| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11969063 | 03/12/2018 |
| NAME OF PROVIDER OR SUPPLIER<br>**EVERLASTING FAMILY HOME CARE SERVICES LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**2722 OKLAHOMA ST WEST PALM BEACH, FL 33406** | |

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

**0000 - Initial Comments**

An unannounced Limited Mental Health and Limited Nursing Services Monitoring visit survey was conducted on at Everlasting Family Home Care, an Assisted Living Facility in West Palm Beach, License # 11960963. The facility had deficiencies at the time of the visit.

**0053 - Medication - Administration - 58A-5.0185(4) FAC**

Based on observation, record review and interview, the facility failed to ensure that a resident consumed ordered medications for one of four sampled residents (R4).

Findings include:
1) The surveyor arrived at the facility on at 8:02 AM and was escorted to the kitchen/ dining , the staff member. The dining table had a plate with food on it and a screen cover over the food. The surveyor asked which resident had not yet eaten. The staff member stated that Resident # 4 liked to get up later than the others and had not yet had her breakfast. Under the screen plate cover was a plastic medicine cup with multiple pills. At 9:20 AM, Resident # 4 approached the table and sat down to consume her breakfast. The staff member heated the food up in the microwave and then handed it to the resident. The resident began to eat her breakfast and spoke to the surveyor. The staff member walked out of the kitchen/ dining area to provide care for resident # 3 who was in his . The staff member returned to the kitchen at 9:35 AM and encouraged the resident to consume the medications in the plastic medicine cup. He then left the kitchen again to attend to residents seated in the formal living . The resident was asked and stated that she doesn't like to take her medications until after she has eaten her breakfast. When the staff member returned to the kitchen/ dining area at 9:42 AM, the surveyor asked him if he observed the resident actually consume her medications. The staff member confirmed that he left the medications unattended at the resident's plate and failed to ensure that she actually consumed her medications.

Class III

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

Based on observation, record reviews and interviews, the facility failed to ensure that administrations administered to a resident were documented in the residents Medication Observation Record for 1 of 4 sampled residents (R3).

Findings include:

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11969063** | **03/12/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **EVERLASTING FAMILY HOME CARE SERVICES LLC** | **2722 OKLAHOMA ST WEST PALM BEACH, FL 33406** |

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

1) On at 8:00 AM, the surveyor arrived at the facility and informed the staff member that the surveyor needed to conduct a medication assistance observation. The staff member was also asked if any of the resident's received . The staff member stated the resident had received earlier that morning. The staff member removed a bag of multiple vials of from the refrigerator and handed it to the surveyor. The prescription label on the indicated that the resident was to receive 36 units of in the morining and in the evening . A review of the clinical record of Resident # 3 confirmed the order for the , however there was no documentation in the resident's records, including the Medication Assistance Records that he was receiving the . When asked, the resident confirmed that the employee pulled up the into the syringe and he self administered the . The resident also confirmed that he conducted sugar monitoring twice daily but that this was not documented. The staff member confirmed that the facility failed to document the self administration of and sugar monitoring for Resident # 3.

Class III