STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910384	R 05/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL CARE A.C.L.F., INC.	**5081 DUNN ROAD** **FORT PIERCE, FL 34981**

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

0000 - Initial Comments

An unannounced revisit to the licensure complaint #2017000005 was conducted on at Royal Care ACLF, Inc., License #7462. The facility had uncorrected and a new deficiency at the time of the revisit.

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

Based on interviews and record review, the facility failed to ensure unlicensed staff who assist residents with self-administration of medications applied required standards by allowing an unlicensed staff member (Staff B) to administer via syringe to 2 of 2 residents receiving injections (Residents #7 and #8).

The findings included:

During review of Resident #7's 2017 Medication Observation Record (MOR) revealed an order for " 10 ML, inject 70 units daily" was discontinued. A new order, dated , for Flextouch 200 units/ml, inject 40 units every day, was listed.

Review of Resident #8's MOR reveals order for Flexpen 15 ml, inject 70 units twice a day (8 AM and 5:00 PM), dated .

During interview conducted on at 12:45 PM with the Staff B regarding injections, she stated Staff would dial the dosage ordered on the pen, and the residents would inject themselves. Staff B expressed her disagreement with not being allowed to administer injections, as she repeatedly stated, "I am a doctor." Staff B stated that she would "do what was necessary to take care of the residents", even if it was not in agreement with state regulations. Staff B confirmed she was not a licensed doctor within the state of Florida.

At 4:30 PM, during observation of medication pass, Staff A stated that Resident # 8 did not get her until the evening before bed, even though the MOR documented Resident #8 was to receive her at 5 PM (see A0056 for additional details)

During interview with Staff B on at 4:45 PM, it was discovered that neither Resident #7 or Resident #8 are receiving with flexpen at this time. These residents are still being provided their via syringe being drawn by Staff B. Staff B stated that she anticipated starting use of the flexpen at the beginning of .

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The Administrator was informed on at 5:05 PM that unlicensed staff cannot prepare syringes for injection and/or inject residents. If a resident could not prepare and give their own injections with a syringe, or the facility could not arrange for a 3rd party source (Home Health Nurse) to give residents their injections, then Dependent residents would not be appropriate for their facility.

Class III

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

Based on medication record reviews and staff interview, the facility failed to maintain a daily medication observation record (MOR) with:
1) accurate listing of medications being provided for 2 of 9 residents (Residents #7 and #8)
2) accurate time the medications is being provided for 1 of 9 residents (Resident #8);
3) information regarding known drug for 7 of 9 residents (Residents # 2 - #7, and # 11)
4) staff initials placed on the MOR to immediately update the each time the medication is offered/received.

The findings included:

1) During review of Resident #7's 2017 Medication Observation Record (MOR) revealed an order for " 10 ML, inject 70 units daily" was discontinued. A new order, dated , for Flextouch 200 units/ml, inject 40 units every day, was listed.

Review of Resident #8's MOR reveals order for Flexpen 15 ml, inject 70 units twice a day (8 AM and 5:00 PM), dated .

On at 4:45 PM, it was discovered through interview with Staff B that neither Resident #7 or Resident #8 are receiving the with the flexpen, as listed on the MOR, at this time. These residents are still being provided their via syringe being drawn by Staff B. She stated they were going to start the flexpens at the beginning of . It was also confirmed that Resident #8 is currently not receiving , but she is receiving .

2) At 4:30 PM, during observation of medication pass, Staff A stated that Resident # 8 did not get her until the evening before bed. I asked her why it was noted on the MOR that Resident #8 was to get her at 5 PM. Staff D directed me to speak with Staff B. During interview with Staff B at 4:45 PM, she explained that the timing on the was changed because Resident #8 did better with receiving her at before bedtime. Staff B was asked to provide orders by the Resident's physician to show that the physician agreed to the change in timing of the . Staff B could not produce any

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orders.

3) The MORs for Residents #2, #3, #4, #5, #6, #7, and #11 do not contain information as to the known drug [illegible] of these residents.

4) The following residents' MOR were missing staff initials on all medications received at 8 PM on [illegible] - Resident #4, #7 (Metroprolol 12.5 mg)
The following residents' MOR were missing staff initials on all medications received at 12 PM on [illegible] - Resident #5
The following residents' MOR were missing staff initials on all medications received at 5 PM on [illegible] - Residents #1, #2, #3, #5, #7, #8
The following residents' MOR were missing staff initials on all medications received at 8 PM on [illegible]: Residents #1, #2, #3, #4 ([illegible] 50 mg only), #5 (all medications except for [illegible] 5 mg), #6, #7, #8, and #10
Resident #10's MOR was also missing staff initials on 5 PM dose of [illegible] 850 mg at 5 PM and 8 PM on [illegible] and 5. [illegible].

On [illegible] at 1:45 PM, when asked why the initials were missing, Staff B stated, "I had to leave... I can't be here all the time." When asked who gave the medications, she responded that staff had given the medications at the appropriate time. Staff B explained that she removes the sealed bubble of prepackaged medications received from the pharmacy, checks it with MOR, and places the bubble inside small cup labeled with resident's name, she would then initial the MOR. The staff passing medications will take the bubble, with the names of the medications to the resident and pop out the medications and give them to the resident. Staff B was informed that the staff who provides the residents with the medications must be the staff that initials the MOR, and the initials must be documented immediately after the medication is offered.
Staff B initialed the blank spaces on the MOR, as indicated above, on [illegible].

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

The facility failed to follow physician orders for the provision of medications prescribed, and at the time the medications were to be provided, for 3 of 12 residents (Residents #7, #8 and #5).

The findings included:

1) During review of Resident #7's [illegible], 2017 Medication Observation Record (MOR), an order for

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" 10 ML, inject 70 units daily" was discontinued. A new order, dated , for Flextouch 200 units/ml, inject 40 units every day, was listed.

Review of Resident #8's MOR reveals order for Flexpen 15 ml, inject 70 units twice a day (8 AM and 5:00 PM), dated .

At 4:30 PM, during observation of medication pass, Staff D stated that Resident # 8 did not get her until the evening before bed. I asked her why it was noted on the MOR that Resident #8 was to get her at 5 PM. Staff D directed me to speak with Staff B. During interview with Staff B at 4:45 PM, she explained that the timing on the was changed because Resident #8 did better with receiving her at before bedtime. Staff B was asked to provide orders by the Resident's physician to show that the physician agreed to the change in timing of the . Staff B could not produce any physician orders or other documentation showing that the change of time was to be offered was appropriate for Resident #8.

On at 4:45 PM, it was also discovered through interview with Staff B that neither Resident #7 or Resident #8 were receiving with a flexpen at this time. Staff B stated that these residents are still being provided their via syringe being drawn by Staff B. She stated they were going to start the flexpens at the beginning of . It was also confirmed that Resident #8 is currently not receiving , as indicated on the MOR, but she is receiving .

2) Review of MOR for Resident #5 shows order for Lumigan Solution 0.01% , 1 drop in each eye at bedtime, dated , had not been provided at any time during , 2017. Staff B stated on at 4:45 PM, "I pay for the residents eye drops because the family won't pay. I talked it over with his doctor and it was decided that this resident doesn't need these eye drops, so we haven't been giving them." I asked Staff B to provide the doctor's order discontinuing the medication, but she could not provide such an order.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on employee record review and staff interview, the facility failed to ensure 1 of 4 staff records reviewed contained documentation showing completion of required in-service training related to Resident Rights (Staff D).

The findings included:

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On , the employee record for Staff D, whose hire date was , was reviewed. There was no certificate showing Staff D completed the required 1 hour in-service training covering the subject of Resident Rights in an Assisted Living Facility.

Interview with the Administrator on at approximately 1:30 PM confirmed the fact that Staff D did not complete the required Resident Right training within 30 days of hire.

Class III

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

Based on record review and interviews, the facility failed to maintain current employment status records in the Care Provider Background Screening Clearinghouse as required for 2 of 4 sampled Staff (Staff C and D).

The findings included:

Review of the facility's Clearinghouse records and personnel records conducted revealed Staff C (hired) and Staff D (hired), both of which are Caregivers and Medication Technician, were not added to the facility's Clearinghouse Employee Roster within 10 days of hire.

Staff D was observed provided direct care and assisting with the provision of medication to residents on . Durimg interview with Staff D on at 4:15 PM, she confirmed she does work at the facility as a resident care aide and medication technician.

Staff C was observed providing direct care to residents by the AHCA surveyor conducting the previous complaint survey on . Staff C was interviewed by the AHCA surveyor conducting complaint survey on at 11:02 AM, and Staff C confirmed at this time that she was hired several years prior and works as a Caregiver and Medication Technician.

During interview conducted with the Administrator on at 2:00 PM, he stated that he had not corrected this deficiency because he had been unclear as to what the deficiency was. He stated that he thought it was related to background screenings. The employee roster process and regulation was discussed with the Administrator at this time.

Unclassified