STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966519	**05/24/2017**
NAME OF PROVIDER OR SUPPLIER **INDIGO PALMS AT MAITLAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **740 NORTH WYMORE ROAD** **MAITLAND, FL 32751**	

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

0000 - Initial Comments

Complaint investigation #2017002603 was conducted on , and . In addition, Complaint investigations #2017003523, and #2017003875 and revisits for Complaint investigations #2017003496, #2017000327, # 2016014670 and # 201613957 were conducted on the same date. Indigo Palms at Maitland Assisted Living facility License #10704, had deficiencies pertaining to #2017002603 at the time of the visit.

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

Based on observation, record review and interview, the facility retained a resident who required total care with all Activities of Daily Living (ADLs) and was not receiving hospice care for 1 of 31 sampled residents (#20).

Findings:

On at 10:05 AM, resident #20 was observed lying in his bed in the memory care unit, eyes closed. The caregiver stated resident #20 required total assistance with his ADLs, including transfers. She said he did not receive hospice services. The caregiver touched his arm and spoke his name. He did not open his eyes and he did not respond, either physically or verbally.

Review of the record for resident #20 revealed the most recent Health Assessment (1823) was dated . The 1823 documented diagnoses of , , and Chronic Kidney . Total care for all ADLs was documented, as well as being noted under "Physical limitations & Nursing Service requirements" on page 1 of the form. He was documented as being "Bedridden."

Resident #20 had been receiving hospice care until the hospice provider discharged him on . An order for a hospice consult from another provider, dated , was reviewed and noted to state the resident was "not eligible for hospice services."

A 45-day discharge notice dated was reviewed. The resident's family was notified that the resident required a higher level of care than they could provide and he needed to move out on or before , 2017. The letter was sent by certified mail and received by the family on . Resident #20 still resided in facility on .

When asked what the facility did to assist the family in relocating the resident, Staff V (interim resident care coordinator) provided a letter addressed to the "AHCA surveyor," dated and signed by the

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business office manager that detailed what happened on what dates. There was no documentation to show the facility provided any assistance to the family, suggested possible nursing homes or did anything to help the resident with placement in a higher level of care.

As of , the resident was past the deadline for the 45-day notice of discharge and was still residing in the memory care unit of the facility during the survey dates of , 22-24, 2017.

Class III

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

Based on observation, record review and interview the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training and preparation and allowed unlicensed staff to administer medications to 1 of 26 (#29) and to apply and remove ankle leg brace and compression hose for resident #17.

Findings:

1. Observations on at 1:30 PM in the secure memory care noted that staff M assisted residents with self-administration of medications. The staff stated she was a "med tech" (Term used for an unlicensed staff who assist residents with self-administration of medication).

Observations of the medication pass noted that staff M took the individual pill from the medication cart, signed the MOR, took water and the pill to Resident #29. The resident sat in a wheelchair in the dining . He was and attempted to feed himself. She told him "I have your 2 o'clock medication". She attempted to have the resident hold the cup with the pill. He was unable to; was sleep/sluggish. She took the cup, brought it to the resident's mouth, and gently tilted his head back as she tried to put the pill in his mouth. He did not take the pill, so she tried again in the same manner. She observed him swallow the pill and she was finished with that medication pass.

In an interview with staff, V on at 2:30 PM who stated the staff needed more training

Observations on at 10:50 AM revealed resident #17 was sitting in his wheel chair. Resident

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#17asked if the Agency for Health Care Administration (AHCA) staff could apply his compression hose and leg brace. He was informed at the time that the ACHA staff could not apply the compression hose and leg brace and he needed to call the staff. He press his call light and three staff arrived. Resident #17 told the staff what he needed.

Further observations revealed Staff CC kneeled down and placed the compression hose on and then she placed the ankle brace on his left side.

Staff CC was asked at the time if she was a Nurse or Certified Nursing Assistant (CNA). Staff CC said she was not.

On at 11 AM, Resident #17 said he could not apply and remove the compression hose and the ankle brace himself. He said the staff would apply the compression hose on the Morning shift and the 3-11 PM staff would remove them.

Record review for Resident #17 revealed a Physician Order Sheet signed by the health care provider on noted Compression Stockings apply to lower extremities in morning, remove at bedtime.

A health care provider order dated noted Left foot ankle foot -apply daily.

On at 1 PM, Staff V (the interim resident care coordinator) said she thought unlicensed staff could apply and remove the compression hose. She was not aware the unlicensed staff were applying and removing the brace.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on review of staff schedules, time sheets and interview, the facility failed to maintain accurate staff work schedules for hours worked.

Findings:

Review of the staff schedules and time sheets provided by the facility, revealed the staff schedules were not accurate.

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Some examples were as follows:
Staff D the time sheet noted that she worked on . . . . . - . . . . . and she was not listed on the schedule.
Staff F the time sheet noted that she worked on . . . . . - . . . . . and she was not listed on the schedule.
Staff AA-the scheduled noted she was off on . . . . and . . . . . and worked on . . . . from 2 PM-10 PM. The timesheet noted she worked on . . . . from 1:54 PM-10:15 PM and on . . . . from 1:56 PM-10:02 PM and she did not clock in on . . . . . On . . . . . , the schedule noted she worked from 3 PM- 11 PM, the time she noted she arrived to work at 10:07 AM and worked until 11:15 PM.
Staff EE-The timesheet noted she worked on . . . . from 9:53 PM-6:45 AM and she was not listed on the schedule
Staff FF-the time sheet noted she worked on . . . . from 10:42 PM-6:45 AM and she was not listed on the schedule
Staff W worked on . . . . from 9:45 PM-6:17 Am and she was not listed on the schedule
Staff P-the schedule noted she worked on . . . . from 10 PM-6 AM, the time sheet noted she did not clock in.
Staff Q-the schedule noted she did not work on . . . . the time she noted she work on . . . . from 10:44 PM-7:33 AM and on . . . . from 10:44 PM-7:20 AM.
Staff II-the scheduled noted she was off on . . . . and . . . . , the time sheet noted she worked on . . . . . from 1:48 PM-10:13 PM and on . . . . from 1:54 PM-10:11 PM
Staff MM-the time sheet noted she worked on . . . . from 6 AM-2:10 PM, ... from 6:03 AM-2:36 PM, on . . . . from 6:06 AM-2:38 PM, on . . . . from 5:57 AM-2:17 PM and she was not listed on the schedule
Staff NN-the time sheet noted she worked on . . . . from 9:30 AM-11:36 AM, ... from 10:05 AM-10:51 AM, ... from 2:45 PM-10:55 PM, ... from 3:52 PM-7:05 AM, ... from 10:48 PM-7 AM, ... from 10:47 PM through 7:09 AM. The time she for . . . . did not have a start time but had a clock out time of 7:04 AM. She was not listed on the schedule
Staff Q-the schedule noted she did not work on . . . . . the time she noted she work on . . . . from 10:44 PM-7:33 AM and on . . . . from 10:44 PM-7:20 AM.
Staff HH-the time she noted she worked on . . . . from 1:45 PM-10:05 PM and she was not listed on the schedule as working this day.
Staff OO-the time sheet noted she worked on . . . . . from 9:07 AM-3:28 PM, on . . . . from 3:06 PM-11:11 PM and she was on the schedule for these days. The schedule noted she worked on from 3-11 PM and she did not clock in.
Staff JJ-The time sheet noted she worked on . . . . 2PM-10 PM and she was not listed on the schedule.
Staff KK Worked on . . . . from 2:02 PM-10:04 PM, ... from 9:55 PM-6:10 AM, ... from 1:57 PM-10:05 PM and . . . . from 1:58 PM-10:45 PM and she was not listed on the schedule.

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On at 12:45 PM, the interim resident care coordinator said she was not aware that the schedule was to be changed that reflected the actual hours the staff worked. She said the employees not listed on the schedule had possibly replaced employees that called out.

On at 1 PM, the interim resident care coordinator was asked to provide a staff schedule for the nurses that worked at the facility. She said at the time that there was no schedule maintained for the nurses because they worked the same hours and times weekly. She said the nurses knew what time they were to work. Staff JJ, KK were License Practical Nurses.

Class III