| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11967214** | **06/20/2017** |
| NAME OF PROVIDER OR SUPPLIER<br>**TM TENDER CARE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**9 PONDEROSA LANE**<br>**PALM COAST, FL 32164** | |

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

**0000 - Initial Comments**

An unannounced change of ownership survey was conducted at TM Tender Care (License #11336) on , 2017.

TM Tender Care had deficiencies found at the time of the visit.

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

Based on observation, record review and staff interview, the facility failed to maintain the Medication Observation Record (MOR) for 2 of 2 sampled residents. (Resident #4 and #5)

The findings include:

1. During an assistance with medication observation on at 12:25 AM, Employee A was observed assisting Resident #4 with taking his medication. Employee A was observed removing a tablet of , 10 milligrams (MG), , 600 MG and , and placing the tablets in a small cup to give to the resident.

Record review of the label on the package of the , 10 MG found directions for one tablet a day with 1:00 PM written in ink as the time to give the medication.

Record review of the package for the , 600 MG found directions to give the medication three times a day.

Record review of the label on the Hydroco/ , , 7.5 -325 MG tablet found instructions to take one tablet by mouth four times a day as needed for pain.

Record review of the most recent physician orders for Resident #4 found the orders for the , - , 325-7.5 MG tablet ever 6 hours as needed for moderate pain.

Record review of the medication observation record (MOR) for of 2017 found " , 10 MG daily" was written on the MOR. Under the days of the month there were no initials to show the medication was given during the month of . On at 12:50 PM Employee A was shown the MOR. She stated the MOR needed to be updated with the time. She then put her initials under the dates of , , and .

Further record review of the MOR found the , 600 MG had written instructions to give

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600 MG 2 X daily at 8:00AM and 8:00 PM. The 1:00 PM dose was not on the MOR. There was no evidence anywhere to show the 1:00 PM dose was given in the month of .

Record review of the 2017 MOR found the / 7.5MG/325 was listed on the MOR as " 7.5 MG/325 MG 3X daily". Further review of the MOR on at 12:25 PM found the caregiver had initialed she had given the 8:00 AM, 1:00 PM and 8:00 PM doses.

During an interview with Employee A at 12:25 PM she stated that the MOR needed to be fixed to reflect the times of the medications and that Resident #4 should only get the pain medication three times a day she did not know the label and the orders were as needed 4 times a day. During further interview with Employee A on at 1:00 PM she stated she did not write on the MOR she was giving the 1:00 PM because the MOR only had the AM and PM medication times.

2. Record review for Resident #5 found she had physician orders for 1 milligram take one tablet at the hour of sleep. The resident's physician signed the orders on . Record review of the 2017 medication observation record (MOR) found the medication was initialed as given every evening in . Record review of the MOR for 2017 found the was not listed. An observation of Resident #5's medications in the medication cart did not find the . The caregiver was asked for evidence on at 11:20 AM if the medication was discontinued. She stated she did not know. She stated they were using a new pharmacy and that she could not provide additional information.

Further record review of Resident #5's MOR found directions to give " / 5-325 MG give 1 tablet by mouth every 6 hours around the clock. *Give 1 tablet every 4 hours for pain as needed." There were times listed on the MOR of 8:00 AM, 2:00 PM, 8:00 PM and 2:00 AM. The last time the medication was annotated as given was on at 8:00 AM. The medication was not listed on the 2017 MOR. Record review of the document from the pharmacy showed the 60 tablets were received by the facility on . Observation of the bubble pack found 18 tablets were missing (Photographic evidence obtained)

Record review of the physician orders for Resident #5's found signed orders dated for / 5-325 MG found there were orders for 1 tablet every 6 hours and for 1 tablet every 4 hour as needed for pain.

Class III

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

Based on observation and staff interview, the facility failed to have a least one staff member present at all times with access to facility and resident records.

The findings include:

During an interview with the caregiver at the facility (Employee A) on at 8:15 AM, she was informed of the reason for the visit. She was asked to contact the Administrator of the facility. She gave the name of the Administrator, which was the past Administrator and past owner according to the current license of record for the facility. She was given the name of the Administrator on record and she stated that she did not know whom that was. She made a telephone call to the past owner/administrator. During a telephone interview with the past owner/administrator on at 8:20 AM she was informed that the surveyor was at the facility to do the change of ownership survey. The past owner was asked where the current new owner/Administrator was located. She stated she was in New York and that she was told that the change of ownership was not being done until . She was informed of the need for the survey and that access to the records was needed. She stated all of her employee files were locked up. She was asked if anyone else had access to the files and she stated "no". She was informed that the surveyor would need to complete the survey. She was informed that the surveyor would be in the facility for most of the day. She stated she was heading south and she was to far away to come back.

During further interview with the caregiver (Employee A) on at 8:20 AM, she was asked how long she had worked at the facility. She stated she has worked at the facility since the end of so that it has been about a month since she started. She stated she had also work at the facility in the past and had left and come back. She was asked when she had left and she stated sometime in She was not able to give a date and said maybe the third or fourth week. She was asked when she works. She stated she works 24 hours a day for 5 days in a row and then another employee takes over. She did not know employees last name or have her telephone number. She stated if there is an emergency she would call the Administrator (meaning the Past Owner). She stated the Administrator also comes over some days in the evening to help. She was asked for the employee schedule and she stated she did not have one. She was asked for the names of other employees and she had one first name to give. She was asked for contact information and she could not provide anything. She stated if there was an emergency she would contact the Administrator (Former Owner). She confirmed she did not have anyone else to contact.

Observation in the facility on from 8:15 AM unit 1:45 PM, found no evidence of an employee schedule posted anywhere or on the desk where resident records were kept.

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Class III

**0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC**

Based on observation, staff interview and record review, the facility failed to ensure the menus used by the facility were reviewed annually by a licensed or registered dietician. The facility failed to post the menu in an area easily accessible to the residents, notify residents of a change in the menu prior to the meal and failed ensure a substitution log was maintained for the 5 residents in the facility.

The findings include:

On at 8:30 AM, a stack of papers was observed on the refrigerator held in place by a magnet and the top of the icemaker system. Under weekly menu was observed under the first page. Record review of the weekly menu found it was not signed or dated.

During an interview with the caregiver at the facility (Employee A), at the time of observation she was asked if it was the menu she was using and she stated "yes".

An observation of the lunch meal on at 12:30 PM, found that with the exception of Resident #4 who wanted soup, Resident #1, #3 and #4 were served chicken, mashed potatoes, broccoli and carrots.

Record review of the menu Employee A stated she was using found the menu for the day was stewed chicken 4 ounces, herbed potato 1 cup, carrots 1/2 cup, mixed salad 1 cup, salad dressing 1 T, gelatin 1/2 cup.

During further interview with Employee A on at 12:03 PM, she was asked what she does when she substitutes something on the menu. She stated she writes it on a piece of paper and puts it on the desk for the Administrator. She was asked for the substitution lag and she stated she did not have access to it. It was in a locked drawer, and there was no evidence produced at the time of the survey that the log was being maintained.

Class III

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

Based on interview, the facility failed to maintain written records at the licensee's physical address that were readily available to the surveyor upon request.

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SUMMARY STATEMENT OF DEFICIENCIES
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The findings include:

During an interview with the caregiver at the facility (Employee A) on at 8:15 AM, she was informed of the reason for the visit to the facility. She was asked to contact the Administrator of the facility. She gave the name of the Administrator, which was the past Administrator and past owner according to the license of record for the facility. She was given the name of the Administrator on record and she stated that she did not know whom that was. She made a telephone call to the past owner/administrator. During a telephone interview with the past Administrator on at 8:20 AM she was informed that the surveyor was at the facility to do the change of ownership survey. The past owner was asked where the current Administrator was located. She stated she was in New York and that she was told that the change of ownership was not being done until . She was informed of the need for the survey and that access to the records was needed. She stated the employee files were locked up. She was asked if anyone else had access to the files and she stated "no". She was informed that the surveyor would need to complete the survey. She was informed that the surveyor would be in the facility for most of the day. She stated she was to far south and would not come back.

During further interview with the caregiver (Employee A) on at 8:20 AM, she was asked for the Admission/Discharge log. She searched the desk in the facility and could not find it. She stated that everything was locked in the desk and she did not have the key. Employee A was asked several times on from 8:20 AM unit 1:45 PM to provide information. She was asked for the substitution logs for the menu, the elopement policy and drills, the emergency management plan, the third party contract for Hospice and the employee schedule. At each request Employee A stated that everything was locked up.

Class III

**0162 - Records - Resident - 58A-5.024(3) FAC**

Based on record review and interview, the facility failed to obtain and document weights semi-annually for 1 of 2 sampled resident's (Resident #5).

The findings include:

Record review of the AHCA 1823 Health Assessment for Resident # 5 found she needs assistance with all activities of daily living and supervision with eating. Further record review for Resident #5 found most recent weight documented in the resident record was 140 pounds on .

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The findings were confirmed during an interview with the Caregiver (Employee A) on at 10:36 AM. She stated that the resident's weights could not be taken because she could not stand up properly. She stated she did not have any other weights for the resident to provide and that the facility did not keep a weight book at the time of the survey.

Class III

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

Based on record review, and staff interview, the facility failed to register and update the employee roster on the agency's background screening clearing house for the Administrator and 1 out of 1 employee's currently working at the facility. (Employee A)

The findings include:

A review was conducted of the Agency for Health Care (AHCA) background screening clearing house found the Administrator listed on the current license for the facility and Employee A was not listed on the facility's employee roster.

During an interview on at with Employee A, she stated she had been working at the facility since the end of . She staed that she did not know the exact date but it was about a month. She stated she had worked at the facility previously and had left around the third week of , of 2017.

The Administrator of the facility was not in the facility during the survey. The Administrator prior to the change of ownership was contacted by phone at entrance on at 8:15 AM. She stated she was heading south an would not be available to provide access to employee records to determine actual start and end dates of the staf.

Unclassified