STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965768	**10/04/2017**
NAME OF PROVIDER OR SUPPLIER **THORNTON GARDENS**	STREET ADDRESS, CITY, STATE, ZIP CODE **618 E CENTRAL BLVD.** **ORLANDO, FL 32821**	

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

0000 - Initial Comments

The re-licensure survey was conducted on , 2017. Thornton Gardens, license #10099, 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 a face-to-face medical examination was conducted and documented on a health assessment form 1823 for 1 of 1 sampled resident (#7) who experienced a significant change.

Findings:

Record review for resident #7 revealed her most recent health assessment form 1823 was dated on . She was admitted to hospice services on .

The record for resident #7 did not contain documented evidence on an 1823 to indicate she was admitted to hospice, which was a significant change.

During an interview with the administrator on at 5:42 pm, she confirmed the finding.

Class III

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

Based on observations and interviews, the facility failed to honor the resident's rights and did not recognize the resident's need for privacy for 1 of 7 sampled residents (#1) and failed to have a written grievance procedure.

Findings:

1. During an interview with resident #1 on at 9:10 am, she said the facility staff used her give other residents their showers.

During an interview with staff A, a caregiver, on at 9:40 am, she said the facility staff did use the private shower located in the resident #1 to provide showers to other facility residents.

Observations made on at 9:45 am revealed the facility was structured with an upstairs and downstairs. There were steps and an elevator available to access the second floor.

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Resident #1 resided in a semi-private contained a private a shower facility.

The first floor of the facility contained no additional shower facilities. A second floor was located in a hallway contained a shower facility.

During an interview with the administrator on at 10 am, she said the staff should not use the private shower in the resident #1 to give other facility residents a shower. Rather, the staff should use the elevator to take the first floor residents to the second floor and use the common shower there.

During an interview with staff D, a caregiver, on at 11:10 am, she said the facility staff did use the private shower located in the resident #1 to provide showers to other facility residents.

2. During an interview with resident #1 on at 9:10 am, she said a couple of months prior some of her personal items went missing. She said she gave a list of the missing items to the administrator but she had not received a response to her concern.

During an interview with the administrator on at 9:49 am, she confirmed resident #1 gave her a list of missing items and said she was given the list about 8 months ago. She said the items were found and returned to the resident.

A request was made to review the facility's written grievance procedure. The administrator said the facility did not have a written procedure and said when she received a resident or family concern, she verbally discussed the concerns and she did not write down any of the information.

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 resident (#1) with self-administration of medications followed the correct procedure.

Findings:

Observations made during a medication pass for resident #1 revealed staff A, an unlicensed caregiver, removed the medication packages from a secured cart. While standing at the cart, she placed an ,

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tablet into her own hand and with the other medication packages, approached resident #1 who was seated at a dining . Staff A said the name of each medication then she placed each pill into the resident's hand, who then took each pill.

Staff A did not take the , bottle to the resident and did not prepare the , in the presence of the resident, as required.

Staff A did not read each prescription label in the presence of the resident, as required.

On at 8:20 am, staff A confirmed the findings.

Record review for resident #1 revealed a health assessment form 1823 that was dated on . The form indicated that she required assistance with self-administration of her medications.

Class III

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

Based on record reviews and interviews, the facility failed to ensure the Medication Observation Record (MOR) was updated for 2 of 4 sampled residents (#1 and #7).

Findings:

1. Record review for resident #1 revealed a health assessment form 1823 that was dated on . The form indicated that she required assistance with self-administration of her medications.

Review of the , 2017 MOR for resident #1 revealed the following medications were listed:

20 milliequivalents (meq,) one tablet daily was scheduled to be given daily at 8 am. The dose on was circled.

25 milligrams (mg,) one tablet daily was scheduled to be given daily at 8 am. The dose on was circled.

75 mg, one tablet daily was scheduled to be given daily at 8 am. The dose on was circled.

40 mg, one tablet daily was scheduled to be given daily at 8 am. The dose on was

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circled.

The MOR did not contain documentation to indicate why the doses were circled.

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

Review of the , 2017 MOR for resident #7 revealed an entry for 150 mg, one tablet two times daily was scheduled to be given daily at 8 am and 8 pm. The 8 am doses on through were circled and the 8 pm doses on through were circled.

The MOR did not contain documentation to indicate why the doses were circled.

On at 5:45 pm, the administrator was unable to provide an explanation for the findings.

Class III

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

Based on interviews and record reviews, the facility failed to make every reasonable effort to ensure prescriptions for 2 of 4 sampled residents (#3 and #6) who received assistance with self-administration of medications, were filled in a timely manner.

Findings:

1. During an interview with resident #3 on at 10:30 am, she said toward the end of each month, the facility ran out of her medications. She said most recently it was her and another time it was her . She said when the facility ran out of her medications; she just had to wait until the medications were refilled.

Record review for resident #3 revealed a health assessment form 1823 that was dated on . The form indicated that she required assistance with self-administration of her medications.

Review of the 2017 Medication Observation Record (MOR) for resident #3 revealed entries for the following medications:

75 milligrams (mg,) one tablet two times each day and was scheduled to be given at 8 am and 8 pm. The 8 am dose on 10/1 through 10/3 was circled and the 8 pm dose on 10/1 and 10/2 was circled.

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Clopidrogel 75 mg, one tablet daily and was scheduled to be given at 8 am. The dose on 10/1 and 10/2 was circled.

The MOR contained no documentation to indicate why the doses were circled.

On at 4:06 pm, the administrator said resident #3 was not given the medications on those dates because she ran out of the medications. The administrator said she ordered refills for the medications on , which was after the medications ran out.

2. Record review for resident #6 revealed a health assessment form 1823 that was dated on . The form indicated that she required assistance with self-administration of her medications.

Review of the 2017 MOR for resident #6 revealed an entry for , 0.5 mg, one tablet daily. The medication was scheduled to be given at 8 am. The dose on through was circled, the dose on was blank, and the dose on was circled.

The MOR contained no documentation to indicate why the doses were circled and blank.

On at 3:55 pm, the administrator said the daughter of resident #3 ordered refills for the resident when the facility notified her of the need for refills. The administrator said she sent a text message to the daughter on to inform her of the need for refills, which was after the medication ran out.

Class III

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

Based on personnel record reviews and interview, the facility failed to ensure 1 of 4 sampled personnel records (E) contained documentation required in-service training within 30 days of hire.

Findings:

Personnel record review for staff E, a caregiver, revealed a hire date of . The record did not contain documented evidence to indicate staff E received a minimum of 1 hour in-service training within 30 days of employment that covered resident rights in an assisted living facility and recognizing and reporting resident , neglect, and , as required.

On at 6 pm, the administrator confirmed the findings.

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

Based on record reviews and interview, the facility failed to ensure a staff member who held a valid ( ) and first aid card was in the facility at all times.

Findings:

Personnel record review for staff C revealed she was hired in the capacity of an unlicensed caregiver on . The record did not contain documented evidence to indicate staff C held a valid and first aid card.

Review of the facility's staffing schedule revealed that staff C was scheduled to work alone on from 7 pm to 7 am.

On at 5:55 pm, the administrator confirmed the record did not contain a valid and first aid card and she said staff C did work alone on .

Class III

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

Based on observations, personnel record reviews, and interview, the facility failed to ensure that 1 of 3 unlicensed staff (A) who provided assistance with the resident's medications, received the annual 2 hours of continuing education on providing assistance with self-administered medications and safe medication practices in an Assisted Living Facility (ALF.)

Findings:

Observations made on at 8:15 am revealed staff A assisted resident #1 with her medications.

Personnel record review for staff A revealed she was hired in the capacity of an unlicensed caregiver on .

The record contained documentation that indicated staff A received the required initial 4 hours of training on .

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There was no documented evidence to indicate staff A received the annual 2 hours of continuing education for the year 2017, as required.

On at 4:58 pm, the administrator confirmed the finding.

Class III

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

Based on observations, interviews, and review of the facility's menus, the facility failed to provide a variety of food to the residents and failed to note a meal substitution before or when a meal was served.

Findings:

During an interview with resident #1 on at 9:10 am, she said that sometimes the facility served the same food over and over.

During an interview with resident #3 on at 10:30 am, she said the facility served the same food over and over. She said sandwiches and hot dogs were often served for the dinner meals.

On at 5:20 pm, resident #3 approached the surveyor and said the facility was serving hot dogs for dinner and said hot dogs were also served for dinner on .

Observations made of the dinner meal on at 5:30 pm revealed the residents were served hot dogs.

Review of the facility's menu for revealed the dinner meal consisted of chicken noodle soup, chicken strips, three bean salad, crackers, and fruit cocktail. There was no documentation to indicate the meal was substituted with hot dogs.

During an interview with the administrator on at 6 pm, she confirmed that hot dogs were served for dinner on and . She said the hot dog substitution was not noted for the dinner meal on .

Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on record reviews and interview, the facility failed to ensure a resident contract contained all the

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required information for 1 of 3 resident contracts (#7.)

Findings:

Review of the residency contract for resident #7 revealed that it was dated on .

The contract did not contain a provision that indicated residents must be assessed upon admission and every 3 years thereafter, or after a significant change, as required.

During an interview with the administrator on at 5:42 am, she confirmed the finding.

Class