STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968547	**10/31/2017**
NAME OF PROVIDER OR SUPPLIER **IDEAL CARE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **612 SPRING OAK CIRCLE** **ORLANDO, FL 32828**	

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

0000 - Initial Comments

The re-licensure survey was conducted on . Ideal Care assisted Living Facility, license #12451, had deficiencies at the time of the visit.

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

Based on observation, record review and interview, the facility failed to ensure a resident was examined by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner within 60 days before admission to the facility and the Health Assessment (form 1823) was complete and accurate for 1 of 2 sampled residents (#3).

Findings:

Resident #3, a hospice resident, was observed sitting in a Gerry chair in the living the facility. She was dressed, alert and watching TV. In an interview with the resident, she stated she moved there in , of this year and likes it there. She said hospice provided the chair for her. She said she enjoyed walking around the facility and yard using her cane. The resident was observed eating lunch independently and was observed being given her medications at lunchtime, which she took without assistance.

Review of the record for resident #3 revealed she was admitted to the facility on . The Health Assessment/1823 from her provider was dated , which was more than 60 days prior to her admission. The 1823 indicated the following concerns: a) the resident required medication administration, b) the box asking if the resident posed a danger to self or others was checked "yes" with a comment that "she can ," and c) the box asking if the resident required 24 hr. nursing or , supervision was checked "yes."

In an interview with the manager/Staff C on at 1:00PM, he confirmed they did not have a current 1823 and stated he was not aware the form indicated the resident was not appropriate for the facility.

Class III

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

Based on resident record review, Medication Observation Record (MOR) review and interview, the facility failed to provide care and services appropriate to the needs of 1 of 2 sampled residents and did not ensure a prescribed medication was given according to physician orders 1 of 2 sampled residents

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(#1)

Findings:

Review of the record for resident #1 revealed she was admitted on . The health assessment, dated , revealed a diagnosis of , and chronic kidney . She required assistance with self-administration of medications, but is able to perform her own glucose checks and injects her own without assistance. Her record contained an order for Tablet, 800 mg. Order stated take 3 tablets (2400mg) three times a day with meals, and take one tablet two times a day with snacks. The order was written on by her nephrologist.

Review of the printed MOR for 2017 for residents #1 revealed the same medication with the same dosing instruction printed on the MOR. The times 8AM, 12PM and 5PM were handwritten on the MOR. There were no place to document the times the medication was given at snack times. The mealtime medications were documented for each day in . There was no documentation of any other times the medication was given in 2017.

In an interview with Staff A on at 12:30PM, she stated the resident is often out for at snack time and does not get the medication. She said she did not know she had to write it down. When asked if she sent a snack and the medication with the resident when she went to , Staff A said no she did not.

In an interview with resident #1 at 12:35PM, she stated she goes to 3 days each week- Monday, Wednesday and Friday. She is in the facility on the other days and is always there for evening snack time. She was not certain she got the medication at snack times consistently.

In an interview with the manager/Staff C on at 12:50 PM, he confirmed the MOR did not indicate if the medication was ever given at snack times and confirmed there was no place to record that information. He also confirmed there were no notes on the back of the MOR indicating any times the medication was not given due to the resident being out of the facility.

Class III

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

Based on personnel record review and interview, the facility failed to ensure that 1 of 3 personnel records (C) contained a healthcare provider statement that indicated freedom from ( ) yearly.

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Findings:

Personnel record review for Staff C, the owner/administrator, revealed no evidence to confirm freedom from for 2016 or 2017. The last documentation for freedom from was dated .

In an interview on at 2:45PM with the Manager/Staff B, he confirmed the findings.

Class III

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

Based on personnel record review and interview, the facility failed to have evidence 1 out of 3 sampled staff (B) who provided direct care to residents had received training.

Findings:

Personnel record review revealed Staff B/manager, hired , did not have proof of training in .

In an interview with Staff B on at 2:30 PM, he confirmed the findings and stated he did have the training but was not sure where the card was at the time.

Class III

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

Based on record review and interview, the facility failed to ensure that 1 of 3 staff sampled (B) had received training in the facility's policies regarding ( ).

Findings:

Personnel record review for Staff B, hired , did not reveal any certificates for training in .

In an interview with Staff B/Manager on at 2:20 PM, he confirmed the findings.

Class III

0092 - Food Service - General Responsibilities - 58A-5.020(1) FAC

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Based on record review and interview, the facility failed to ensure the staff member in charge of Dining (C) had complied with the food service continuing education requirements specified in Rule 58A-5.0191, F.A.C.

Findings:

Personnel record review for the Staff C/owner did not reveal a certificate for the 2 hour annual update required for food and nutrition services. The most recent update in the record was dated .

On at 3:30 PM, the manager/Staff B confirmed the findings and stated they would all be getting the training very soon.

Class III

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

Based on observation and interview, the facility failed to: 1) Maintain a 6-month record of menu substitutions.
2) Maintain a sufficient supply of water for use by the residents in the event of an emergency.

Findings:

1. Observation of the facility menus for the previous 6 months showed no indication of substitutions. There was no separate list of substitutions to review.

2. Observation of the emergency food supply on revealed the supply of water for use in the event of an emergency was not sufficient. The facility had 6 residents at the time of the survey and would require 18 gallons of water. They had 11 gallons of water in the facility.

On at 1:30 PM, the manager/Staff B confirmed the findings. He stated he did not know they needed more water and would get it the same day. He stated he was not aware of the rule about substitutions.

Class III

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

Based on resident record review and interview, the facility failed to ensure that resident records for 1 of

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4-sampled resident's records included semi-annual weight records and documentation of Power of Attorney (POA) and 3 of 4 sampled resident records contained Hospice Integrated Plans of Care (#3, #4 & #6).

Findings:

Review of the record for resident #3, admitted on , revealed an admission weight from . There was no documentation of subsequent weights in the record.

Resident #3 is receiving hospice care. There were visit notes from the hospice provider in the record, but a copy of the hospice Integrated Plan of Care was not found in the record.

Resident #3's contract was dated and was signed by her Power of Attorney (POA). The record was not found to contain a copy of documentation of the POA.

Review of the records for resident #4 and resident #6 revealed they were receiving hospice care. A copy of the hospice Integrated Plan of Care was not found in the records for residents #4 or #6. .

In an interview with the manager/Staff B on at 2:30PM, he confirmed the findings and stated he did not have any of the missing forms.

Class III

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

Based on facility record review and interview, the facility failed to ensure a copy of the facility's comprehensive emergency management plan, with documentation of review and approval by the county emergency management agency annually, as described in Rule 58A-5.026, F.A.C., was readily available by facility staff.

Findings:

A copy of the facility's Comprehensive Emergency Management Plan and approval letter was requested for review. A letter from the Orange County Office of Emergency Management, dated , was reviewed. There was no approval of the facility's plan as of the survey date. The facility was given 30 days from to correct the missing items.

In an interview with the manager/Staff B on at 10:30 AM, he stated this was the only letter he

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had to show. When asked for a copy of the approval of the previous year's plan, he said he did not have any older plan approvals to show.

Class III

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

Based on Observation, Record Review and Interview, the facility failed to register and maintain the employment status of employees within the Agency's Background Screening Clearinghouse for 3 of 3 sampled staff employees (Staff A, B, C).

Findings:

Review of the Agency's Background Screening website for 3 sampled staff revealed the facility did not have a Roster on the Agency's website.

In an interview with the manager/Staff B on at 2:45 PM, he confirmed that he had not created a roster.

Unclassified