STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910275	**12/18/2017**
NAME OF PROVIDER OR SUPPLIER **GOOD SAMARITAN RETIREMENT HM**	STREET ADDRESS, CITY, STATE, ZIP CODE **507 S.E. 1ST AVENUE** **WILLISTON, FL 32696**	

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

0000 - Initial Comments

On 12/18/2017, an unannounced complaint survey (CCR#2017015136) was conducted at Good Samaritan Retirement Home in Williston (Licence #25). Deficiencies were identified as a result of the survey. The facility was not in compliance at this time.

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

Based on interview and record review the facility failed to contact the residents health care provider when resident exhibited a significant change in health status for 2 (Resident #1 and Resident #3) of 5 sampled residents.

Findings:

On 12/18/17, record review of Resident #3's 1823 dated 5/19/17 shows resident with a diagnosis of type 2 diabetes, hypertension, and dementia with episodes of confusion/inappropriate behavior (smearing poop on walls/all over body). Nursing/treatment/therapy service requirements show, 1:1 observation for safety reasons. In activities of daily living; resident requires supervision to ambulate, bathing, dressing, grooming, toileting, transferring; and is independent in eating. Resident status under section (C) shows he pose a danger to self or others and requires 24-hour nursing or psychiatric care due to Resident #3 places feces inside hand and sometimes smears it onto the wall. Resident #3 required daily observation of well-being, whereabouts, and reminders for important tasks.

On 12/18/17 at 9:30 AM, interview conducted with Staff A revealed Resident #3 went to UF-Urology on Thursday, 12/7/17 and had his catheter removed. She stated on Monday, 12/11/17 Resident #3 was not able to get out of bed or walk on his own when she arrived to work. Staff A stated she reported it to the Administrator and later emergency medical services arrived to transport resident to the emergency room for treatment. Staff A stated that she is off on Saturday and Sundays and is not sure what happen when she was off. She stated staff was not notified to contact the home health nurse regarding Resident #3's condition.

On 12/18/17 at 9:45 AM, interview conducted with Staff E revealed when she was on duty on Saturday, 12/9/17 during second shift Resident #3 seemed a little weak and was having a hard time going to the bathroom to urinate. She stated she notified the manager but was not informed to call the doctor or notify the nurse.

On 12/18/17 at 10:00 AM, interview conducted with Staff C. She stated that she works the morning shift

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mainly in the memory care unit and she does not assist with medication administration. Staff stated Resident #3 was kind of weak on Saturday and Sunday(12/9/17 and 12/10/17), and was having trouble walking and going to the bathroom. Staff C stated the Administrator was called and staff put a diaper on resident so he would not have to walk to the bathroom. Staff C stated the administrator did not tell staff to call 911 and the resident was still eating his food, drinking fluids and taking his medication with no problems.

On 12/18/17 at 10:38 AM, interview conducted with the facility administrator; he stated I am new here and unaware of the location of resident files, incident reports, the location of the communication log book, how change in medication orders are handled and documentation kept. I do not know if the physician was notified of the five resident medication refusals. In regards to Resident #3 instruction from the nurse, I'm not sure where to begin looking for any notation or documentation made by the prior Administrator. "I will contact the owner to address those questions for you because I'm still learning this facility".

On 12/18/17 at 12:00 PM, interview conducted with the facility owner revealed there was no incident report completed on Resident #3's incident which resulted in him being transported to the emergency department via EMS. When surveyor asked why isn't that information documented in the resident service log, the owner responded by saying, "I don't know". The owner stated she could not be at the Williston facility because she had another facility in Apopka she needed to be at. She stated that her son, former Administrator had been arrested and she is not sure what Resident #3's follow-up recommendation were and what the nurse told him to do. The facility's owner stated she would question her son as to what the nurse advised him to do regarding Resident #3 and his condition after his catheter had been removed.

On 12/18/17 at 1:45 PM, interview conducted with the home health nurse reveal the Administrator was instructed on 12/8/17 to monitor if Resident #3 is having problems urinating and to call if resident has a fever or is showing confusion. The Home Health nurse stated she received a call on 12/ 11/17 stating resident #3 was not able to get out of bed and walk on his own and needing assistance. Nurse ordered facility to send resident to the emergency room via EMS. At 12:40 PM, 911 was called and resident was sent to the hospital for medical care.

On 12/18/17 at 3:15 PM, interview conducted with Staff D, stated the weekend of 12/9/17, Resident #3 was walking slower but his appetite was good and he had no fever. She stated that he was having a problem voiding, it was taking longer to come out and he had a few accidents so staff put a diaper on him. Staff D was ask, "at what time would you call for medical assistance". She responded by saying, " if a resident was unresponsive she would call 911, tell the manager and administrator. She stated "I would

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call 911 if a resident is bleeding or falls and hits their head too." Staff D stated she did not document resident's condition on his observation log but the manager was called.

On 12/18/17 at 3:45 PM, interview conducted with Staff F revealed she works the majority of the time on third shift, but sometimes cover second shift. She stated Resident #3 was having some trouble going to the bathroom during the weekend his catheter came out and the administrator was notified. She also stated he needed more assistance to walk about the memory care area. Staff F stated Resident #3's condition was not documented in the resident service log/observation log.

Record review of the UF Shands Emergency Department report reveals Resident #3's diagnosis were urinary retention and history of urethral stricture. Procedures and tests performed during the ER visit were: basic metabolic panel, bladder scan, CBC and differential, CBC with differential panel result, urinalysis with Micro, and urine culture. Resident #3's discharge instructions stated; "You were seen at the Shands Emergency department for urinary retention. The exam and diagnostic studies during this visit showed signs of increased bladder volume but an ability to pee, just not enough to fully empty your bladder. This may be due to the stricture or scar tissue from your previous injury. There was no urinary tract infection. Based on these findings, follow-up with the Urology clinic for catheter removal and your primary care doctor is recommended. Return to the emergency room as needed for worsening of your symptoms or new fevers, chest pain, shortness of breath, or injury."

On 12/18/17 at 5:42 PM, contact made with Resident #3's daughter revealed resident will not be allowed to return to the facility due to the family's displeasure regarding the delay in obtaining medical attention for Resident #3. She stated she is not satisfied with the care facility has provided thus far.

On 12/18/2017, record review of Resident #1's 1823 dated 11/21/17 shows resident needs supervision with ambulation (fall risk), dressing, eating (aspiration precautions), and grooming; resident independent with toileting and transferring. Resident need daily observing of well being, whereabouts, and reminders for important tasks. Resident #1's medications are: Amlodipine 10 mg, Aspirin 81 mg, Levothroxine 25 mcg, Lisinopril 20 mg Metoprolol Tartrate 50 mg, Diclofenac 75 mg, Quetiapine 200 mg, Lorazepam 0.5 mg, Temazepam 15 mg, Loperamine 2 mg, Metoprolol 25 mg.

Record review of resident #1's file revealed he was admitted to UF Health on 12/2/17 then discharged back to the facility on 12/5/17 for moderate malnutrition with recommendations to follow-up with family medicine specialist in 3 days. No documentation in resident file showing resident #1 received follow-up appointment as recommended at discharge.

Record review of Resident #1 medication administration record revealed medication refusals 12/1/2017

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through 12/15/2017 for Amlodipine Besylate 10 mg (Hypertension), Aspirin 81 mg (Heart Health), Levothroxine 25 mg (Thyroid), Lisinopril 20 mg , Metoprolol tartrate 25 mg, Diclofenac 75 mg, Quetiapine Fumarate 200 mg (Mood stabilization), Lorazepam 0.5 mg (Anxiety), Temazepam 15 mg (Sleep).

On 12/2/17 through 12/4/17, documentation shows resident #1 was in the hospital for moderate malnutrition. Review of residents file revealed no documentation that the resident's primary care physician or family were contacted regarding refusal of medications. Doctors orders on file for the following medications: Levothyroxine 25 mcg to start on 11/21/17 to take 1 tablet by mouth every morning 1 hour before breakfast; Record review of MAR shows take 1 tablet by mouth daily for thyroid. Lorazepam 0.5 mg tablets, take 1 tablet by mouth every 12 hours as needed for anxiety with a start date of 11/21/17; the residents MAR shows Lorazepam 0.5 mg tablets, take 1 tablet by mouth twice a day for anxiety. Aspirin 81 mg tablet chewable, chew 1 tablet daily; the residents MAR shows the same. Amlodipine 10 mg tablet, take 1 tablet by mouth daily; the residents MAR shows the same. Quetiapine 200 mg tablet, take 1 tablet by mouth 2 times a day; the residents MAR shows the same. Metoprolol Tartrate 25 mg tablets, take 1 tablet by mouth 2 times a day with a start date of 11/21/17; the residents MAR shows Metoprolol Tartrate 50 mg tablets, take 1 tablet by mouth 2 times a day ; hold if BR<60 or SBP<100. Loperamide 2 mg capsule, take 1 capsule by mouth 4 times daily as needed for diarrhea with a start date of 11/21/17; the residents MAR shows Loperamide 2 mg capsule, take 1 capsule by mouth every 6 hours as needed for diarrhea. No order on file for Temazepam 15 mg capsule.

Prior interview conducted on 12/15/17 at 1:36 PM, interview conducted with Staff A when asked questions regarding: Resident #1's medications: Staff stated she was not aware resident's medication were changed on 11/21/17 on his Lorazepam, Metoprolol, Loperamide, and Levothyroxin. She states that all doctors' orders go to the Administrator and they make the necessary changes or updated to the medication record then update the Med Techs as to the changes to include the start date and /or discharged medication if any. Staff A stated, "If the administrator or manager does not notify the staff of medication changer, there is no way that staff would have known of the orders." In reference to resident medication refusals, Staff A stated "staff notified the manager and owner of resident refusing his medication but she only documented the information on the back of the medication record and did not notates it on his observation log the she report it to management. She stated she was not sure if the manager or owner contacted the physician or resident family during the earlier parts of December. She states that the doctor visits the facility to provide care and treatment on occasion but she was not sure of the date of his last visit, no documentation is on file related to physician's visits to the facility for the month of November and December. Regarding the incident with resident going to the hospital via EMS; staff stated the resident son was call due to decline and the resident's son informed staff to call 911 for medical attention, so they did. Staff A stated, "resident has not been eating or taking his medication for

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many days; she states information regarding resident not eating was in staff communication log book. She stated the communications logbook is kept in the Administrator's office.

Class III