STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911143	01/24/2018
NAME OF PROVIDER OR SUPPLIER **JOHN KNOX VILLAGE OF CENTRAL F**	STREET ADDRESS, CITY, STATE, ZIP CODE **101 NORTHLAKE DRIVE ORANGE CITY, FL 32763**	

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

0000 - Initial Comments

On , 2018 an abbreviated biennial relicensure survey with Extended Congregate Services monitoring was conducted at John Knox Assisted Living Facility (License # 5177). Deficient practice was identified during the survey.

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

Based on observations, record reviews, and staff interviews the facility failed to maintain an awareness of the health status for 1 of 4 residents receiving Extended Congregate Care (ECC) services, related to the use of Resident #3.

The findings include:

An observation was conducted on at 10:47 AM of Resident #3 sitting in her recliner in her being administered via nasal cannula at 2.5 liters per minute via a concentrator.

A record review of Resident #3's Medication Observation Record (MOR) for , 2018 revealed that Resident #3 did not have any current orders on it for her administration.

On at 11:37 AM, an interview was conducted with Employee B, Licensed Practical Nurse, (LPN) regarding Resident #3's order. Employee B opened Resident #3's chart to an order dated , stating that Resident #3 was to receive 4 liters of via nasal cannula per minute. Employee B stated "this is not the correct order", and stated her supervisor, Employee C (also a LPN), was online trying to locate the current order. Employee B stated Resident #3 was only supposed to be on 2 liters.

A record review was conducted of Resident #3's paper medical chart, and it was confirmed Resident #3 had an order for at 4 liters per minute, continuously, dated . Further review of the record revealed an order located in the progress notes section with instructions to "try to wean to 3 liters", dated . At the time of the survey, Resident #3's records did not contain an order for at either 2 or 2.5 liters per minute. The most recent physician order on file was for 4 liters per minute, dated .

Review of the 1823 Health Assessment for Resident #3 showed on page 1, under the section titled "Physical or sensory limitations", it was written " @ 4L continuous".

On at 2:46 PM an interview was conducted with Employee C. She clarified that the date the 1823 was updated by a health care provider was written in the corner of the assessment. The

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911143	01/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN KNOX VILLAGE OF CENTRAL F	101 NORTHLAKE DRIVE ORANGE CITY, FL 32763

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

assessment showed a date of as the most recent update. Employee C confirmed that Resident #3 does not currently have an order for her ( ) at 2 liters/minute, however, there is a note in the nurses progress notes. Employee C confirmed that the person whom entered the progress note failed to transfer the order to the computer. Employee C stated " would be documented on the MOR, if the order had been put into the computer. Employee C stated "according to their records Resident #3 should be on 4 liters/minute, and they are not currently monitoring her level, because the two orders go hand in hand in the computer, so when they failed to enter her order, no order showed on the MOR for Resident #3's levels.

An interview was conducted with the Administrator at 3:55 PM on . The Administrator stated "LPN's check the MOR which is generated by the computer against physician orders monthly. When a new order is generated by a Physician or a Advanced Registered Nurse Practioner (ARNP) a nurse types it into the computer and the next day another nurse checks to make sure the order was entered. In a follow up interview at 4:06 PM, she was asked who was responsible for ensuring the is being administered correctly, and she stated "it is the nurse's responsibility. "

On an interview was conducted with Advanced Registered Nurse Practitioner (ARNP) at 4:56 PM. The ARNP stated, "I thought Resident #3 was receiving 2 Liters of , we started her last year. I like to have the Residents at the lowest possible rate. I was not aware she was receiving 2.5 L of ". ARNP was asked how she would wean an level, and ARNP stated" I would write an order to wean to lowest possible dose". The ARNP was informed that was at 2.5 liters today when Resident #3 was observed. ARNP was asked when she was notified of the current order for 4 liters, ARNP stated, "I was notified today of the order for 4 liters, by the facility. When asked how she ensures the orders are followed through on, the ARNP stated, "I write orders and trust the nurses to put it in the computer".

An observation was conducted of Resident #3 in the dining at 5:32 PM. Resident #3 was sitting in her wheelchair, with a nasal cannula in place. Resident #3 was observed leaning over with her head down. Upon review of the portable tank that was attached to Resident #3's nasal cannula, the tank was empty, according to the level gauge on the tank.

On at 5:41 PM an interview was conducted with Employee A, Licensed Practical Nurse, (LPN) regarding the administration for Resident #3. Employee A, LPN observed the concentrator in Resident #3's , and confirmed that it was set at 2.5 liters per minute. Employee A was questioned regarding the current order for Resident #3's , and Employee A stated, "I think it's supposed to be around 3 liters". Surveyor then asked Employee A what Resident #3's saturation was. At the time, Resident #3 was located in the dining .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911143	01/24/2018
NAME OF PROVIDER OR SUPPLIER **JOHN KNOX VILLAGE OF CENTRAL F**	STREET ADDRESS, CITY, STATE, ZIP CODE **101 NORTHLAKE DRIVE ORANGE CITY, FL 32763**	

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

Upon entering the dining , Resident #3 was observed sitting in her wheel chair, with her head down. Employee A then woke Resident #3 up, and asked for a finger to obtain her saturation. Employee A placed the saturation machine on Resident #3's left hand, pointer finger. The result was 78%. Employee A was then asked to look at Resident #3's portable tank on the back of the wheelchair (the tank Resident #3's tubing was connected to), Employee A confirmed that the tank was empty. Employee A then stated, "I do not know how it could be empty, I just put it on in her she came down to the dining , and the tank was full".

Employee D, a Med Tech, then entered the dining , and was asked who brought Resident #3 to the dining . Employee D stated, "I brought her in here". She confirmed Resident #3 was brought in at 5:00 PM. Employee A was then observed with a key. She turned the key, and the tank showed 2000 liters of air. Employee A stated, "The tank was turned off. I did not turn it on, because she was still in her ". Surveyor then asked Employee D, Med Tech, if she had looked to see if the tank was on or full when she had brought her to the dining , and Employee D stated, "No, I thought the nurse turned it on". Employee A was asked what Resident #3's level was. Employee A placed the saturation machine on Resident #3's left hand, pointer finger, and after approximately 5 minutes of receiving , Resident #3's level had increased to 86%. The saturation climbed between % two minutes later.

Review of the facilities policy and procedure for administration was conducted. The policy title Administration, dated reported the second step is to verify the physician order for Resident, the rate of liters to be administered, the time and type of supply to be used for administering .

Photographic evidence obtained

Class II

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on observations, record review, and staff interviews the facility failed to have licensed staff administer in accordance with Florida statue 58 A-5.0185 (4), FAC for Resident #3, who received in the facility, which resulted in a Class II deficiency related to medication practices.

The findings include:

An observation was conducted on at 10:47 AM of Resident #3 sitting in her recliner in her

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911143	01/24/2018
NAME OF PROVIDER OR SUPPLIER **JOHN KNOX VILLAGE OF CENTRAL F**	STREET ADDRESS, CITY, STATE, ZIP CODE **101 NORTHLAKE DRIVE ORANGE CITY, FL 32763**	

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

with ,, being administered via nasal cannula at 2.5 liters per minute via a concentrator.

A record review of Resident #3's Medication Observation Record (MOR) for , 2018 revealed that Resident #3 did not have any current orders on it for her ,, administration.

On at 11:37 AM, an interview was conducted with Employee B, Licensed Practical Nurse, (LPN) regarding Resident #3's ,, order. Employee B opened Resident #3's chart to an order dated , stating that Resident #3 was to receive 4 liters of ,, via nasal cannula per minute. Employee B stated "this is not the correct order", and stated her supervisor, Employee C (also a LPN), was online trying to locate the current order. Employee B stated Resident #3 was only supposed to be on 2 liters.

A record review was conducted of Resident #3's paper medical chart, and it was confirmed Resident #3 had an order for ,, at 4 liters per minute, continuously, dated . Further review of the record revealed an order located in the progress notes section with instructions to "try to wean ,, to 3 liters", dated . At the time of the survey, Resident #3's records did not contain an order for ,, at either 2 or 2.5 liters per minute. The most recent physician order on file was for 4 liters per minute, dated .

Review of the 1823 Health Assessment for Resident #3 showed on page 1, under the section titled "Physical or sensory limitations", it was written " @ 4L continuous".

On at 2:46 PM an interview was conducted with Employee C. She clarified that the date the 1823 was updated by a health care provider was written in the corner of the assessment. The assessment showed a date of as the most recent update. Employee C confirmed that Resident #3 does not currently have an order for her ,, ( ) at 2 liters/minute, however, there is a note in the nurses progress notes. Employee C confirmed that the person whom entered the progress note failed to transfer the order to the computer. Employee C stated " would be documented on the MOR, if the order had been put into the computer. Employee C stated "according to their records Resident #3 should be on 4 liters/minute, and they are not currently monitoring her ,, level, because the two orders go hand in hand in the computer, so when they failed to enter her order, no order showed on the MOR for Resident #3's ,, levels.

An interview was conducted with the Administrator at 3:55 PM on . The Administrator stated "LPN's check the MOR which is generated by the computer against physician orders monthly. When a new order is generated by a Physician or a Advanced Registered Nurse Practioner (ARNP) a nurse types it into the computer and the next day another nurse checks to make sure the order was entered. In a follow up interview at 4:06 PM, she was asked who was responsible for ensuring the ,, is being

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911143	01/24/2018
NAME OF PROVIDER OR SUPPLIER **JOHN KNOX VILLAGE OF CENTRAL F**	STREET ADDRESS, CITY, STATE, ZIP CODE **101 NORTHLAKE DRIVE ORANGE CITY, FL 32763**	

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

administered correctly, and she stated "it is the nurse's responsibility. "

On an interview was conducted with Advanced Registered Nurse Practitioner (ARNP) at 4:56 PM. The ARNP stated, "I thought Resident #3 was receiving 2 Liters of , we started her last year. I like to have the Residents at the lowest possible rate. I was not aware she was receiving 2.5 L of ". ARNP was asked how she would wean an level, and ARNP stated" I would write an order to wean to lowest possible dose". The ARNP was informed that was at 2.5 liters today Resident #3 was observed. The ARNP was asked when she was notified of the current order for 4 liters, ARNP stated, "I was notified today of the order for 4 liters, by the facility. When asked how she ensures the orders are followed through on, the ARNP stated, "I write orders and trust the nurses to put it in the computer".

An observation was conducted of Resident #3 in the dining at 5:32 PM. Resident #3 was sitting in her wheelchair, with a nasal cannula in place. Resident #3 was observed leaning over with her head down. Upon review of the portable tank that was attached to Resident #3's nasal cannula, the tank was empty, according to the level gauge on the tank.

On at 5:41 PM an interview was conducted with Employee A, Licensed Practical Nurse, (LPN) regarding the administration for Resident #3. Employee A observed the concentrator in Resident #3's , and confirmed that it was set at 2.5 liters per minute. Employee A was questioned regarding the current order for Resident #3's , and Employee A stated, "I think it's supposed to be around 3 liters". Surveyor then asked Employee A what Resident #3's saturation was. At the time, Resident #3 was located in the dining .

Upon entering the dining , Resident #3 was observed sitting in her wheel chair, with her head down. Employee A then woke Resident #3 up, and asked for a finger to obtain her saturation. Employee A placed the saturation machine on Resident #3's left hand, pointer finger. The result was 78%. Employee A was then asked to look at Resident #3's portable tank on the back of the wheelchair (the tank Resident #3's tubing was connected to), Employee A confirmed that the tank was empty. Employee A then stated, "I do not know how it could be empty, I just put it on in her she came down to the dining , and the tank was full".

Employee D, a Med Tech, then entered the dining , and was asked who brought Resident #3 to the dining . Employee D stated, "I brought her in here". She confirmed Resident #3 was brought in at 5:00 PM. Employee A was then observed with a key. She turned the key, and the tank showed 2000 liters of air. Employee A stated, "The tank was turned off. I did not turn it on, because she was still in her ". Surveyor then asked Employee D if she had looked to see if the tank was on or full when

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911143	01/24/2018
NAME OF PROVIDER OR SUPPLIER **JOHN KNOX VILLAGE OF CENTRAL F**	STREET ADDRESS, CITY, STATE, ZIP CODE **101 NORTHLAKE DRIVE ORANGE CITY, FL 32763**	

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

she had brought her to the dining , and Employee D stated, "No, I thought the nurse turned it on". Employee A was asked what Resident #3's level was. Employee A placed the saturation machine on Resident #3's left hand, pointer finger, and after approximately 5 minutes of receiving , Resident #3's level had increased to 86%. The saturation climbed between % two minutes later.

Review of the facilities policy and procedure for administration was conducted. The policy title Administration, dated reported the second step is to verify the physician order for Resident, the rate of liters to be administered, the time and type of supply to be used for administering .

In accordance with 429.42 F.S. & 58A-5.033 F.A.C., the facility must now employ or contract with a licensed registered nurse. Consultation services must begin within 14 days of the notice of uncorrected deficiencies. The facility must have available for review by the agency, a copy of the consultant ' s license and a signed and dated review of the corrective action plan within 10 days subsequent to initial on-site consultation visit. The facility must provide the agency with, at minimum, quarterly on-site corrective action plan updated until the agency determines after written notification by the consultant and the facility administrator that deficiencies are corrected and that staff have been trained to ensure that proper medication standards are followed and that consultation services are no longer required. The agency must provide the facility with written notification of such determination

Class III

E207 - ECC - Services - 58A-5.030(8) FAC

Based on observations, record reviews, and staff interviews, the facility failed to follow physician orders for the provision of extended congregate care (ECC) services for 1 of 4 residents (Resident # 3).

The findings include:

An observation was conducted on at 10:47 AM of Resident #3 sitting in her recliner in her being administered via nasal canula at 2.5 liters per minute via a concentrator.

On at 11:37 AM an interview was conducted with Employee B, Licensed Practical Nurse, (LPN), who was assigned to Resident # 3 on the day of the survey. Employee B was asked what Resident #3's order was, and after reviewing the computer she stated, "I'm not really sure from looking at this, I

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911143	01/24/2018
NAME OF PROVIDER OR SUPPLIER **JOHN KNOX VILLAGE OF CENTRAL F**	STREET ADDRESS, CITY, STATE, ZIP CODE **101 NORTHLAKE DRIVE** **ORANGE CITY, FL 32763**	

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

will have to look at Resident #3's hard chart in the office".

Employee B returned with the hard chart said, "there is not a current order in the chart". Employee B opened Resident #3's chart to an order for 4 liters via nasal canula per minute. Employee B stated that this is not the correct order, and her supervisor, Employee C, (also an LPN) was online trying to locate the current order. Employee B said Resident #3 is supposed to be on 2 liters of ,, per minute.

A record review was conducted of Resident #3's paper medical chart, and Resident #3 had an order for ,, 4 liters per minute continuous, dated . Further review of the record revealed an order located in the progress notes section to try to wean ,, to 3 liters, dated . The Health Assessment (1823) in her chart also instructed she get 4 liters. No orders could be found in her chart for ,, at 2 or 2.5 liters per minute; the only order in the record is for 4 liters per minute.

Record review of Resident #3's Medication Observation Record (MOR) for , 2018 revealed that Resident #3 did not have any sections to document ,, administration. Records also showed that Resident #3's required monthly assessments for ECC dated 2016, 2016, 2016, and , 2017 documented Resident #3 was receiving 2 liters of ,, not 4. Review of the required service plan revealed that it had not been updated or changed since completion on .

On at 2:17 PM an interview was conducted with the Administrator regarding the service plan for Resident #3. The Administrator confirmed that the plan was initiated on and should have been updated to reflect any changes.

On at 2:46 an interview was conducted with Employee C regarding the current order for Resident #3's ,, . She confirmed the 1823 gets dated in the top right corner when it is updated. The 1823 for Resident #3 (which indicated she was to get ,, at 4 liters per minute) showed it was last updated . Employee C confirmed that Resident #3 does not currently have an order for her ,, ( ) at 2 liters/minute, however, there is a note in the nurses progress notes. Employee C confirmed that the person who entered the progress note failed to transfer the ,, order to the computer. Employee C stated that they would be documenting the ,, on the MOR, if it had been entered into the computer. Employee C stated "according to their records Resident #3 should be on 4 liters/minute, and they are not currently monitoring her Spo2 (,,) level, because the two orders go hand in hand in the computer, so when they failed to enter her ,, order, no order showed on the MOR for Resident #3's ,, levels. She confirmed that the service plan should have been updated with changes to the Resident #3, and that the monthly assessments were incorrect, due to not having the correct ,, order.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911143	**01/24/2018**
NAME OF PROVIDER OR SUPPLIER **JOHN KNOX VILLAGE OF CENTRAL F**	STREET ADDRESS, CITY, STATE, ZIP CODE **101 NORTHLAKE DRIVE** **ORANGE CITY, FL 32763**	

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

An interview was conducted with the Administrator at 3:55 PM on . The Administrator stated "LPNs check the MOR which is generated by the computer against physician orders monthly. When a new order is generated by a Physician or a Advanced Registered Nurse Practioner (ARNP) a nurse types it into the computer and the next day another nurse checks to make sure the order was entered. In a follow up at 4:06 PM, she was asked who was responsible for ensuring the is being administered correctly, and she stated" it is the nurses' responsibility."

On an interview was conducted with the ARNP at 4:56 PM. The ARNP stated, "I thought Resident #3 was receiving 2 Liters of , we started her last year. I like to have the Residents at the lowest possible rate. I was not aware she was receiving 2.5 L of ". The ARNP was asked how she would wean an level, and ARNP stated" I would write an order to wean to lowest possible dose". The ARNP was informed that the was at 2.5 liters today when Resident #3 was observed. The ARNP was asked when she was notified of the current order for 4 liters, she stated, "I was notified today of the order for 4 liters, by the facility. When asked what the protocols are in place to ensure that all of her orders are entered executed correctly, she stated, "I write orders and trust the nurses to put it in the computer".

The facilities policy and procedure for administration dated was reviewed on . The second step reported to "verify the physicians order for Resident, rate of to be administered, the time and type of supply to be used for administering .

Class III