STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911279	08/30/2017
NAME OF PROVIDER OR SUPPLIER **GREEN TREE ASSISTED LIVING, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8207 FOREST CITY ROAD** **ORLANDO, FL 32810**	

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

0000 - Initial Comments

The re-licensure survey with Limited Mental Health (LMH) and Limited Nursing Service (LNS) was conducted on , 2017. Green Tree Assisted Living LLC, license #5578, had deficiencies at the time of the survey.

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

Based on record reviews and interview, the facility failed to ensure the health assessment form 1823 was complete for 2 of 4 sampled residents (#8 and #12).

Findings:

Record review for resident #8 revealed a health assessment form 1823 that was dated on . The question on the form that pertained to how much assistance he required with his medications was not answered.

On at 4:32 pm, the director of nursing confirmed the finding.
Record review for resident #12's revealed the health assessment form 1823 dated did not have the physician information and signature on page 4.

On at 4:30 PM, an interview was conducted with the owner who confirmed the findings.

Class III

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

Based on observations, record reviews, and interview, the facility failed to ensure a chair alarm worked properly for 1 of 1 sampled residents (#7) who had a history of a .

Findings:

Observations made on at 9:45 am revealed that resident #7 was sitting in a wheelchair. There was a chair alarm device on the back of the wheelchair. Staff G, a caregiver, assisted resident #7 to transfer from her wheelchair to a recliner chair. When resident #7 was lifted from the chair the pressure , in the wheelchair, did not alarm.

When questioned, staff G was unable to explain why the alarm did not sound. Staff G then applied pressure to the , with her hand and when she removed her hand, the device alarmed.

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Record review for resident #7 revealed a health assessment form 1823 that was dated on . The form indicated that resident #7 had diagnosis of 's . She required assistance with walking and transferring.

An observation note that was dated on indicated that resident #7 was observed on the floor in the television area. A chair alarm would be placed on her wheelchair to notify staff when she got up.

An order from a health care provider that was dated on indicated that a chair alarm was to be placed on her wheelchair for safety due to .

An observation note that was dated on indicated that an alarm was placed on her wheelchair for safety.

An observation note that was dated on indicated that she was observed getting out of her wheelchair and was trying to walk to the couch.

An observation note that was dated on indicated that she kept getting out of her wheelchair and was trying to sit on the couch.

During an interview with the facility owner and director of nursing on at 4 pm, neither of them were able to provide an explanation as to why the chair alarm did not work properly.

Class III

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

Based on observations, record review, and interview, the facility failed to ensure the unlicensed staff who assisted 1 of 1 sampled residents (#12) with self-administration of medications followed the correct procedure.

Findings:

Observations made during a medication pass for resident #12 on at 12:10 pm revealed that staff F, an unlicensed caregiver, used hand sanitizer. Staff F removed a medication card from a medicine cart and compared the prescription label to the electronic medication observation record, placed the pill into a cup, then handed the cup with a glass of water to resident #12, who took the medication without assistance.

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Staff F did not read the medication label in the presence of resident #12, as required.

During an interview with staff F on at 12:20 pm, she confirmed the findings.

Class III

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

Based on record reviews and interview, the facility failed to maintain an updated Electronic Medication Observation Record (E-MOR) for 1 of 2 sampled residents (#7) who required assistance with self-administration of medications.

Findings:

Record review for resident #7 revealed a health assessment form 1823 that was dated on . The form indicated that resident #7 required assistance with self-administration of her medications.

Review of the 2017 E-MOR for resident #7 revealed that a dash mark, not initials, was charted in some of the boxes that were meant to represent when she was given her medications. Some examples include:

500 milligram (mg) by mouth two times a day for pain was scheduled at 8 am and 7 pm. The 7 pm doses on , , , and contained only a dash mark.

50 mg by mouth three times a day for pain was scheduled at 8 am, 2 pm, and 8 pm. The 2 pm doses on , , and and the 8 pm dose on contained only a dash mark.

The key on the E-MOR indicated that a dash mark meant, "not recorded."

During an interview with the facility owner on at 4:40 pm, she confirmed the findings. She said the medications were given to resident #7 as prescribed but there was a flaw in the E-MOR system that did not allow the staff to place their initials in the boxes.

Class

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on observations, personnel record reviews and interview, the facility failed to ensure 2 of 4 direct

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care staff (A and B) received 4 hours of and Related (ADRD) continuing education annually and failed to ensure 1 of 1 staff (administrator) who had only incidental contact with residents with ADRD received the required general written information.

Findings:

Observations made during a tour of the facility on at 9:30 am revealed the facility had a secured memory care unit.

1. Personnel record review for the administrator revealed a hire date of . The facility owner indicated the administrator did not provide direct care and was not in regular contact with the residents. The personnel record for the administrator contained no evidence to indicate the administrator received general written information on interacting with residents with ADRD, as required.

On at 4:44 pm, the facility owner confirmed the finding. She said the facility opened the memory care unit in , 2016.

2. Personnel record review for staff A, a caregiver, revealed a hire date of . The record contained evidence that staff A received 's level 1 training on and level 2 training on .

The personnel record contained no evidence to indicate staff A received 4 hours of ADRD continuing education annually, as required.

On at 5 pm, the facility owner confirmed the finding and said she was unaware the staff were required to have an annual update.

Review of staff B's personnel record revealed date of hire . There was no documentation provided for the 4-hour annual update 's and Related (ADRD) training completed for year 2016 and 2017.

On at 4:30 PM, an interview was conducted with the owner who was provided the opportunity to locate the training certificate. The owner confirmed the findings.

Class III

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

Based on personnel record reviews, review of the Agency's background screening clearing house, and interview, the facility failed to maintain an employee roster on the Agency's background screening clearing house that listed 2 of 5 sampled employees (C and director of nursing) who were subject to a background screening.

Findings:

Personnel record review for staff C, a caregiver, revealed a hire date of .

Personnel record review for the director of nursing revealed a hire date of .

Review of the Agency's background screening clearing house revealed that staff C and the director of nursing were not listed on the facility's employee roster, as required.

On at 4:29 pm, the director of nursing confirmed the findings.

Unclassified