STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953618	07/19/2017
NAME OF PROVIDER OR SUPPLIER **ABSOLUTE CARE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **3621 NW 90TH TERRACE** **SUNRISE, FL 33351**	

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

0000 - Initial Comments

An unannounced Relicensure survey was conducted on at Absolute Care ALF, License #8626. The facility had deficiencies at the time of the visit.

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

Based on records review and interviews, the facility failed to ensure that the Medication Observation Record was signed after assisting residents with self-administration of their medications, for 1 out of 10 residents (Resident #2) residing at the facility.

The Findings included:

During a visit to the facility conducted on , it was observed during the tour that some of the residents were gathered in the dining ; a couple of residents were in the family television, and three other residents were in their . During an interview with the Manager in charge, she reported at 9:30 AM that morning med pass is from 8:00 AM to 9:00 AM. She also informed that med pass was done.

Review of the Medication Observation Record (MOR) revealed there was no signature on one of the 10 residents' MOR scheduled to receive medications every morning. Resident #2 was scheduled to receive:
Axed 2 soft gel twice a day at 8: AM and at 8:00 PM; , 81 mg once daily at 8:00 AM;
2.5 mg 1 tablet twice a day after breakfast and 2 before dinner. 8:00 AM and 5:00 PM;
1 tablet daily at 8:00 AM.

An interview with the Nurse Manager, who assisted the residents during medication pass (med/pass) on at 9:35 AM, revealed that all the residents had received their morning medications.

Review of Resident #2's health assessment record revealed that he needed assistance with self-administration of medication. The record also revealed that Resident #2 has diagnoses of , single episode, history of , , , Insufficiency and muscle with unsteady gait.

During an interview with Resident #2, he confirmed that he never missed his medications and that he did receive his medications on the morning of .

Class III

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0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on record observation, record review and interviews, the facility failed to discard or return medications no longer in use and belonging to two non-sampled residents (Resident #7 & 8), no longer residing in the facility.

The findings included:

Observation conducted of the medication cart on during med pass at about 12:30 PM revealed that multiple medications bottle and packages had residents' names not listed on the resident's census log. The medications were identified as: Iron 65 mg; , 0.5 mg tablet, expiring ; Loperam/IMOD 2 mg cap; , 0.25 mg tablet with an expiration date of ; and , - , expiring .

During an interview with the Facility's Manager with whom a review of the medication cart was done, she reported that Resident #7 and #8 were no longer residing at the facility. She said that she was not sure which facility they were transferred to.
Review of the Admission Transfer Discharge log revealed that the Residents #7 and #8 were discharged from the facility in , 2017 to another facility.

During an interview with the Administrator, on at 4:07 PM, he confirmed the findings and admitted that Residents #7 and #8 were no longer residents in the facility.

Class III

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

Based on records review and interview, the facility failed to ensure that 2 of 3 employees (Employee A & B) completed the required trainings in Elopement Response, Emergency Preparedness and Evacuation training, and Incident Reporting.

The findings include:

During review conducted on it was noted that Employees A and B did not have in their records verification of completion for the Elopement Response, Emergency Preparedness and Evacuation, and Incident Reporting trainings.

Review of Employee A's record revealed that she was hired on and Employee B was hired on . Additionally, Employee A was observed working at the facility. An interview conducted with

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Employee C confirmed she works at night at the facility.

During an interview with the Administrator, on at 4:00 PM, he reported that he did not have evidence that Employees A and B had completed the aforementioned trainings. However, he said that he will ensure that all employees' files are updated.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on records review and interview, the facility failed to ensure that 2 of 3 sampled employees (Employees A & B) completed the required trainings in policy and procedures relating to resident's advance directives or (P & P).

The findings include:

During record review conducted on , it was noted that Employee A and B did not have verification of having completed the Policy and Procedure training. Review of Employee A's record revealed that she was hired on and Employee B was hired on . Additionally, Employee A was observed working at the facility. An interview conducted with Employee B confirmed she works at night at the facility.

During an interview with the Administrator, on at 4:00 PM, he reported that he did not have evidence that Employees A and B had completed the aforementioned training. However, he said that he will ensure that all employees' files are updated.

Class III

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

Based on observation, record review and interviews, the facility failed to ensure that 1 of 10 residents' meals (Resident #9) followed the physician's order for a therapeutic diet.

The findings included:

During meal observation on , Employee A, who prepared the residents' meals was observed using a blender to puree Resident #9's meals. She placed each meal in the blender, the chicken stew and the mixed vegetables before pureeing. Then, she poured in some water to facilitate the blending of the food items. The mixed vegetable was watery and the chicken stew in the end was not fully blended

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(Photographic evidence obtained).

During dining observation, Resident #9 was observed having a difficult time eating the chicken stew, chunks of the chicken particles were noted to remain in the resident's mouth and she could not eat them. Employee B was asked to help Resident #9 remove some of the meat hanging out of the resident's mouth.

Review of Resident #9's health assessment (AHCA form 1823) dated revealed in section B of the form Special Diet Instructions Pureed diet with thickened liquid to nectar consistency. It was further noted that Resident #9 had the diagnoses of , , Parkinson's and needed supervision for eating.

During an interview with the Facility's Manager and the Administrator on , they agreed with the findings. The Administrator indicated that the facility's designated equipment (food processor) for preparing puree foods was not used in the resident's meal preparation as the employee should have done.

Class III

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

Based on record review and interviews, the facility failed to maintain an updated employee roster, in the Clearing House for 4 out 4 active sampled employees (Employees A & B, The Administrator and the Manager).

The findings include:

Record review conducted on revealed that the Administrator, the facility Manager and two other employees (A & B) had completed their background screenings and that they were current. The following were revealed:

a) The Administrator's background eligibility date was .
b) The Manager's background eligibility date was .
c) Employee (A) background had an eligibility date of .
d) Employee (B) an eligibility date of .

However, during a follow-up interview with the Administrator, on at 2:00 PM, he said that she did not know that she was supposed to register all employees into the clearinghouse. He stated that the

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facility did not have any employees registered in the Clearing House.

Review of the Background Screening website to verify the Facility's employee Roster on at 3:00 PM revealed that none of the employees were added in the Roster.

Unclassified