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	AL11965343	**09/18/2017**
NAME OF PROVIDER OR SUPPLIER **CHRISTIAN MANOR OF CLEARWATER, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1845 N. KEENE ROAD CLEARWATER, FL 33755**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

Assisted Living Facility

On , , 2017, a biennial re-licensure survey in conjunction with three complaint surveys, (CCR# 2017007558, CCR# 2017008421, and CCR# 2017008775), were conducted at Christian Manor of Clearwater, Inc. Deficient practice was identified during the surveys.

(License # 9718)

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

Based on record review, observation and interview, the facility failed to ensure that residents had complete, accurate and updated medical assessments recorded on AHCA Form 1823 for 2 of 6 (Resident #2 and Resident #3) resident records reviewed.

Findings included:

A review of Resident #2's record was conducted at 10:00am on . The resident's record stated the resident was admitted to the facility on . The resident's 1823 assessment dated , the only assessment in the record, contained the following information, which should have been clarified and documented: a statement saying the resident required assistance with medications but did not specify what type of assistance the resident needed (assistance with self-administration or administration, for example) and the 1823 was marked "Yes" that the resident required 24 hour nursing or , , care. Requiring 24 hour nursing or , , care would call into question the appropriateness of the resident being place in an assisted living facility. In an interview at 3:30pm on with Staff A and the Administrator, Staff A expressed not being involved with the documentation of the residents. The Administrator had no comment.

A review of Resident #3's record was conducted at 10:30 on . The resident's record stated the resident was admitted to the facility on . The resident's 1823 dated , the only assessment in the record, contained the following information, which should have been clarified and documented: a statement saying that the resident needed medication administration. At 12:30pm, Resident #3 was observed receiving assistance with medication self-administration, not medication administration. Staff

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B stated at 12:30pm that the facility assists Resident #3 with medication self-administration.

Class III

0009 - Admissions - Admission Package - 58A-5.0181(3) FAC; 400.0078(2)

Based on record review and interview, the facility admission package had omissions of required information for 4 of 4 resident records reviewed (Residents #1, 2, 3 and 6).

Findings included:

A record review of Resident #1's record at 1:00pm on revealed that the resident was admitted to the facility on . The resident's Face Sheet revealed the resident's name, the date of birth, race and , the name of the pharmacy and the pharmacy phone number and where the resident had previously resided. The face sheet had no other information such as the resident's doctor, insurance, social security, case manager, or emergency contact information. There was no health assessment in the records to indicate any diagnoses, , activities of daily living abilities, if the resident was appropriate for the facility if there was any special needs that the resident had. The 1823 assessment form in the records was completely blank (Photographic evidence obtained). There was no contract between the resident and the facility, no informed consent for having unlicensed personnel assist with medication, and no observation notes about the resident. The only other information in the resident's records, other than the sparse Face Sheet, was a copy of the resident's medication orders. In an interview with Resident #1, the resident stated there was never a contract signed with the facility.

A review of Resident #2's record at 10:30am on revealed that the resident was admitted to the facility on . Resident # 2's record did not contain a signed informed consent for having unlicensed personnel assist with medications and the contract in the resident's record was never signed by the resident or the resident's representative. In an interview with Resident #2's family member and representative on , the family member stated no recollection of ever signing a contract with the facility on behalf of Resident #2.

A review of Resident #3's record at 10:00am on revealed that the resident was admitted to the facility on . Resident #3's record did not contain any weights ever recorded for the resident, there was no informed consent for having unlicensed personnel assist with medications and the contract in the resident's record was never signed by the resident or the resident's representative.

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A review of Resident #6's record at 1:30pm on revealed that the resident was admitted to the facility on . Resident #6's record did dot contain an informed consent for having unlicensed personnel assist with medications and the contract in the resident's record was never signed by the resident or the resident's representative. The resident's record indicates that the resident was discharged from the facility on , however the resident's medication records indicated that the resident was receiving all ordered medication up to .

In an interview at 3:30pm on with Staff A and the Administrator, Staff A expressed not being involved with the documentation of the residents. The Administrator had no comment.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to provide evidence of a negative examination documented on an annual basis (Exam) for three (Administrator, Staff A, and Staff B) of three employee records reviewed. Additionally, the facility failed to provide proof within 30 days of employment, written statements from a healthcare provider documenting that the individual does not have signs or symptoms of a communicable (Communicable Statement) for two (Staff A and Staff B) of three employee records reviewed.

Findings included:

A review of employee records conducted on showed that the Administrator was hired in 1995, Staff A was hired on , and Staff B was hired on . A review of the three employee records showed no proof of a Exam. Additionally, a review of Staff A and Staff B's records showed no proof of a Communicable Statement.

Staff A was interviewed at 3:53 PM on concerning the missing proof of Exams and Communicable Statements and acknowledged that they were not there.

Class III

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0080 - Training - Core & Competency Test - 429.52(1-2) FS; 58A-5.0191(1) FAC

Based on record review and interview, the facility failed to ensure that its administrator participated in 12 hours of continuing education in topics related to assisted living every two years (Continuing Education) as provided under Section 429.52 F.S. for one (Administrator) of one record reviewed.

Findings included:

A review of the Administrator's employment record on showed that they had completed 12 hours of continuing education effective . There were no additional continuing educations credits/certificates present for the past two years.

An interview was conducted with Staff A at 3:51 PM on concerning the lack of proof of Continuing Education for the Administrator. Staff A reviewed the Administrator's record and stated that they didn't see it.

Class III

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

Based on record review and interview, the facility failed to provide proof of in- service training for staff that provided direct care to residents, within 30 days of employment, for one (Staff B) of three employee records reviewed.

Findings included:

A review of employee records conducted on showed that Staff B was hired on . Staff B was observed cooking the lunch meal and assisting residents with self-administered medications during the survey.

A review of Staff B's record showed no proof of required training in the following topics: control, reporting major and adverse incidents, facility emergency procedures including chain- of- command and staff roles relating to emergency evacuation, resident rights/recognizing and reporting , neglect, and , , resident behavior and needs/providing assistance with the activities of daily living, safe

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food handling practices, and resident elopement response policies and procedures.

An interview was conducted with Staff A at 3:55 PM on concerning the lack of proof of training described above for Staff B. Staff A was not able to provide proof of required in-service training for Staff B.

Class III

0082 - Training - / - 58A-5.0191(3) FAC

Based on record review and interview, the facility failed to provide proof of training, within 30 days of employment, in the topic of / , (/ Training), for one (Staff B) of three employee records reviewed.

Findings included:

A review of Staff B's record showed a date of hire of . A review of Staff B's records also showed a lack of proof of / Training.

An interview was conducted with Staff A at 3:55 PM on concerning the lack of proof of / Training for Staff B. Staff A was not able to provide proof of / Training for Staff B.

Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on record review and interview, the facility failed to provide proof of first aid and ( ) training for two (Administrator and Staff B) of three records reviewed.

Findings included:

The surveyors entered the facility at 9:10 AM on . The only employees present at the time were the Administrator and Staff B. A review of the Administrator and Staff B's employee record showed no

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proof of current training in first aid or .

An interview was conducted with Staff A at 3:54 PM on concerning the lack of proof of training in first aid and for the Administrator and Staff B. Staff A looked through records and acknowledged that proof of training was not present.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on record review and interview, the facility failed to provide proof that unlicensed persons, as defined in Section 429.256(1)(b) F.S, who provide assistance with self-administered medications have successfully completed the initial four hour training (Med Tech Training) for two (Staff A and Staff B) of three employee records reviewed. Additionally, the facility failed to provide proof of a minimum of two hours continuing education training on providing assistance with self -administered medications and safe medication practices in an assisted living facility (Continuing Education) for one (Administrator) of three records reviewed.

Findings included:

A review of employee records for staff that assisted with self-administered medications was conducted on . A review of Staff A and Staff B's records showed no proof of Med Tech Training. A review of the Administrator's record showed no proof of Continuing Education.

An interview was conducted with Staff A at 3:53 PM on concerning the lack of proof of Med Tech Training and Continuing Education for staff that assisted with self-administered medications. Staff A acknowledged that the records did not contain proof of required training.

Class III

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

Based on record review and interview, the facility failed to provide proof of training in the facility's policies and procedures regarding (Training), within 30 days of employment, for one (Staff B) of three employee records reviewed.

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Findings included:

A review of employee records on showed that Staff B was hired on . Staff B was a direct care staff member and was observed assisting residents with self-administered medications during the survey. A review of Staff B's record showed no proof of Training.

An interview was conducted with Staff A at 3:55 PM on concerning the lack of proof of Training for Staff B. Staff A was not able to provide proof of the required training for Staff B.

Class III

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

Based on observation, interview, and record review, the facility failed to maintain six-month files of dated regular and therapeutic menus and menu substitutions noted before or when the meal was served. Additionally, the facility failed to post a dated menu planned at least a week in advance for both regular and therapeutic menus.

Findings included:

A dining and food service review was conducted on . Requests were made to review the facility's six-month files of dated menus and menu substitutions.

The lunch meal was observed and a substitution of fruit cocktail was made for the registered dietitian approved dessert of gelatin. A review of the facility's menu substitution log showed no items listed of any kind.

A review of the posted menu located in the kitchen area showed the menu for week number two in the menu cycle. Staff A stated that this was the menu for the current week. The menu observed did not have a date indicating that this was the menu being used for the current week.

Staff A was interviewed at 3:47 PM on concerning the request for the facility's six month file of

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dated menus, the menu substitution log, and undated posted menu. Staff A acknowledged that the menu substitution log was empty, and that there were no dated menus for the past six months.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on records review and interview, the facility failed to maintain an accurate and up to date admission and discharge log for 3 of 6 residents reviewed.

Findings included:

A review of the facility admission and discharge log (Photograph #9) at 9:30am on revealed the following: Resident #1 was admitted to the facility on , Resident #2 was admitted to the facility on and Resident #6 was admitted to the facility on and discharged on .

Further review of resident's records on revealed that Resident #1 was admitted to the facility on and Resident #2 was admitted to the facility on . Resident #6's record revealed no discharge date, however the resident's medication record revealed that the facility signed off that the resident received all ordered medications from up to , even though the resident was identified as being discharged from the facility between those dates.

In an interview at 3:30pm on with Staff A and the Administrator, Staff A was not able to explain the discrepancy between the facility's admission and discharge log and the resident's records. The Administrator had no comment.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review and interview, the facility failed to ensure that personnel records for each staff member contained a copy of the employment application with references furnished for one (Staff A) of three employee records reviewed.

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Findings included:

A review of employee records conducted on showed that Staff A was hired on . A review of Staff A's record showed no copy of an employment application with references furnished.

Staff A was interviewed at 3:55 PM on and acknowledged that their record did not contain an application with references.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on records review and interview, the facility failed to maintain resident records including pertinent demographic information, health assessments, weights, resident care information and contracts for 4 of 6 resident records reviewed.

Findings included:

A record review of Resident #1's record at 1:00pm on revealed that the resident was admitted to the facility on . The resident's Face Sheet revealed the resident's name, the date of birth, race and , the name of the pharmacy and the pharmacy phone number and where the resident had previously resided. The face sheet had no other information such as the resident's doctor, insurance, social security, case manager, or emergency contact information. There was no health assessment in the records to indicate any diagnoses, , activities of daily living abilities, if the resident was appropriate for the facility of if there was any special needs that the resident had. The 1823 assessment form in the records was completely blank (Photographic evidence obtained). There was no contract between the resident and the facility, no informed consent for having unlicensed personnel assist with medication, and no observation notes about the resident. The only other information in the resident's records, other than the sparse demographic information sheet, was a copy of the resident's medication orders. In an interview with Resident #1, the resident stated there was never a contract signed with the facility.

A review of Resident #2's record at 10:30am on revealed that the resident was admitted to the facility on . Resident # 2's record did not contain a signed informed consent for having

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unlicensed personnel assist with medications and the contract in the resident's record was never signed by the resident or the resident's representative. In an interview with Resident #2's family member and representative on , the family member stated no recollection of ever signing a contract with the facility on behalf of Resident #2.

A review of Resident #3's record at 10:00am on revealed that the resident was admitted to the facility on . Resident #3's record did not contain any weights ever recorded for the resident, there was no informed consent for having unlicensed personnel assist with medications and the contract in the resident's record was never signed by the resident or the resident's representative.

A review of Resident #6's record at 1:30pm on revealed that the resident was admitted to the facility on . Resident #6's record did not contain an informed consent for having unlicensed personnel assist with medications and the contract in the resident's record was never signed by the resident or the resident's representative.

In an interview at 3:30pm on with Staff A and the Administrator, Staff A expressed not being involved with the documentation of the residents. The Administrator had no comment.

Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on records review and interview, the facility failed to demonstrate that they offered a contract for execution by the resident or resident's representative for 4 of 6 residents whose records were reviewed (Resident #1, 2, 3 and 6).

Findings included:

A record review of Resident #1's record at 1:00pm on revealed that the resident was admitted to the facility on . The record contained no contract between the resident and the facility. The only other information in the resident's records, was a copy of the resident's medication orders. In an interview with Resident #1, the resident stated there was never a contract signed with the facility.

A review of Resident #2's record at 10:30am on revealed that the resident was admitted to the facility on . Resident # 2's record contained a contract that was never signed by the resident or

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the resident's representative. In an interview with Resident #2's family member and representative on , the family member stated no recollection of ever signing a contract with the facility on behalf of Resident #2.

A review of Resident #3's record at 10:00am on revealed that the resident was admitted to the facility on . Resident #3's record contained a contract that was never signed by the resident or the resident's representative.

A review of Resident #6's record at 1:30pm on revealed that the resident was admitted to the facility on . Resident #6's record contained a contract that was never signed by the resident or the resident's representative.

In an interview at 3:30pm on with Staff A and the Administrator, Staff A expressed not being involved with the documentation of the residents. The Administrator had no comment.

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

Based on interview and record review, the facility failed to maintain the employment status of employees within the employee roster listed in the AHCA background screening clearinghouse (Employee Roster), within 10 business days of initial employment, for one (Staff B) of three employee records reviewed.

Findings included:

A copy of the facility's Employee Roster dated was saved to file (photographic evidence obtained).

A review of employee records showed that Staff B was hired on . A review of the Employee Roster dated showed that Staff B was not listed. A review of the Level II background screening website showed that Staff B was entered in to the Employee Roster on .

Staff A was interviewed at 3:50 PM on concerning Staff B not being listed on the Employee Roster within 10 days of initial employment. Staff A acknowledged that Staff B's information was not entered within 10 business days of initial employment.

Unclassified