STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965739	**01/17/2018**
NAME OF PROVIDER OR SUPPLIER **HERON CLUB AT PRESTANCIA (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **3749 SARASOTA SQUARE BLVD. SARASOTA, FL 34238**	

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

0000 - Initial Comments

An unannounced relicensure survey was conducted through at Heron Club Prestancia (the), an assisted living facility (license #10107) in Sarasota, 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 observations, record reviews, and resident and staff interviews, the facility failed to ensure 2 (Resident #3 and #13) of 4 residents observed during self-administration of medications received their medications according to the physician's orders.

The findings included:

1. Review of the physician's orders showed Resident #3 was prescribed Mapap 500 mg., 2 tablets by mouth three times daily.

On at 8:16 a.m., Certified Medication Assistant (CMA) Staff D was observed assisting Resident #3 with his morning medications. Included in the medications was Mapap (,) 500 mg., 2 tablets. Staff D handed Resident #3 his medications and he self-administered them.

Review of the , 2018 Medication Observation Record (MOR) showed the scheduled dosing times of 8 a.m., 12:00 p.m., and 8:00 p.m. for the Mapap. The MOR failed to show Resident #3 received the 12:00 p.m. dose of the medication between , 2018 through , 2018.

On at 11:30 a.m., the Health and Wellness Director (HWD) could not confirm Resident #3 received the 12:00 p.m. doses of the Mapap.

On at 12:00 p.m., CMA Staff D said she gives the 12:00 p.m. dose of the Mapap either in the resident's in the medication . She admitted she did not sign off she had given the 12:00 p.m. dose of the medication during the month of , 2018.

On at 12:10 p.m., Resident #3 said he received the Mapap in the morning. Resident #3 said he does not receive the 12:00 p.m. dose in his , nor in the medication .

2. Review of the physician's orders showed Resident #13 was prescribed 3.125 mg. twice

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daily with meals and 325 mg. tablets twice daily with breakfast and dinner.

On at 8:45 a.m., Certified Medication Assistant (CMA) Staff E was observed assisting Resident #13 with his medications. Included in the pill cup was 3.125 mg. and 325 mg. After entering Resident #13's , Staff E handed him his medications and he self-administered them.

On at 9:00 a.m., Staff E said Resident #13 usually gets up at 11:00 a.m. and does not eat breakfast. Instead, Resident #13 has to be woken up, given his medications, and then he goes back to sleep. Staff E admitted Resident #13 does not take the and according to physician's orders. Staff E said Resident #13's medication schedule should be changed according to when he likes to wake up.

Class III

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

Based on record review and staff interview, the facility failed to obtain a written statement completed by a health care provider (Medical Doctor, Physicians Assistant, or Advanced Registered Nurse Practitioner) within 6 months prior to hire or within 30 days of hire that they are free of communicable , including , for 2 (Staff A and C) of 3 staff reviewed.

The findings included:

Record review of Staff A's employee file revealed a hire date of as an Assisted Living Attendant. Staff A's file contained no written statement from a health care provider documenting that Staff A does not have any signs or symptoms of communicable .

Record review of Staff C's employee file revealed a hire date of as a Memory Care Attendant. Staff C's file contained a communicable statement dated , which is more than 6 months prior to Staff C's date of hire.

On at 12:45 p.m., the Administrator said she had not realized this documentation was incomplete.

Class III

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

Based on record review and staff and resident interview, the facility failed to ensure documentation of

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the appointment of a power of attorney was present in the clinical record for 1 (Resident #6) of 2 records reviewed. The facility failed to follow the directives in Resident #6's power of attorney and health care surrogate documents.

The findings included:

1. During an interview on at 9:43 a.m., Resident #6 was alert and able to answer simple questions. Her private caregiver was present and indicated Resident #6 could be at times.

Review of Resident #6's admission contract showed her daughter signed and dated the contract as the Power of Attorney (POA) for the date of .

Review of Resident #6's ( ) was signed by Resident #6's daughter.

Review of Resident #6's record failed to show documented evidence that her daughter was the POA and could sign the admission contract and .

On at 2:00 p.m., the Executive Director (ED) wasn't aware Resident #6's record was missing evidence that her daughter was the POA and said the and admission contract was signed prior to her employment.

On at 8:30 a.m., the ED said Resident #6's daughter brought in documentation which showed she was Resident #6's POA and health care surrogate. Review of page 4 of the health care surrogate paperwork (Five Wishes) documented the following, "...If I [Resident #6] am no longer able to make my own health care decisions, this form names the person [daughter] I choose to make these choices for me..."

Review of page 10 of Resident #6's Durable Power of Attorney documented, "...Arrange for and consent to medical, therapeutical and surgical procedures for me, including the administration of drugs, if I am unable to express my decisions regarding the same..."

There was no indication in Resident #6's record she was deemed incapable of signing her own and admission contract.

Class III

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Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on record review and staff interview, the facility failed to ensure that persons subject to screening had not had a break in service from a position that requires a level 2 screening for more than 90 days for 1 (Staff B) of 3 staff reviewed.

The findings included:

Review of the employee record for Staff B showed a hire date of as a Memory Care Attendant. Staff B's application revealed she had left her last position requiring Level 2 screening in of 2017. The Agency for Health Care Administration Background Screening revealed an eligible date of .

On at 12:45 p.m., the Administrator said she had not realized there was a 90 day gap in employment which required a Level 2 background screening for Staff B and would have this updated when Staff B returned from maternity leave.

Unclassified