STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968835	**04/27/2017**
NAME OF PROVIDER OR SUPPLIER **PINEWOOD ESTATES ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **4055 PINEWOOD RD** **MELBOURNE, FL 32934**	

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

0000 - Initial Comments

6/6/17-AMENDED STATE FORM

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The re-licensure survey with Limited Mental Health (LMH,) Limited Nursing Services (LNS,) and Extended Congregate Care (ECC) was conducted on April 27, 2017. Pinewood Estates Assisted Living Facility, license #12678, had deficiencies at the time of the survey.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on resident record review and interview the facility failed to ensure that the AHCA Health Assessment form 1823 was completed entirely by the healthcare provider for 1 of 2 sampled residents (#4).

Findings:

Resident #4's record review revealed an AHCA 1823 Health Assessment form dated with omission of relevant information and information required by the healthcare provider below:

1. Page 2, question 4 "pose a danger to self or others" was left blank & not answered.
2. Page 4, question B "does individual need help with taking his or her medications (meds)" was left blank & not answered. In addition, what type of assistance with medications required was not marked in the appropriate box.

On 4/27/2017 at 3 PM, an interview with staff A, who reviewed #4's AHCA1823 Health Assessment form and confirmed the findings.

Class III

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

Based on observations, record reviews, and interviews the facility failed to ensure the unlicensed staff who assisted 1 of 1 sampled residents (#4) with self-administration of medications followed the correct procedure.

Findings:

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Observations made during the medication pass for resident #4 on at 5:15 pm revealed that while standing at the medication cart, staff A, an unlicensed caregiver, removed the medication cards from the cart, popped the pills into a medicine cup, and placed the medication cards back into the cart. She approached resident #4, who was seated at the dining room table, and handed her the medication. Resident #4 took the medication without assistance.

On 4/27/17 at 5:30 pm, staff A confirmed the findings.

Class III

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

Based on observations, record reviews, and interview the facility failed to ensure the Medication Observation Record (MOR) for 1 of 2 sampled residents (#5) contained all of the required information and failed to ensure the MOR was updated each time the medication was given to 1 of 2 sampled residents (#4.)

Findings:

1. A review of the April 2017 MOR for resident #5 revealed entries for 5-325 milligrams (mg,) , 100 mg, 37.5 mg, 25-100 mg, 5 mg, 0.25 mg, 10 grams (gm) per 15 milliliters (ml), 10 mg, 81 mg, 2.5 mg, 40 mg, 100 mg, 50-8.6 mg, 325 mg, 3 mg 5 mg 50-200 mg, and 220 mg. The entries did not contain the route of the medications.

An entry for did not contain the strength or route of the medication.

2. Observations made during the medication pass for resident #4 on at 5:15 PM revealed that while standing at the medication cart, staff A, an unlicensed caregiver, removed the medication cards from the cart, popped the pills into a medicine cup, and placed the medication cards back into the cart. She approached resident #4, who was seated at the dining room table, and handed her the medication. Resident #4 took the medication without assistance.

Staff A did not immediately sign the MOR after the medication was given to resident #4.

A review conducted on 4/27/17 at 5:25 PM revealed the April 2017 MOR for resident #4 contained entries for 20 mg, 2.5 mg, 1000 micrograms (mcg,) 600 mg,

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800 mg 750 mg, 300 mg, 150 mg, 15 mg, 40 mg, 135 mg, 25 mg, 75 mcg, 65 mg, and HCL 60 mg. All of these medications were scheduled to be given in the AM and the MOR reflected that these medications were not signed as given on

On 4/27/17 at 5:30 PM, staff A confirmed the above findings and said she gave resident #4 her medications on the morning of but she had not signed the MOR.

Class III

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

Based on personnel record reviews and interview the facility failed to ensure that 2 of 4 personnel records (A and B) contained documented evidence of a negative Tuberculosis (TB) examination on an annual basis.

Findings:

Personnel record review for staff B revealed she was hired on 11/01/15 in the capacity of a certified nursing assistant. Her record contained a freedom from communicable disease statement dated 5/20/15. There was no evidence of a negative TB examination in 2016.

Staff A's personnel record review revealed last read tuberculosis (TB) examination was on 12/17/2015, and no documentation of the annual 2016 tuberculosis (TB) examination was completed. Date of hire 12/17/2015.

On 4/27/2017 at 3:30 PM, an interview with staff A, who stated that she completed the TB test but was not able to locate it at this time and confirmed the finding.

Class III

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

Based on personnel record reviews and interview the facility failed to ensure that 1 of 3 unlicensed staff (B and Administrator) who provided assistance with the resident's medications, received the annual 2 hour update on providing assistance with self-administered medications and safe medication practices in

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an Assisted Living Facility (ALF).

Findings:

1. Personnel record review for Staff B revealed a certificate of completion dated 11/11/15 for 8 hours of training on providing assistance with self-administered medications. There was no documented evidence Staff B received the required annual 2 hour update in 2016.

2. Personnel record review for the administrator revealed a certificate of completion dated 4/14/16 for 2 hours of training on providing assistance with self-administered medications. There was no documented evidence the administrator received the required annual 2 hour update in 2017.

During an interview with staff A on 4/27/16 at 5:45 pm, she provided no explanation.

Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(6) FAC

Based on personnel record reviews and interview the facility failed to ensure the person responsible for the facility's food service (administrator) received the required annual 2 hours of continuing education.

Findings:

Personnel record review for the administrator, identified as the person responsible for the facility's food service, revealed a certificate of completion in topics pertinent to nutrition and food service in an Assisted Living Facility that was dated 4/26/16. There was no evidence the administrator received the required 2 hours of continuing education in 2017.

During an interview with staff A on 4/27/17 at 5:45 PM, she did not provide an explanation.

Class III

0090 - Training - Do Not Resuscitate Orders - 58A-5.0191(11) FAC

Based on personnel record reviews and interview, the facility failed to ensure that 1 of 4 sampled staff (B) received the required in-service training on the facility's policies and procedures regarding Do Not Resuscitate Orders (DNROs) within 30 days of hire.

Findings:

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Personnel record review for staff B, a certified nursing assistant, revealed a hire date of 11/01/15.

There was no evidence to indicate staff B received in-service training on the facility's policies and procedures regarding DNROs, as required.

On 4/27/17 at 5:30 PM, staff A did not offer an explanation.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on facility's admission and discharge log review and interview, the facility failed to ensure residents were listed on the admission/discharge log for 1 of 5 sampled residents (#2).

Findings:

The facility's admission and discharge log was not documented or not updated with required resident #2's information including name & date of admission into the facility of

On 4/27/2017 at 10 AM, the legal assistant for the administrator updated the facility's admission and discharge log with resident #2's information.

On 4/27/2017 at 5:45 PM, during exit interview staff A confirmed the finding.

Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on resident record review and interview the facility failed to ensure a completed resident contract agreement for 1 of 2 sampled residents (#4).

Findings:

Resident #4's record review revealed an incomplete contract dated missing provisions listed below:

1. Facility's refund policy that conform to Section 429.24(3), F.S;
2. 45-day notice of discharge;

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3. 30 day advance notice of rate increase; and
4. Residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C. every 3 years thereafter, or after a significant change.

On 4/27/2017 at 2 PM, an interview with staff A, who confirmed the findings.

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on personnel record reviews and interview, the facility failed to ensure staff who had direct contact with mental health residents in a licensed limited mental health facility, received the required minimum 6 hours of training within 6 months of employment for 1 of 3 staff (A.)

Findings:
Staff A's personnel record review revealed no documentation of the required minimum 6 hours of specialized training in working with individuals who have a mental health diagnosis provided or approved by the Department of Children and Families (DCF) required to be taken within 6 months of employment in a limited mental health facility. Date of hire 12/17/2015.

On 4/27/2017 at 3:30 PM, an interview with staff A, who stated that she was not able to locate her certificate and confirmed the finding.

Class III