STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968840	**11/20/2017**
NAME OF PROVIDER OR SUPPLIER **DIAMOND ALF, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3339 HWY 17** **GREEN COVE SPRINGS, FL 32043**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

On a biennial relicensure survey in conjunction with a complaint survey (CCR #2017010086) was conducted at Diamond ALF (License Number: 12748). Deficient practice was identified during the survey.

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

Based on record review and interview, the facility failed to ensure the Agency for Health Care Administration Health Assessment (form 1823) was complete upon admission for 5 Residents (Residents #1, #4, #7, #12 and #13) out of 16 sampled residents.

The findings include:

A record review was conducted for Resident #1 on . The Agency for Health Care Administration Health Assessment (form 1823) was reviewed. The form was not dated; the physician did not sign the form or fill in his/her medical license number. Section 2-B, B was marked as "No" to the question "Does the individual need help with taking his or her medications (meds)? If yes, please make a check mark in the appropriate box. A check mark was made in front of the box that read, "Needs assistance with self-administration of medications." Page 5, Section 3 of the form was blank.

Record review for Resident #4 revealed two mandatory 1823 forms were incomplete. The first sampled 1823 for Resident #4 was found to have no date of examination noted on page 4, making it impossible to determine the date of the assessment. It was also found to have no signatures on page 5, as well as no listed services arranged by the facility for the resident. The second sampled 1823 for Resident #4, dated , was found to have no signatures on page 5, as well as no listed services arranged by the facility for the resident.

Record review for Resident #7 revealed two incomplete mandatory 1823 forms. The first sampled 1823 for Resident #7 was found to have no signatures on page 5, as well as no listed services arranged by the facility for the resident. The second sampled 1823 for Resident #7 was found to have no date of examination noted on page 4, making it impossible to determine the date of the assessment. It was also found to have no signatures on page 5, as well as no listed services arranged by the facility for the resident.

The mandatory 1823 dated was reviewed for resident #12. Page 5 of the form listing the identified needs of the resident and the services to be provided was blank.

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During an interview with the Health and Wellness Director, Licensed Practical Nurse (LPN), at 5:25 pm, she stated that Resident #12 does receive assistance with most activities of daily living (ADLs).

The 1823 form dated . . . . . was reviewed for resident #13. Section 2-B, B was not marked as "Yes" or "No" to the question "Does the individual need help with taking his or her medications (meds)? If yes, please make a check mark in the appropriate box. The address and phone number of the examiner was left blank. Page 5 of the form listing the identified needs of the resident and the services to be provided was blank.

During an interview with Employee E at 5:25 pm, she stated that Resident #13 receives assistance with medication administration. She brings his medications to him in a medication cup and she leaves them with him.

Photographic evidence was obtained

Class III

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

Based on observation, interview, and record review, the facility failed to properly assist residents with self-administration of medication for 1 of 6 sampled residents (Resident # 4, 5, 7, 8, 13, and 17) evidenced by late medication assistance and improper procedures being utilized during medication pass.

The findings include:

1. On , Employee C (an unlicensed medication technician), was observed performing the 8:00 AM medication pass. It was noted that Employee C was the only staff member working to provide 42 residents with their scheduled medication. This medication pass of the 8:00 AM medications was at 10:30 AM, at which time Employee C confirmed that she was still assisting with medications ordered to be given 2 and a half hours prior.

At 10:40 am on , Employee C handed Resident #17 her medication in a paper cup, and the resident self-administered the medication. Employee C did not identify the medications for the resident. At 10:50 am, Employee C handed Resident #7 his medication in a cup of applesauce, and the resident was able to spoon the pills into his mouth and swallow. Employee C did not identify the medications for the resident. At 11:15 am, Employee C handed Resident #8 his medication in a paper cup, and the resident self-administered the medication. Employee C did not identify the medications for the resident.

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At 11:25 am, Employee C handed Resident #5 her medication in a paper cup, and the resident self-administered the pills. Employee C did not identify the medications for the resident. At 11:35 am, Employee C attempted to hand Resident #4 her medication in a paper cup, but the resident refused the medication. Employee C did not identify the medications for the resident.

On at 1:00 pm, an interview was conducted with the facility's supervising Licensed Practical Nurse (LPN). The LPN reported that it was her expectation that all medication technicians followed the "Nine Rights to Medication Administration," when passing medication, which included confirmation of the right drug for the right patient. The LPN provided the surveyor with a copy of the document, entitled Florida State Medication Practices for Med Techs, that was part of the curriculum for medication technicians. Page 2 of this document listed the nine rights to medication administration and details the importance of following the nine rights. Photo evidence obtained.
2. During an interview with Resident #13 on at 12:25 pm, he stated that at the time of that interview, he had missed two medications . He was not sure why he did not get them. He stated he was supposed to get them at 8:00 am. A red capsule in a medication cup was observed on his bed. He stated he would take that medication later. He stated he always took his medications and the staff left them with him because they knew he would take them when he was ready.

During n interview with Employee C on at 1:05pm, she stated the medication ( ) for Resident #13 was not on the medication cart and she did not know why. She had reported it to the Health and Wellness Director (H&WD) and was waiting to find out.

Review of the Agency for Health Care Administration Health Assessment (form 1823) dated revealed the resident was assessed as requiring assistance with medication administration.

Review of the Medication Observation Record for Resident #13 for the month of 2017 revealed the resident's medications were all scheduled for 8:00 am for morning doses and 8:00 pm for evening doses. The medication technician initialed and circled her initials on and for the 8:00 am dose of , indicating the medication was not given. Documented on the back of the form it read: " Resident refused." And " Not in cart."

During an interview with Employee E at 5:25 pm, she stated that Resident #13 received assistance with medication administration. She brought his medications to him in a medication cup and she left them with him.

During an interview with the H&WD at 3:45 pm, she confirmed that the pill observed on Resident #13's bed was an 8:00 am medication. She stated he got medications at 8:00am and 8:00pm. She did not

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know what the medication was, but would go check.

She returned to the interview at 5:25 pm and stated that the medication was an 8:00 am medication and the medication technician should not be leaving the medications with him. They should stay and watch him take the medications. Resident #13 was not given his medication ( ) at 8:00 am due to it not being on the cart. The H&WD stated the medication was in the medication storage the medication technician (Employee C) should have gone and gotten it and given it to the resident.

Class III

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

Based on observation, interview, and record review, the facility failed to maintain accurate medication observation records (MORs) for 2 of 5 residents observed during assistance with self-administration of medication or medication administration. (Residents #7 and #17).

The findings include:

On , Employee C, an unlicensed medication technician, was observed during the 8:00 AM medication pass. The surveyor's observation commenced at 10:30 am, at which time Employee C was passing medications scheduled for 8:00 am. Employee C was observed preparing and assisting with the self-administration of medication for Resident #17. Employee C prepared Resident #17's ordered medications with the exception of 1000 mcg, as no supply was available in the medication cart. Employee C acknowledged that she did not have any for the resident and mentioned it to a nearby clinical staff member.

At 10:46 am, Employee C prepared Resident #7's ordered medications with the exception of 75 mg, as no supply was available in the medication cart. She acknowledged that no supply was available, and continued on with the medication pass.

A review of the the MORs for Resident #17 and Resident #7 was done on at 1:50 pm. It was observed that Resident #17's was marked as not administered on at 8:00 am, as evidenced by Employee C's circled initials in the designated box. Review of the opposite side of the MOR revealed that Employee C had documented that the reason the resident had not received the was that it was "refused." When asked about the notation, Employee C proceeded to cross out

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"refused," and write "no medication," while the surveyor watched.

At 2:00 pm, Employee C was observed with her personal belongings and confirmed that she had completed her shift and was leaving. The surveyor requested that Employee C review the MOR for Resident #7, which she agreed to do. She confirmed that her initials were present on the resident's MOR in the designated box, representing that she provided Resident #7 with his at 8:00 am on . She stated that she had provided the resident with his . However, when asked to produce the bubble pack or bottle of , Employee C was unable to do so, and she showed the surveyor that there was no present in the medication cart for Resident #7. In the presence of the surveyor and the supervising LPN, Employee C attempted to circle her initials in the designated box. She confirmed that she had not given Resident #7 his ordered , although she had marked that she had.

In an interview at 2:10 pm, the supervising LPN stated that it is her expectation that the medication technicians document unreceived medications according to the Florida State Medication Practices for Med Techs, 9 Rights of Medication Administration. At this time Employee C stated that she was familiar with the correct procedure of initialing and then circling her initials to document an unreceived medication, although she did not adhere to that procedure.

Class III

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

Based on interview and record review, the facility failed to ensure that "as needed" (PRN) medication orders contained the circumstances, or indication for use; a specific frequency in hours; and a prescribed limit of tablets that could be provided in 24 hours, for 2 of 2 residents whose medications were reviewed (Resident #8 and #15), who recieve assistance from unlicensed personnel for medication self-administration. The facility also failed to ensure that prescriptions for residents who receive assistance with self-administration of medication, or medication administration, were filled or refilled in a timely manner for 4 of 4 sampled residents (Residents #6, 12, 14 and 16).

The findings include:

1. Review of the 2017 Medication Observation Record (MOR) for Resident #8 revealed that an order for , 0.5 mg, with instructions to take 1 tablet by mouth three times a day as needed, did not include the circumstances under which the medication could be provided by unlicensed staff , and

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did not list the specific number of hours that must pass between doses. Photographic evidence obtained.

Review of the 2017 MOR for Resident #15 revealed the following order: / mg tablet, take 1 tab PO q 4 or q 6 PRN for pain on scale of 4 to 6. It was observed that this medication order did not include an upper limit on the number of tablets that can be given in 24 hours. It also required that the unlicensed medication technician interpret if 4-6 hours had elapsed since the last dose was provided. Photographic evidence obtained.

An interview was conducted with Resident #8 on at 11:20 AM. When asked why he was prescribed the and when he takes it, he could not give an explanation. An interview was conducted with Employee C, the unlicensed medication technician, on at 11:26 AM, and she was asked how she determined if Resident #8 requires . Employee C stated that she would provide the resident with if an aide came and informed her that "there was something different about him."

In an interview with the supervising LPN on at 5:45 pm, she confirmed that the PRN medication order for did not have written circumstances or an indication for use, and did not have a frequency written in terms of hours. She confirmed that the PRN order for / did not specify an upper limit on the number of tablets that could be provided, and included a range of hours (4-6) instead of a set number of hours between doses. She agreed that per the Florida State Medication Practices for Med Techs, 9 Rights of Medication Administration, which she uses as a guide to instruct the facility's unlicensed personnel, these elements were missing from the provider's order and should have been clarified. She also agreed that unlicensed medication technicians are not permitted to interpret these items, so they must be present in the provider's order.

2. Review of the Medication Observation Record (MOR) for Resident #16 revealed a provider's order for 100 mg tablet, with instructions to take 1 tab by mouth every morning. Based on the MOR, the medication was ordered for (condition in which the does not produce enough hormone). Review of the opposite side of the MOR revealed that 5 consecutive doses of the ordered were not provided on through , because of the documented reason "no medication." Photo evidence obtained.

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Review of the Medication Observation Record (MOR) for Resident #12 revealed a provider's order for 12.5 mg tablet, take 1 tablet by mouth twice a day. Based on the MOR, the medication was ordered for (high). Review of the opposite side of the MOR revealed that 5 doses of the ordered were not provided on through , and one dose on , because of the documented reason "no medication." Photo evidence obtained.

Review of the Medication Observation Record (MOR) for Resident #6 revealed a provider's order for D3 2,000 I.U. tablet, take 1 tablet by mouth once daily. Based on the MOR, the medication was ordered for " D deficiency." Review of the opposite side of the MOR revealed that 9 doses of the ordered D were not provided on 11/ through , because of the documented reason "no medication." Photo evidence obtained.

Review of the Medication Observation Record (MOR) for Resident #14 revealed a provider's order for , with instructions to take 1 capsule by mouth every 12 hours. Based on the MOR, the medication was ordered for . Review of the opposite side of the MOR revealed that at least 8 doses of the ordered were not provided on through , because of the documented reason "no medication." Photo evidence obtained.

In an interview with the supervising LPN on at 1:07 pm, she stated that the medication technicians are responsible for monitoring the number of pills remaining for a resident and reordering the medications as appropriate. In a follow-up interview at 5:45 pm, the LPN reviewed the MOR documentation and acknowledged that there were many missed doses. She reported that she has no formal system in place for auditing the MOR or missed doses, and stated that she has informally communicated to the medication techs "that if they don't have time to do it [reorder] they need to tell me."

Class III

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

Based on a review of employee records, and interview with staff, the facility failed to obtain a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable for 3 of 3 employees reviewed for health screening (Employees A,

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B and the Administrator), and failed to obtain a statement of freedom from for 2 of 3 sampled employees (Employee A and the Administrator).

The findings included:

A personnel file review conducted for Employee A found she was hired as a Certified Nursing Assistant in . Further review of the file found no documentation from a health care practitioner that she was free of communicable , including .

A personnel file review conducted for Employee B found she was hired as a Certified Nursing Assistant on . Further review of the file found no documentation from a health care practitioner that she was free of communicable other than .

A personnel file review conducted for the Administrator found she was hired . Further review of the file found no documentation from a health care practitioner that she was free of communicable , including .

The facility owner, and the Assistant Administrator acknowledged the missing health clearances in an interview at 6:30 pm on .

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation and interview, the facility failed to provide enough qualified staff to supply residents with services in accordance with their scheduled and unscheduled service needs, evidenced by medications being given past the deadline for 5 of 6 residents sampled (Residents #4,5,7,8, and 17).

The findings include:

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Employee D was interviewed on . . . . . at 10:40 AM, and stated the staffing levels are not enough to meet the resident care needs.

Resident #13 stated in an interview at 12:25 PM on . . . . . that he found staff to be short tempered at times because they appeared to "have too much to do".

At 1:38 PM, Resident #2 stated his medications are usually over an hour late, and he did not feel there was enough staff present to meet the needs of residents.

Resident #5 stated at 4:00 PM on . . . . . that the facility could use more staff to provide care to residents.

During an observation on of Employee C, an unlicensed medication technician, assisting residents with their morning medications, it was observed that Employee C was the only staff member working to provide 42 residents with their scheduled medication. At 10:30 AM on , Employee C confirmed that she was still assisting with medications ordered at 8:00 AM. She was unable to state how long it typically takes her to complete the morning medication pass.

At 10:40 am, Employee C handed Resident #17 her 8:00 am medication in a paper cup, and the resident self-administered the medication. At 10:50 am, Employee C handed Resident #7 his 8:00 am medication in a cup of applesauce, and the resident self-administered his medication. At 11:15 am, Employee C handed Resident #8 his 8:00 am medication in a paper cup, and he self-administered the medication. At 11:25 am, Employee C handed Resident #5 her 8:00 am medication in a paper cup, and the resident self-administered her pills. At 11:35 am, Employee C attempted to hand Resident #4 her 8:00 am medication in a paper cup, but the resident refused the medication.

On at 1:00 pm, an interview was conducted with the facility's supervising LPN. When asked for policy and procedure on medication administration, she stated that it is her expectation that all medication technicians follow the "Nine Rights to Medication Administration," when passing medication. The LPN provided the surveyor with a copy the document, entitled Florida State Medication Practices for Med Techs, that she stated is part of her instruction for the facility's medication technicians. Page 2 of this document, titled The Nine Right to Medication Administration, specifies that medications must be given at the correct time: "It is considered a med error to administer a medication at the wrong time. (Remember the hour before, and an hour after rule)" Photo evidence of the document was obtained. The supervising LPN then confirmed that medication technicians providing 8:00 am medications after 9:00 am would be unacceptable.

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During an interview on at 2:50 PM, EMployee Q, a caregiver responsible for providing direct care to residents, stated the facility's population requires more assistance than what is currently scheduled. SHe said that based on the needs of the residents, there should be more staff available to ensure their needs get met.

An interview was conducted with the facility owner at 6:30 pm on . When told of the observation of the medication technician's unsuccessful attempts to provide roughly the residents with their 8:00 am medications on time, he confirmed that more staff would be need to be added to ensure medications are passed out at the correct times, according to nursing standards and facility policy.

Class III

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

Based on a review of employee records and interview with staff, the facility failed to provide or arrange for the required in-service trainings to 3 of 3 employees whose files were reviewed for training requirements (Employees B and C).

The findings included:

A personnel file review conducted for Employee A found she was hired as a Certified Nursing Assistant on . Further review of the file found no evidence she had received the required in-service trainings in the facility ' s resident elopement response policies and procedures, facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation, reporting adverse incidents, resident rights, or recognizing and reporting resident , neglect, and , within 30 days of hire, as required.

A personnel file review conducted for Employee B found she was hired as a Certified Nursing Assistant on . Further review of the file found no evidence she had received the required inservice training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. Her certificate for training in activities of daily living (ADLs) and behavioral needs dated only reflected 1 of 3 required hours of training. Employee B had no evidence of training in emergency preparedness and evacuation response training, or reporting adverse incidents, as

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required within 30 days of hire.

A personnel file review conducted for Employee C found she was hired as a Medication Technician on . Further review of the file found no training in control including universal precautions, and facility sanitation procedures before providing personal care to residents. She had only received 1 hour of training in ADLs and behavioral needs, per the certificate dated , and no training in resident rights.

An interview was conducted with the Assistant Administrator on 11/ at 4:44 pm . He acknowledged the missing trainings for Employees A, B and C, and stated he would have them completed as soon as possible.

Class III

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

Based on a review of employee records, and interview with staff, the facility failed to ensure 1 of 3 sampled employees reviewed for trainings (Employee C) completed a one-time education course on / , including the topics prescribed in the Section 381.0035, F.S. within 30 days of hire.

The findings included:

A personnel file review conducted for Employee C found she was hired as a Medication Technician on . Further review of the file found no training in / since employment commenced.

An interview was conducted with the Assistant Administrator on 11/ at 4:44 pm . He acknowledged the missing training and stated he would have it completed as soon as possible.

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

Based on a review of employee and facility records and interview with staff, the facility failed to ensure that a staff member who had completed a course in first aid and ( ) was in the facility at all times.

The findings included:

A personnel file review conducted for Employee A found she was hired as a Certified Nursing Assistant (CNA) in . Further review of the file found no certification in .

A personnel file review conducted for Employee B found she was hired as a Certified Nursing Assistant on . She did not have a CNA license number or verification in the employee file. Both her first aid and certificated had expired on .

A personnel file review conducted for Employee C found she was hired as a Medication Technician on . Further review of the file found no first aid training. Her card had no issue and no expiration date.

A full review of all current employees' files was conducted and compared to the facility's current week's schedule. The comparative investigation revealed the following:

On , 2017 on the 3:00 pm - 11:00 pm shift, Employee E (Medication Technician), L (CNA), N (Medication Technician), M (Medication Technician), and Q (Caregiver) worked. Personnel file reviews found Employee E's first aid and expired , Employee L had no first aid, Employee N had no first aid, Employee M's first aid and expired , and Employee Q (Caregiver) had no or first aid training. There was no employee certified in first aid on the shift.

On , 2017 on the 3:00 pm - 11:00 pm shift, Employees M (Medication Technician), Employee A (CNA), Employee Q (Caregiver), Employee E (Medication Technician), and K (Medication Technician) worked. Employee M's first aid and expired , Employee A had no ,

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Employee Q had no first aid or , Employee E's first aid and expired , and Employee K had no first aid or . There was no employee certified in on the shift.

An interview was conducted with the Assistant Administrator at 4:00 pm on . He reviewed the employee list, credentials and facility schedule. He stated he did not realize there were any shifts without first aid or trained employees.

Class III

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

Based on employee record reviews and staff interview, the facility failed to ensure 1 of 3 sampled employees reviewed for trainings (Employee A) received at least one hour of training in the facility ' s policies and procedures regarding ( ) within 30 days of hire.

The findings included:

A personnel file review conducted for Employee A found she was hired as a Certified Nursing Assistant on . Further review of the file found no evidence she had not received at least one hour of training in the facility ' s policies and procedures regarding ( ).

An interview was conducted with the Assistant Administrator on 11/ at 4:44pm . He acknowledged the missing training for Employee A, and confirmed it needed to be completed.

Class III

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

Based on a review of facility and employee records, and interview with staff, the facility failed to ensure 1 of 3 employees' (Employee B) file contained a copy of the job description given to each staff member pursuant to Rule 58A-5.019, F.A.C..

The findings included:

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

A review of the facility census at the time of survey found there were 42 residents living in the facility.

A personnel file review conducted for Employee B found she was hired as a Certified Nursing Assistant on . Further review of the file found no copy of her job description.

In an interview with the Assistant Administrator at 4:44 pm on , he acknowledged the missing job description.

Class III