STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968119	**05/23/2017**
NAME OF PROVIDER OR SUPPLIER **TERRACE AT IVEY ACRES AL**	STREET ADDRESS, CITY, STATE, ZIP CODE **3964 FLORIDA AVE** **JAY, FL 32565**	

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

0000 - Initial Comments

An unannounced licensure survey with limited nursing services specialty was conducted at The Terrace at Ivey Acres Assisted Living Facility from . . through . . . Deficient practice was identified at the time of the survey.

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

Based on record review and interview, the facility failed to ensure the health assessment, (AHCA Form 1823 Resident Health Assessment for Assisted Living Facilities), was complete for 1 of 2 sampled residents (#12).

The findings are:

Record review for sampled resident #12 revealed he was admitted to the facility on . His most recent AHCA 1823 Resident Health Assessment for Assisted Living Facilities was dated and signed by the physician on . The review revealed page 4, section B, of the AHCA Form 1823, which asked the physician to indicate whether the resident needed assistance with self-administration of medications or needed medication administration was not completed by the physician. The physician also did not indicate the type of diet the resident should have been receiving.

Interview and record review with the facility's director of nurses on at approximately 10:21 AM confirmed these findings. She stated the resident needed assistance with self-administration of medications and unlicensed staff assisted him with his medications.

Class III

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

Based on record reviews and staff interviews the facility failed to ensure all residents had a face to face medical exam, recorded on AHCA form 1823, after a significant change in condition for 1 of 2 sampled residents (#12) who was placed on hospice care.

The findings are:

Record review for sampled resident #12 revealed he was admitted to the facility on . . . . with the latest AHCA 1823, Resident Health Assessment for Assisted Living Facilities completed on . Record review of hospice notes for this resident revealed the resident was admitted to hospice services on . Further review revealed indicated that he was receiving hospice services, with the most

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recent benefit period date of to .

Interview with the Director of Nurses on at approximately 10:21 AM confirmed this is the most recent 1823, and stated she did not realize a new AHCA 1823 assessment needed to be completed to reflect the change in the resident's condition and the need for hospice care.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review, and interview, the facility failed to provide care and services to meet the needs, and failed to notify the physician of changes in condition for 2 of 2 sampled residents (#2, #12).

The findings are:

Resident #2 was observed on at 10:49 am in his , with feet , complaining of pain to bottom of his right foot, and indicated there was a large callous on his foot. Observation noted a large callous with black colored area around it. The right outer side of foot had a small dark area, and his feet were blue in color. He said no one had looked at his feet since he had been there. He indicated he bathed himself, but he did need help at times due to .
Review of his health assessment dated indicated he needed supervision with bathing, and had remarks for staff to supervise resident #2 for completion of bathing and . Attached to his assessment were orders to weigh resident #2 daily, and notify the physician if there was a 2 lb weight gain in 24 hours or 5 lbs in 48 hours. Also attached to the resident's assessment was a " Negotiated Service Plan" between resident #2, and the facility indicating resident was independent with bathing, but required oversight and set up due to . Review of weights for resident #2 revealed he was not being weighed daily per orders, or every 6 months per facility policy. His weight was 181 lbs on , no weight on , no weight on and 190 lbs on .

Interview with director of nursing on at 2:15 PM confirmed that the resident was not receiving required assistance with his showers, was not being weighed daily, and the physician had not been notified of the resident's weight gain, or the painful areas on the resident's foot.
Review of resident #12's medication observation record (MOR) for , 2017 revealed the resident was to weigh himself daily and staff were to document the weights, and notify the physician if the resident gained 3 pounds or more in 3 days. Review of resident weights showed that on the resident weighed 147 lbs, two days later on he weighed 151 lbs for a total weight gain of 4 lbs in two days.

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Interview with the director of nurses on at approximately 10:45 AM revealed that staff were to report the resident's weights to her, and then she would notify the physician of the weight gain. She was asked if she had notified the physician of these weights, and she stated "No, I did not because I did not know about them".

Class III

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC

Based on record review, and interview with residents and staff, the facility failed to coordinate care and services between the facility and the Home Health Agency for 1 of 2 sampled residents receiving home health care. (#7)

The findings are:

Review of the health assessment for resident #7, dated , indicated an order for home health services for nursing, physical , , and occupational , , . The record lacked evidence of these services. Review of the home health sign in sheet noted staff from the home health agency had been at the facility at different times. Review of the home health record in the facility lacked evidence of a plan of care for treatment and services explaining who would provide the services, and the time frames for which these services would be provided.

Interview with the director of nursing on at 10:30 am indicated this was all she had. She phoned the home health agency and had them fax over the plan of care for resident #7. She indicated the facility should have had the plan of care, and should have evidence of communication between the facility and the agency for the care of the resident.

Class III

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

Based on observation, record review, and interview the facility failed to ensure unlicensed staff appropriately provided assistance with self administration of medication for 3 of 5 sampled residents observed during medication pass observation (#13, 14 and 15).

The findings are:

On at approximately 11:39AM a medication administration observation was conducted with

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sampled staff A, an unlicensed medication technician. Observation revealed the staff placed her medication cart in front of sampled resident #13 opened . She identified the resident who was sitting in her recliner watching television. The staff was standing in the open doorway with her back to the resident at the medication cart. She told the resident she was going to get her medications. The staff removed the bottle of 1 gram/10 milliliters (ml) liquid from the medication cart and poured up 5ml. The staff then obtained an over the counter bottle of 325mg from the cart drawer and she placed two tablets in a medication cup. The staff told the resident the names of each of the the medications, then took the medications into the resident who took them with some water. At no time did the staff in the presence of the resident, read the label, or open the container, removing a prescribed amount of medication from the container, and closing the container where the resident was able to see the medications prior to taking the medications. Review of the resident's most recent health assessment by the physician revealed the resident needs assistance with self administration of her medications.

The medication pass observation continued on at approximately 11:44 AM with sampled staff A. The staff identified sampled resident #14 and then told her she was getting her Norco at that time. The staff removed the medication from the locked medication box on the medication cart, which was in the hallway. The staff punched the Norco from the packet, placed it in a medication cup and took it to the resident who took the medication with water. At no time did the staff in the presence of the resident, read the label, or open the container, removing a prescribed amount of medication from the container, and closing the container where the resident was able to see the medications prior to taking the medications. Review of the resident's most recent health assessment by the physician revealed the resident needs assistance with self administration of her medications.

On at approximately 11:37 AM an observation of a medication administration for resident #15 was conducted with sampled staff A. Observation revealed sampled staff A opening the resident's door and informing the resident she was going to get her medications. Resident #15 was observed in her next to the window in her recliner watching TV. Staff A pulled the medication cart close to the open door, but still in the hallway. She told the resident she was going to get her 5 milligram (mg) tablet and her 50mg tablet. She punched each of the medications from their packets into the medication cup with her back to the resident, who could not see the staff performing the task. She then placed the medication packs back into the medication cart and closed the drawer. She took the two pills to the resident in the medication cup, and the resident took the medication with water. At no time did the staff show the medication packs or read the label to the resident to ensure she knew what she was taking. Record review of sampled residents #15's most recent physician assessment dated indicated the resident needs assistance with self-administration of medications.

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Interview with the sampled staff A was conducted on at 12:10PM. She stated that she thought it was okay if she did not show the resident the medication card or the medication bottle, just as long as they were in view of her while doing the medication preparation.
Interview with the facility director of nurses on at 12:39 PM revealed the unlicensed staff should have taken the medications to the resident so they could see the medication packets and/or the medication bottles prior to them being placed in the medication cup so the resident was aware of the medications they were taking.

Class III

0092 - Food Service - General Responsibilities - 58A-5.020(1) FAC

Based on observation and interview, designated facility staff failed to conduct food services in a sanitary manner for 1 of 1 dining observation.

The finding are:
Observation of the noon meal service was conducted on . Staff were observed wearing gloves and disposable gowns while delivering food trays from the kitchen area to two dining , and down hallways to residents . Delivery of food trays required staff to touch doors, door knobs, tables, and residents. Upon returning to the kitchen to pick up other trays the staff did not change gloves or remove their gowns. They wore the same gloves and gowns for the entire meal.
Flies were seen in the hallways and in 2 of 2 dining areas. Three fly swats were seen lying on the dining tables while food was being served, and while residents were eating.
Interviews with the residents in 325 and 326 were conducted on at approximately 12:30 PM. Both residents stated they had fly swats, and said the flies were terrible. They indicated it had been that way for a week, and stated that staff knew about them, because they see us using our fly swats and they use them too.

Interview with the Dietary Manager on at approximately 10:15 am indicated that when staff deliver food trays, they are supposed to change their gloves and wash their hands anytime that have to touch residents or any other item.

Interview with the director of nursing on at approximately 10:45 am confirmed the situation with the flies.

Class III

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N276 - LNS - Nursing Services - 58A-5.031(1) FAC

Based on record review and interview with the director of nursing, the facility failed to conduct nursing assessments by a registered nurse or under the direct supervision of a registered nurse for 2 of 3 sampled residents receiving Limited Nursing Services (#2, #10).

The findings are:

Interview with the director of nursing on at approximately 9:20 am found the facility had never contracted, or had on staff, a registered nurse to conduct assessments for LNS residents. The director of nursing, a Licensed Practical Nurse (LPN), stated she was the person responsible for completing the assessments.

Review of the records for residents #2 and #10 found all assessments had been completed by the director of nursing, who was an LPN.

Interview with the owner on at approximately 3:00 PM indicated he was unaware that they needed a registered nurse to conduct the assessments.

Class III

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

Based on record review and staff interview the facility failed to maintain the employment status of all employees within the background screening clearinghouse for 1 of 3 sampled staff (D).

The findings include:

Review of the background screening roster failed to reveal sampled staff D listed on the roster. Record review of the sampled employee D record revealed she was a personal service assistance with a hire date of and a Level II background screening with an eligible date of .

On at approximately 3:45PM an interview was conducted with the director of nurses who indicated the former facility administrator was responsible for this task and apparently she had not placed the employee's name on the roster as required.

Unclassified