STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968469	**08/15/2017**
NAME OF PROVIDER OR SUPPLIER **TOUCH OF GRACE ASSISTED LIVING FACILITY, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3425 SW RIVERA STREET** **PORT SAINT LUCIE, FL 34953**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

An unannounced Relicensure survey was conducted on at Touch of Grace Assisted Living Facility, License #12380. The facility had deficiencies found at the time of the visit.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review and staff interview, the facility admitted into the facility 1 of 6 residents who failed to meet the minimum criteria for admission based on initial health assessment completed by health care provider (Resident #5).

The findings included:

Resident #5 was admitted to this assisted living facility on . A review of Resident #5's current health assessment was completed on . Resident #5's health assessment was signed by a medical doctor on after conducting a face-to-face examination of the resident. Based on this examination, the medical doctor who completed the assessment documented in Section 1, Part D that, in his/her opinion, Resident #5's needs could not be met in an assisted living facility which is not a medical, nursing, or , facility.

On at 8:15 AM, during interview with the Administrator via telephone, she seemed unaware of the physician's documented opinion that the needs of Resident #5 could not be met in an ALF. It was discussed with the Administrator that results of examinations by a health care provider documented on the Health Assessment is to be used to determine the appropriateness of potential residents. The Administrator stated she would contact Resident #5's physician to confirm the assessment.

Class III

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

Based on observation, interviews, and record review, the facility failed to provide diversified, individual and group activities in keeping with each resident's needs, abilities and interests for 5 of 6 sampled residents (Resident #1, #2, #3, #4, and $5).

The findings included:

On , the activity schedule for this day listed an exercise activity from 10:00 AM - 10:30 AM; however, no exercise activity was conducted for the residents at this time. From 1:00 PM - 2:00 PM, a music activity was listed on the schedule, but no music activity was conducted. The 5 residents

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observed on , from 8:15 AM until 2:30 PM, were watching television as their main form of activity.

Per regulation, the facility must consult with the residents in selecting, planning and scheduling activities. A review of the facility's activity schedule for Thursday from 1:00 PM - 3:00 PM lists "Fun with Nails". This activity was not an activity the 3 male residents stated were of interest to them. There was nothing scheduled on this day which would have been an alternative for the male residents. Observation of the nails of the 2 female residents did not show any evidence of nail polish or manicure which, according to the activity schedule, would have occurred 5 days previously.

On , interviews were conducted with 5 of 6 residents who were at the facility during the relicensure survey. When asked about activities at the facility, the following responses were given:
Resident #1 stated during interview at 10:30 AM, "There are no activities to do. We don't do anything."
Resident #2 stated during interview at 10:00 AM, "Sometimes we play a game, but that gets boring. We don't do any activities, we just sit here and look crazy."
Resident #3 stated during interview at 11:05 AM, "There are no activities here. I would like to go out to a recreation area or community center. We don't go on any outings, except for church each week. I would like to go someplace where we could meet other people."
Resident #4 stated during interview at 10:50 AM, "We don't do anything, just watch TV."
Resident #5 stated during interview at 10:15 AM, "I don't go to a day program; I like BINGO. I used to play it at the place I was at before, but they don't play it here."
Each of the residents interviewed expressed a desire to participate in some activities outside of the facility (i.e. field trips, shopping, community/senior centers, etc).

During interview with Staff A on at 10:40 AM, she stated when she works her shift, she is usually alone with the residents. The 3 residents in wheelchairs require assistance with getting out of bed and dressed in the mornings. She then makes them breakfast and provides their medications. A few of the residents like to sleep in later in the morning, so she will make them a later breakfast. "The Activities in the morning can be difficult and some of residents don't want to do it."

On at 8:15 AM, the Administrator stated, "I take the residents to church every week, and I do activities with them during the week...I don't know if they are getting activities while I am gone, but when I am there, I do activities with them."

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

Based on observation and staff interview, the facility failed to post in full view in a common area accessible to all residents the required telephone numbers for lodging complaints against a facility or facility staff. The telephone numbers are to be posted in close proximity to a telephone accessible by residents and must be in a minimum 14 point font.

The findings included:

During a tour of the facility's common areas on at 9:30 AM, a list of the required telephone numbers to agencies where residents would be able to lodge complaints against the facility and/or it's staff was not found. The required telephone numbers for the following agencies must be posted in full view in a common area accessible to all residents:
1) , Rights Florida (800) 342-0823
2) Agency Consumer Hotline (888) 419-3456
3) Florida Hotline (800) 96- or (800) 962-2873
The required number for the Long Term Care Ombudsman Program was posted on the LTCOP poster hanging on the wall in the formal dining , next to the kitchen.

On at 2:00 PM, Staff A was asked for the location of the telephone residents would use to make a call. She pointed to the location of a cell phone and stated that the phone was for resident use. When asked for the location of the required telephone numbers to the state agencies for lodging complaints, she could not provide a location for the numbers.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interviews and record review, the facility failed to have a licensed staff member available to perform glucose monitoring and administer to 2 of 2 residents who require injections (Resident #2 and Resident #5).

The findings included:

On at 9:19 AM, Staff A, who is not a licensed nurse, donned gloves and removed a vial of and drew up 20 units into a syringe from small vial which she had removed from a small locked refrigerator located next to informal dining area across from kitchen. Staff A proceeded to inject the -filled syringe into the right side of Resident #5's stomach area.

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A review of Resident #5's 2017 Medication Observation Record verifies Resident #5 is to receive 20 units of every morning and every evening. Staff A's initials are documented as providing Resident #5's injections on , , and the morning of . A different set of initials (possibly the administrator's, but not verified) are documented on the evening of . There are no staff initials on any other dates.

A review of Resident #2's 2017 Medication Observation Record shows Resident #2 receives 15 units of if sugar is greater than 100. Staff A's initials are documented as providing on - , which a glucose level of 89 recorded on .

Interview with Staff A on at 9:25 AM, confirms she conducts the glucose testing on Resident #5 and Resident #2. Staff A also confirms that she provides their injections. Staff A stated Resident #2's sugar level was 89 this morning ( ); therefore, he did not receive an injection. The 89 glucose level is recorded in error on date of instead of .

On at 8:15 AM , an interview was conducted with the Administrator. The Administrator stated she thought it was permissible for Staff A to give the injections to Resident #2 and #5 as long as she, a registered nurse, provided Staff A with the necessary training on how to administer them. The Administrator was informed of the state regulation prohibiting glucose testing, liquid medications being drawn up and measured into a syringe , and these medications being injected into a resident by any staff other than a licensed nurse.

Class

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

Based on observation and interview, 1) the administrator failed to designate in writing a staff member who is at least and physically present to be in charge of the facility during a temporary absense of more than 48 hours; 2) the facility failed to produce documentation showing it maintains a written work schedule that reflects its 24-hour staffing pattern for a given time period.

The findings included:

1) On at 8:15 AM, Staff A stated the Administrator of the facility was out of town on a trip to attend her daughter's wedding. She stated she thought the administrator would be back on .

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During interviews with Resident #1, #2 ,#3, and #5 on . . . . . , they stated they had not seen the administrator since the previous Thursday, . During a confidential interview, it was revealed the Administrator had told (confidential interview person) that she was leaving for Atlanta on . . . . and would be gone for a week.

On at 8:15 AM, the Administrator confirmed, during an interview conducted via telephone, she has been out of state and absent from the facility for more than 48 hours. She also confirmed that she did not designate in writing a person who would be physically present to be in charge of the facility in her absence.

2) On at 1:30 PM, a request was made to Staff A for a copy of the written staffing schedule for the past 2 weeks. Staff A stated she was not aware of a written staffing schedule and did not know where it would be located. She stated that she works a 3 day, 24 hour schedule each week, and the administrator works the remaining 4 day, 24-hour period. She was not aware of any other staff.

During interview with Administrator on at 8:15 AM, she stated she is at the facility 24 hours a day, 7 days a week. During random confidential interviews, it was revealed that the Administrator is not present often and not seen by residents and/or family often.

Class III

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

Based on observation, record review and staff interviews, the facility failed to:
1) Prepare and serve food as ordered by the health care provider for 1 of 6 residents (Resident #5);
2) Serve the amount of food per serving as listed on the approved menu for 6 of 6 residents (Residents #1-#6)

The findings included:

1) On . . . . , a review was conducted of Resident #5's current health assessment, dated . . Resident #5 was admitted to the facility on . His diagnoses includes , , (difficulty swallowing) and , and, per health care provider, his diet is to consist of pureed foods.
A review of physician orders that accompanied him from previous nursing facility documented physician order for honey-thickened liquids, also, but this was not documented on current assessment.

During observation of lunch meal on . . . at 12:35 PM, Resident #5 was served a half of a turkey

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sandwich, a bowl of beef, bean and vegetable soup, a cup of chopped lettuce and tomato, and a small bowl of sliced cantaloupe. None of the food choices served to Resident #5 for his lunch meal was pureed. Resident #5 attempts to eat the meal provided, but begins coughing. He does not finish his meal. Resident #5's beverages are not thickened.

When interviewed on at 1:00 PM, Resident #5 stated he could not finish most of his meal because he couldn't eat it. He stated he didn't eat the soup because it was too spicy for his stomach. No alternative was offered to the resident.

During interview with Staff A on at 1:15 PM, she stated she they tried to blend his food in a blender, but he didn't like it and wouldn't eat it. It was explained to Staff A that pureed food is not "blended" food. Food which is pureed is usually prepared in a food processor and should have the consistency of smooth mashed potatoes. The food should not be lumpy, dry, sticky or runny. The pureed food provided should be the same food offered to the other residents, unless an alternative is requested by the resident.

During interview with the Administrator on at 8:15 AM, she stated Resident #5 did not like his food blended and would talk to his doctor about his diet.

2) The menu reviewed and approved by registered dietitian for the lunch meal to be served on was listed as:
6 oz. Soup of the Day
3 oz. Turkey and Cheese on 2 slices of Bread
1 cup Lettuce and Tomato
1/2 cup Pears

During lunch observation on at 12:35 PM, the 5 residents were all served:
1 very thin slice of turkey (1 oz.) on 1 slice of Bread, no cheese was added.
Beef, Bean and Vegetable soup (approximately 8-12 ounces, most was broth...no visible chunks of beef observed in the bowls)
1 cup Lettuce and Tomato
1/2 cup sliced cantaloupe

During interview with Staff A on at 1:00 PM, she stated she did not provide a full sandwich with more turkey and cheese because there was beef and beans in the soup. She could not provide any information as to the amount of beef or beans added to each of the residents' bowls of soup to make up

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for the substitutions.

On at 8:15 AM, the Administrator was apprised of the concern that residents did not receive the required serving size of protein, dairy, and , listed on the menu. The Administrator stated that the extra protein was in the soup because it had beef and beans in it. It was discussed with the Administrator that there was no measurements done by staff of the beef and beans added to the soup and contained in each of the resident's bowls. Staff A did not measure and weigh out additional protein and starch to add to the serving size of each resident's soup to account for the missing nutrients from turkey, cheese and slice of bread. The soup itself could not be the substitution, as it was already a menu item to be provided to the residents as part of their lunch meal. The substitution would have had to have been added to each of the resident's soup above and beyond what was already in the soup to make up for the in the residents' meal.

Class III

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

Based on observation, record review, and interview, the facility failed to obtain a new background screening for 1 of 1 resident who had a greater than 90 day break in employment (Staff A).

The findings included:

On from 8:15 AM - 11:30 AM, Staff A was observed providing direct care assistance to 5 residents currently residing in this facility.
Interviews with these 5 residents on confirm Staff A assists with their care needs, including providing them with their medications.
On , during employee record review for Staff A, it was noted that the latest Level II Background Screening for Staff A was conducted on .

On at 11:36 AM, Staff A stated she first began working at the facility on , but she left in of 2015. She had recently come back to work in , of 2017 as a live-in caretaker for the 6 residents currently residing in the facility. Staff A stated that from of 2015 to , of 2017, she had worked occasionally for a Home Health Services in the Virgin Islands. Staff A confirmed there had been lapses in employment greater than 90 days from her last background screening in , of 2015 until she was re-hired in , of 2017.

During interview with Administrator on at 8:15 AM, she acknowledged that Staff A required a new background screening due to a greater than 90 break in employment from her last screening.

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Unclassified

Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation, interviews, and record review, the facility exceeded its licensed capacity of 5 residents by accepting a 6th resident on (Resident #5).

The findings included:

On at 8:36 AM, Staff A was asked the number of residents currently residing at this facility. She responded, "There are 6 residents. One resident is out on leave with [family member]... [Resident #5] just came here last week."

A review of the Admission and Discharge Log only contains the names of 4 residents who are to be currently residing in the facility (Resident #1, #2, #3, and #4); Resident #5 and #6 are not listed on the Admission & Discharge Log.

A review of Resident Records show a contract for residency for Resident #5, dated , and for Resident #6, dated .

Resident #5 stated on at 10:15 AM, "I have been here for a week." Resident stated he had previously been in Broward County, but he moved up here to be closer to family.

On at 10:26 AM, an interview was conducted with the parent of Resident #6. She confirmed Resident #6 had actually moved into the facility in of 2016. He ended up spending a couple months in jail and went back to the facility in of 2017. The family member verified Resident #6 is still currently residing at the facility.

A tour of the facility was conducted on at 12:00 PM. There were were 3 shared resident and 1 private . Two female residents shared one a private (#); Two male residents shared # ; one male resident was in a shared , himself (#), and 1 male resident was in the private (#). The resident's personal belongings were seen in each , and Staff A verified the where each resident slept.

On at 8:15 AM, the Administrator stated she had sent in for a license for 6 residents. I confirmed with her that both her initial license and her current license clearly state on the license that the capacity for the facility was 5 residents.

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