STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968902	10/26/2017
NAME OF PROVIDER OR SUPPLIER **MAGNOLIA GARDENS LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **350 MAGNOLIA RD** **VENICE, FL 34293**	

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

0000 - Initial Comments

An unannounced state relicensure survey was conducted on at Magnolia Gardens LLC, an assisted living facility (license #12776) in Venice, Florida.

The following is description of the deficiencies.

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

Based on observation, record review, staff interview, and review of Centers for Control guidelines for hand hygiene, the facility failed to ensure staff followed standard hand hygiene practice during assistance with self-administration of medications for 2 (Resident #2 and #3) of 3 residents and failed to assure health care was provided by a licensed professional for 1 (Resident #3) of 1 residents with pressure sores.

The findings included:

1. Review of the CDC (Centers for Control) guidelines(https://www.cdc.gov/handhygiene/providers/index.html) for cleaning your hands included the following:
·Before eating
·Before and after having direct contact with a patient ' s intact skin (taking a pulse or , , performing physical examinations, lifting the patient in bed)
·After contact with , body fluids or excretions, , non-intact skin, or dressings
·After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient
·If hands will be moving from a contaminated-body site to a clean-body site during patient care
·After glove removal
·After using a

CDC Guideline for Hand Hygiene in Healthcare Settings recommends: "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers.
Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet... Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times."

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During an observation on at 9:41 a.m., Certified Nursing Assistant (CNA) Med tech Staff C walked over to the medication remove medications for Resident #1. Without washing or sanitizing her hands, Staff C put on a pair of gloves and placed medications into a pill cup. Staff C scratched her head and put her glasses on top of her forehead and handed Resident #1 his medications. Staff C knelt down in front of Resident #1 and placed her gloved hand on her chin. Staff C went over to the sink in the kitchen, and using the same gloved hands, cleaned Resident #1's mouthpiece. Staff C poured medication into the chamber and handed the to Resident #1. Staff C went into the kitchen with her gloved hands and removed trash out of the trashcan and walked it outside. She returned with the same gloved hands and walked into the kitchen. Staff C replaced the trashbag, removed her gloves, washed her hands less than 10 seconds, turned the faucet off and dried her hands with a dishtowel that was gray in appearance.

On at 11:30 a.m., CNA Med Tech Staff C put on a pair of gloves and entered Resident #3's a glucometer, lancet, and wipe. She assisted Resident #3 to an upright position, and after obtaining a sample, handed Resident #3 an wipe to remove the from his finger. Staff C threw the wipe into the trash in the . Staff C removed her gloves and without washing her hands, removed medications from the cupboard, put on another pair of gloves, and assisted Resident #3 with self-administration of his medications.

On at 12:00 p.m., CNA Med Tech Staff C was observed preparing lunch. Without washing her hands first, Staff C placed buns, chicken patties, lettuce, tomatoes, and onions on plates with her bare hands. Staff C was observed removing ice from the ice container in the freezer with her bare hands and placing the ice into glasses for the residents.

On at 2:30 p.m., Staff C said she forgot about using proper hand hygiene when caring for the residents. The Administrator (ADM) said he keeps telling his staff over and over about the proper way of washing their hands.

2. During an observation on at 10:38 a.m., Certified Nursing Assistant (CNA) Staff C assisted Resident #3 with bathing. A small pressure , was observed to Resident #3's left inner . The periphery of the was bright red. Yellow dry tissue was observed in the center of the . Staff C said she had been gone from the facility for a couple of days and thought it had healed. Staff C walked over to a table, picked up a dressing (an opaque or transparent dressing that adheres to the skin) and after cutting the dressing to fit over the pressure , placed the dressing on top of the .

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Record review found a home health agency note dated , which documented a pressure to the left . The area was cleansed and a applied.

There was no other documentation available for review from the home health agency.

During an interview on at 2:30 p.m., the Administrator was not aware Resident #3's pressure re-opened and said he would call the home health agency. Staff C said she thought she was doing first aid. The Administrator acknowledged it was not within the scope of CNA Staff C to treat Resident #3's pressure .

Class III

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

Based on observation, record review, and staff interview, the facility failed to ensure 1 (Resident #3) of 3 residents reviewed for assistance with self-administration of medications received a medication according to physician's orders and failed to ensure licensed staff were safely assisting Resident #3 with a medication requiring judgement and discretion for the provision of the medication.

The findings included:

During an observation on , Certified Nursing Assistant (CNA) Med tech Staff C assisted Resident #3 with self-administration of medications. She entered Resident #3's took a radial pulse. Staff C said Resident #3's pulse was 76. She walked out of Resident #3's documented she was not giving Resident #3 his (medication) because his rate was less than 100.

Review of the physician's orders included the following: , 50 mg. tablet, take 1 tablet by mouth two times a day. Hold (the medication) if , (SBP) is less than (<) 100, rate < 76.

Review of the Medication Observation Record (MOR) for 2017 showed Resident #3 received approximately 45 doses of the . The record lacked evidence the resident's or rates were monitored prior to receiving the doses of medication.

During an interview on at 2:00 p.m., CNA Med tech Staff C said they are not supposed to take in an assisted living facility. She was not aware Resident #3's rate was within

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acceptable parameters as ordered by the physician.

On at 2:15 p.m., the Aministrator said the med techs in the facility should not have been assisting with medications requiring interpretation of the physician's order and would call the physician.

Class III

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

Based on personnel file review and staff interview, the facility failed to ensure 1 (Staff A) of 3 employees had documentation of a negative examination on an annual basis.

The findings included:

Record review on found no documentation of a negative examination for 2016 in the Administrator's (Staff A) file.

During an interview on at 2:00 p.m., the Administrator said at times he does assist residents with self-administration of medication and confirmed he had not gotten a examination.

Class III

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

Based on record review and interview, the facility failed to ensure 1 (Staff B) of 2 employees received in-service training on emergencies and elopement response policies and procedures.

The findings included:

Review of the personnel file for Staff B showed a hire date of . The file lacked evidence of a 1 hour in-service training for emergency procedures and the facility's elopement response policies and procedures.

During an interview on at 2:15 p.m., the Administrator confirmed Staff B lacked the in-service training required.

Class III

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

Based on record review and staff interview, the facility failed to ensure 1 (Staff B) of 2 employees completed training on / within 30 days of employment.

The findings included:

Review of the personnel file for Staff B showed a hire date of . The file failed to show Staff B completed training on / .

During an interview on at 2:15 p.m., the Administrator confirmed Staff B failed to complete the training.

Class III

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

Based on observations, record reviews, and staff interviews, the facility failed to obtain clarification orders for medications for 3 (Resident #1, #2, and #3) of 3 residents reviewed for assistance with self administration of medications; failed to retain a complete copy of the 1823 Health Assessment for 2 (Resident #2 and #3) of 3 resident records reviewed; and failed to ensure weights were recorded semi-annually for 2 (Resident #1 and #3) of 3 residents receiving assistance with activities of daily living.

The findings included:

1. Record reviews for Resident #2 and Resident #3 found the first page of the 1823 Health Assessments missing.

During an interview on at 2:00 p.m., the Administrator wasn't aware the first pages were missing and was unable to provide evidence they were completed.

2. On at 8:23 a.m., the Certified Nursing Assistant (CNA) Med tech (Staff C) was observed assisting Resident #1 with his medications. Included in the pill cup was D3 1000 iu (international units).

Review of the physician's orders showed an order for D3, 5000 iu's every other day.

During an interview on at 1:30 p.m., neither Staff C or the Administrator could find the order for D 3 1000 iu. The Administrator said he would try and call the physician for clarifications of the

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order.

3. On at 9:41 a.m., CNA Med tech Staff C was observed assisting Resident #2 with medications. Included in the medications was ER (Extended Release) 50 mg. and disc inhaler.

Review of the physician's orders failed to show an order for the ER 50 mg. tablet and

During an interview on at 2:00 p.m., the Administrator could not find an order for the medications and said he would call the physician immediately.

4. On at 11:30 a.m., CNA Staff C was observed handing Resident #3 a 60 mg. tablet. The resident self-administered his medications.

Review of the physician's orders showed one prescription dated for 60 mg. and a second prescription dated for 30 mg.

During an interview on at 2:15 p.m., Staff C and the Administrator said there were 2 prescriptions for the same medication. Staff C said the orders should be clarified.

5. Review of the 1823 Health Assessments for Resident #1 and Resident #3 showed they required assistance with activities of daily living.

Record review for Resident #1 and Resident #3 failed to show weights were obtained semi-annually.

During an interview on at 2:15 p.m., the Administrator said he could not find the weight book containing the weights of the residents.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and staff interview, the facility failed to develop and submit an emergency management plan to the local emergency management agency.

The findings included:

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Record review on . . . failed to show the facility submitted an emergency management plan for 2016 and subsequently there was no plan to submit for review and approval for 2017.

During an interview on . . . at 2:30 p.m., the Administrator said he started to develop a plan but didn't finish it. He said he was going to contact someone for assistance but didn't get a chance to ask someone for help.

Class III