to curse and raise her voice, yelling at Resident #5. The representative stated that while this incident was occurring Resident #5's cell phone line remained open and the resident's family member could overhear the conversation. She stated that Resident #5 was very upset after the incident which prompted the family member to call the POA to obtain the Administrator's phone number. The legal representative/ POA stated that she had been notified by the facility management that Employee #D had been fired and was no longer employed at the facility. The POA stated that she felt the employee's reaction was towards the resident.

Review of the AHCA Incident report database indicated no adverse incident report had been filed by the facility regarding the incident on involving Resident#5 and Employee #D.

Review of Resident #5's medical record indicated no documentation of any incident on or after was noted in the facility progress notes.

In an interview with Employee #A, current working at facility, on at 10:30 AM she was asked about her knowledge of an incident between Resident #5 and Employee #D, she stated that she was aware of the incident but had no specific details. She stated that she was employed at the facility when the incident had occurred. She stated that Resident #5 had confided in her on numerous occasions, and he indicated that there was a " mean employee" who no longer worked at the facility. Employee #A stated that Resident #5 expressed that he was happy and calmer since Employee #D had left.

In an interview with the Administrator and Assistant Administrator/ owner on at 1:00 PM they were questioned about an incident involving Resident #5 and Employee #D which occurred in 2017. The Assistant Administrator stated that he recalled an incident on when he received a call from Employee #D informing him that Resident #5 had became very agitated when she attempted to supervise him while he was ambulating alone without his walker. The Assistant Administrator stated that he was unsure of the exact time of the incident but he recalled it was after lunch, around 1-1:30 PM on . He stated that when he arrived at the facility approximately 15 minutes later, everything appeared calm and Resident #5 was not agitated. The Assistant Administrator stated when he arrived Resident #5 appeared not to have been physically injured, was calm but refused to talk about the incident with him. He stated that he interviewed Employee #D about the incident and was informed that Resident #5 became very agitated when Employee #D was instructing the resident not ambulate alone to the . He stated that while discussing the incident with Employee #D, and expressing his expectations for proper resident care, she informed him that she could no longer work at the facility and resigned on the spot. He stated that he had not completed or filed any incident report with the Agency or with the Department of Children and Families. He stated that he had made no documentation of his

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investigation regarding the incident between Resident #5 and Employee #D. He confirmed that Employee #D had returned to work at the facility on and abruptly resigned on after he questioned her about the incident.

Class III

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

Based on observation, interview and record review, the facility failed to maintain an employee roster with the employment status of all employees of the facility within the background screening (BGS) clearinghouse.

The findings include:

A record review of the employee roster for the facility on the Agency for Health Care Administration Care (AHCA) Provider Background Screening Clearinghouse website was conducted on at 2:47 PM. No employees were listed under the employee roster section.

Review of the facility staffing schedule for , 2017 indicated there are 3 care staff scheduled to work at the facility, along with the facility owner and Administrator.

In an interview with the Administrator and Owner/Assistant Administrator on at 2:48 PM they stated that they were not aware of the employee roster on the Background Screening Clearinghouse website and the requirement to maintain the employee roster. They stated that they would make the necessary corrections.

Unclassified