STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967845	03/08/2018
NAME OF PROVIDER OR SUPPLIER **TRANQUILITY HAVEN, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1346 WILDERNESS LANE** **TITUSVILLE, FL 32796**	

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

0000 - Initial Comments

Complaint Investigation #2017015479 was conducted on . . . . . Tranquility Haven LLC, License #11805, had deficiencies at the time of the visit.

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

Based on observations, record review and interview, the facility allowed unlicensed staff to give as needed medication. This was not consistent with their level of education, training and preparation, and experience. The nurse did not give medications to the resident who was not capable of requesting the medication, and allowed staff who were not certified nursing assistants (CNAs) or nurses to apply and remove anti- hose to 1 of 3 sampled residents (#3).

Findings:

Resident #3's record revealed she received hospice services. On the resident health assessment form 1823, dated , the health care provider noted anti- . . . . hose to each leg every morning and remove before bed.
There was a health care provider's order, dated . . . , that noted anti- . . . . hose on in the morning and off at bed time.

The medication observation record (MOR) for , 2018 revealed unlicensed staff were initialing the MOR as applying and removing the anti- . . . . hose.

On . . . . at 11:05 AM, the administrative assistant said she spoke with the facility's nurse who indicated the hospice staff applied the anti- hose on shower days, and facility's caregivers applied and removed the anti- . . . . hose on the other days.

On . . . . at 12:10 PM, the facility's license practical nurse (LPN) said resident #3 did wear anti- hose and the facility's caregivers would apply and remove the hose. She said not all of the staff were CNAs. She was not aware that only CNAs and nurses could apply and remove the hose.

On . . . . at 12:15 PM, the resident was observed without the anti- . . . . hose. Staff A said she put the hose on resident this morning but the resident had an accident and staff A removed them to be washed.

The . . . . , 2018 MOR noted . . . . , . . , for . . . , 0.5 milligrams (mg.) one tablet every 4 hours as

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needed with an unlicensed care giver's initials marked on the MOR as given. On the back MOR was noted on at 3:45 PM " Tab 0.5 mg. for agitation during hands on care. Approved by nurse." The LPN's name was written but the front of the MOR was initialed by the unlicensed staff.

On at 12:10 PM, the LPN said the unlicensed staff would call her and she would instruct the unlicensed staff to give the as needed over the telephone. She said the unlicensed staff would tell her the resident's behavior, such as agitated and kicking, and she would instruct the unlicensed staff to give after she determined the resident was agitated. She was not aware she was to actually be at the facility to observe the resident in order to determine whether or not the resident actually needed the

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on the substitution menu log review and interview, the facility failed to plan the menu at least 1 week in advance to ensure that the menu was served according to what was prepared by the dietitian.

Findings:

Review of the substitution menu log revealed for numerous days, the facility did not have all of the food to serve according to the menu on certain days, and substitutions were served on the following 25 days as follows:
(it noted beef stew was to be served but Chili was served and noted it was brought in by a family member),

On at 11 AM, the administrative assistant said the facility staff would use food that was suppose to be used for another day, and then when it was time to use the food that was to be served, it would have been used already and they would have to substitute.

On at 12:30 PM, the licensed practical nurse (LPN) said when the administrator became aware that the facility did not have all of the food needed for the recipes, she informed when requesting food, staff have to request everything needed for the menu for the meals. She said the night staff would prepare all of the meals for the next day and they were made aware to always order food in advance for the menu.

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Class III