STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911335	**05/31/2017**
NAME OF PROVIDER OR SUPPLIER **KINGSHOUSE RETIREMENT CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **151 SOUTH MISSOURI STREET** **LA BELLE, FL 33935**	

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

0000 - Initial Comments

An unannounced relicensure and a limited nursing services survey was conducted on through at Kingshouse Retirement Center, an assisted living facility (license# 4901) located in LaBelle, Florida.

The following is description of the deficiencies.

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

Based on interview and record review, the facility failed to ensure a complete health assessment for 1 (Resident #7) resident of 2 residents surveyed by failing to complete whether the resident required any assistance with administration of medications.

The findings included:

Review of Resident #7's health assessment (AHCA Form1823) dated showed page 4 of the form was incomplete. There was no documentation noted on section B as to whether the resident needs assistance with her medication. There were no boxes checked as to the type of assistance Resident #7 required with her medications.

On at 3:20 p.m. the Administrator said she was not aware the form was not complete. The Administrator said she felt Resident #7 needed all of her medications administered to her.

Class III

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

Based on interview and record review, the facility failed to obtain a face to face health assessment for 1 (Resident #9) resident of 2 residents reviewed after a significant change in condition.

The findings included:

Review of Resident #9's record showed her last health assessment (AHCA form 1823) was completed on upon admission. The record showed Resident #9 became and was admitted to hospice .

On at 3:30 p.m. the administrator verified Resident #9 had a significant change. The administrator said she was not aware she needed to complete another 1823 when the resident went on

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Hospice.

Class III

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on resident and staff interview and observation, the facility failed to ensure they had organized activities which encouraged the residents to participate in social, recreational and community activities for 6 (Resident #1, #2, #3, #4, #5, and #7) residents of 9 residents reviewed. Resident based activities are used to promote the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community

The findings included:

In an interview on at 9:30 a.m., Resident #4 said, the facility has an activity calendar but they do not conduct the activities listed on the calendar. Resident #4 said, "All we do is watch television and feed squirrels every day. They use to have a church group who would come to the facility, but since the minister got sick a couple of months ago the facility has not attempted to find another church group to visit the facility."

In an interview on at 9:40 a.m., Resident #1 said, "There are no choices in activities. I don't think they have any activities."

In an interview on at 9:58 a.m., Resident #2 said, "I feel like I am in prison. There are no activities. All I can do is feed the squirrels and birds."

In an interview on at 10:07 a.m., Resident #3 said, "What activities? They don't have any activities. I would like to have some activities."

In an interview on at 10:15 a.m., Resident #5 said he has not seen an activity calendar posted in the facility. The facility doesn't conduct many activities for the resident and he cannot remember the last time a facility staff member asked him to attend a facility activity.

On observations from 9:00 a.m. to 4:00 p.m., noted no activities conducted with the residents. Residents were observed sleeping in their , watching television, and wondering the halls. The activity calendar was found partly hidden behind the organ on a cork board and dated , 2017.

In an interview on at around 9:00 a.m., Resident #7's family member said she has never seen a

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posted activity calendar for the residents. The only activity she has seen is 1 or 2 residents feeding squirrels with peanuts in the front of the building.

An interview on at 2:50 p.m., with the owner confirmed the 2017 activity calendar was posted , and was not posted at the beginning of the month as required. She confirmed they had not conducted activities listed for and . She said if they were to ask the residents to attend the activities they would refuse to attend the activities anyway. She confirmed they had a church group who used to visit the facility several months ago. She said the residents had liked it when the church group had visited, but she had not attempted to find another church group or organization to visit the residents at the facility. She also said she has no documentation the facility had asked the residents what type of activities they would like to attend and/or incorporate the resident's activities of choice on the monthly activity calendar.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, interview, and record review, the facility failed to ensure the rights of 1 (Resident #7) of 2 residents surveyed to ensure the residents ( ) was signed by the resident or by a legal representative. The facility failed to maintain a clean, safe environment by leaving household chemicals in the hall of the facility unsecured and failing to change dirty air conditioning filters.

The findings included:

1. Resident #7 is a female that was admitted to the facility with a history of .

Review of Resident #7's record showed A form signed on by the resident's mother. Review of the record showed Resident #7's mother was not the resident's legal Power of Attorney (POA), or Health Care Surrogate.

On at 2:30 p.m., the Administrator stated the resident's mother is currently in a nursing home. The Administrator said the family does not want to obtain legal services to obtain the paperwork to make a family member the resident's POA or Health Care Surrogate. She verified the Mother had no legal authority to sign the resident's .

2. On at 9:20 a.m., a cart was observed in the hallway of the facility with bleach, toilet bowl cleaner, comet cleaner, and an all purpose cleaner. These chemicals were unsecured and residents

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	AL11911335	05/31/2017

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were observed walking in the hall.

On at 9:25 a.m., two air conditioner filters were observed in the hall of the facility that were covered with dirt. Another air conditioner filter was observed in the dining the facility that was covered in dirt.

On at 8:15 a.m., a cart was observed in the hall of the facility with a bleach bottle sitting on it. The chemical was noted to be unsecured. Resident #7 was observed walking up and down the hallway and mumbling incoherently.

On at 3:30 p.m., the Administrator verified chemicals should not be left out unsecured. The Administrator verified the vents on the air conditioner should be changed.

Class III

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

Based on observation, interview, and record review, the facility failed to follow a physician's order to administer a medication to 1 (Resident #8) of 5 five residents surveyed.

The findings included:

On at 8:30 a.m., the Administrator was observed administering medications to Resident #8. The Administrator was observed to administer one pill of 1000 units of D3 to Resident #8.

Review of the Medication Record showed Resident #9 was ordered 4000 units of D3 twice daily.

Review of the physician's order the resident was ordered to have 4000 units of D3 twice daily on admission on .

At 9:40 a.m., the Administrator said the physician's order was not correct. The Administrator said she only gives the resident one pill of 1000 units of D3. The Administrator said she would have difficulty getting Resident #9 to take four of the D3 tablets.

Class III

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

Based on resident and staff interviews and record review of the monthly staffing schedule, the facility

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failed to ensure they maintained a written work schedule which reflected 24-hour staffing pattern.

The findings included:

In an interview on at 9:45 a.m., Resident #4 said she has never seen the facility staff schedule posted and does not know which staff is scheduled to work at any given time.

In an interview on at 1:30 p.m., the owner said monthly staffing schedule for , 2017 was not at the facility and she thinks it is at Staff A's house.

In an interview on at 1:45 p.m., Staff A said the , 2017 staffing schedule has been at her house for several weeks and she would bring the staff schedule back in the morning. She said does not work with the residents but does secretarial and light housekeeping duties.

In an interview on at around 9:00 a.m., Resident #7's family member said she has never seen the 24 hour facility staff schedule posted and does not know which staff is supposed to be working at any given time.

On review of the , 2017 staff schedule noted the owner is listed as working the 3:00 p.m. to 11:00 p.m., (3-11) and 11:00 p.m. to 7:00 a.m., (11-7) shift 7 days a week. There was no staff listed working the 7:00 a.m. to 3:00 p.m., (7-3) shift Sunday through Saturday. Further review of the , 2017 staffing schedule noted no direct care staff listed working the 7-3 shift on , , , , and .

In an interview on at 11:00 a.m., with the facility owner, she confirmed the , 2017 staffing schedule does not reflect 24-hour staffing pattern. The monthly staffing schedule only list the hours she and her husband work at the facility. She confirmed the , 2017 staffing schedule does not show a direct care staff member working the 7-3 shift. She confirmed the staffing schedule for , 2017 does not reflect a direct care staff was in the facility on the 7-3 shift for , , , , and . She said she had worked the 7-3 shift on the dates listed, but confirmed the , 2017 staffing schedule does not reflect she had worked the 7-3 shifts as required.

Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on interview and record review, the facility failed to have a legal contract with 1 (Resident #7) of 2 residents surveyed.

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The findings included:

Resident #7 is a female with a history of .

Review of Resident #7's contract with the facility showed the form had been signed by the resident's mother. Review of the record showed Resident #7 did not have a Power of Attorney (POA) or Health care surrogate.

On at 2:30 p.m., the Administrator verified Resident #7's mother had no legal authority to sign a contract for the resident.

Class III