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	AL11969308	**03/21/2018**
NAME OF PROVIDER OR SUPPLIER **GOLDEN YEARS ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **401 SW 44TH ST** **CAPE CORAL, FL 33914**	

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

0000 - Initial Comments

An announced initial licensure survey was completed on . . . . . at Golden Years Assisted Living Facility, an assisted living facility (license number pending) in Cape Coral, Florida.

The following is a description of the deficiencies:

0009 - Admissions - Admission Package - 58A-5.0181(3) FAC; 400.0078(2)

Based on record review, and interview, the facility failed to ensure the admission packet contained all required documentation as per 58A-5.182 Florida Administrative Code.

The findings included:

On . . . . record review of the contract found it did not contain all required information (see A0167 and A0168).

On at 3:00 p.m., the administrator was unable to produce the following:
a. A written grievance procedure;
b. House Rules;
c. Resident Responsibilities;
d. and smoking policies;
e. Medication storage policy;
f. Administration schedule and housekeeping schedule;
g. . . . . control, universal precautions and sanitation policies;
h. Third party coordination policy;
i. Advance directives and . . . . . policies; and
j. Beneficiary designation form.

On at 3:00 p.m., the administrator verified the contract did not contain all required information. She also verified she had no resident handbook or other materials required for the admission packet.

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

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Based on record review, and interview, the facility failed to ensure each resident's changes in conditions and contacts with physicians were documented in the resident record for 1 (Resident #1) of 2 residents reviewed.

The findings included:

On record review revealed Resident #1 had lost 7 pounds of her body weight in 5 months. The record documented the weight on as being 98.3 pounds; on as being 96.3 pounds; on as being 96.0 pounds and on as being 91.2 pounds. The record had no documentation of the physician being notified or any interventions.

On at 1:30 p.m., the administrator Staff A said the physician was aware of the weight loss. The physician had ordered ensure to be used if she did not eat. She verified the record did not contain any documentation of the physician being notified of the weight loss, the usage of ensure or the parameters for when ensure was to be used to supplement the lack of food intake.

Class III

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0051 - Medication - Pill Organizers - 58A-5.0185(2) FAC

Based on observation, record review, and interview, the facility failed to ensure only a resident who could self administer medications used a pill container for 1 (Resident #1) of 2 residents using a pill container.

The findings included:

On at 10:00 a.m., the resident medications were observed in a lockable cabinet in the kitchen. Both Residents #1 and #2 had medications in a twice daily pill container.

On at 10:00 a.m., the administrator Staff A said the husband Resident #2 filled the pill containers for himself and his wife (Resident #1) weekly. She said she kept the medications in baggies in the locked cabinet. She said when it was time she would take the pill containers for both Resident #1 and Resident #2 out of the cabinet, take the medication out of the appropriate pill container section and place the pills in a pill cup. She would then give these pills cups to the residents. She would watch Resident #1 to make sure she took the medications and did not spit them out. She verified Resident #2

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could manage his own pill container and did not need her to place the medication into a pill cup. She verified she had medication training on and again during Assisted Living Facility CORE training in 2017. She verified she was not a nurse, nor had she hired a nurse.

On at 1:00 p.m., Resident #1's Agency for Health Care Administration Health Assessment AHCA Form 1823 was reviewed. It documented the resident had and documented the resident needed a nurse to administer medications.

Class III

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0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, record review, and interview, the facility failed to assist with medications as required for 2 (Residents #1 and #2) of 2 residents.

The findings included:

1. On at 10:00 a.m., the resident medications were observed in a lockable cabinet in the kitchen. Both Residents #1 and #2 had medications in a twice daily pill container.

On at 10:00 a.m., the administrator Staff A said the husband Resident #2 filled the pill containers for himself and his wife weekly. She said she kept the medications in baggies in the locked cabinet. She said when it was time she would take the pill containers for both Resident #1 and Resident #2 out of the cabinet, take the medication out of the appropriate pill container section and place the pills into a pill cup. She would then give the pill cups to the residents. She would watch Resident #1 to make sure she took the medications and did not spit them out. She verified she did not take them out of the original prescribed container to place in the pill cup before giving them the medications. She verified she did not read the prescription label to the residents at the time she gave the medications to the residents. She also verified she had medication training on and again during Assisted Living Facility CORE training in 2017. She verified she was not a nurse, nor had she hired a nurse.

On at 1:00 p.m., Resident #1's Agency for Health Care Administration AHCA Form 1823 was reviewed. It documented the resident had and needed a nurse to administer medications.

2. On at 10:00 a.m., Resident #2 was observed to have Lantus 100 units inject 40 units in a.m., but the MOR documented the resident was only taking 20 units. The 0.5 mg was to take 1

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tablet twice a day, but the MOR documented the resident was taking 2 tablet at hours of sleep. The MOR documented the resident was to take Oral Capsule 1000 mg, take 1 twice a day. There was no in house. The administrator was unaware of the not being available to take.

Class III

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0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to secure the refrigerated medication for 1 (Resident #2) of 1 resident.

The findings included:

On at 12:00 p.m., observation of the facility refrigerator in the kitchen section of the main living area revealed 3 boxes of pens in a bin. The boxes contained Lantus 100 units 6 pens per box with 1 box opened. The was not in a lockable container, nor was the refrigerator observed to be lockable.

On at 12:00 p.m., the administrator Staff A verified the was not secured and said she remembered that she needed to get a box to lock the medications in.

Class III

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0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation, record review, and interview, the facility failed to ensure that over-the-counter medications were given in accordance with labeled manufactures directions or a labeled health care providers directions for use for 2 (Resident #1 and #2) of 2 residents' medication reviewed.

The findings included:

1. On at 12:30 p.m., Resident #1's medications were reviewed. The resident was observed to have a bottle labeled 'Elixinol cinnamint drops." The labeled manufacture's instructions said to give 1/2 a dropper twice a day for . There was no resident name on the bottle. A review of the medication observation record (MOR) revealed the over-the-counter medication was being given 1/2 a dropper 0.5

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mg once a day for .

On at 12:30 p.m., Resident#2's medications were reviewed. Resident #2 was observed to have 81 mg. The manufacturers label noted take 4-8 pills every 4 hours, but not more than 48 in a 24 hour period. There was no resident name on the bottle. The MOR documented Resident #2 was to take 1 tablet daily.

2. On at 12:30 a.m., the administrator Staff A said she had discussed both the residents' medications with the physician and Resident #1 and #2 were to take these medications once a day. She verified the medications had not been re-labeled with the correct instructions, nor were their names on the bottles.

Class III

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

Based on record review and interview, the facility failed to ensure all staff had a freedom from communicable including ( ) statement from a health care provider within 6 months before hire or 30 days after hire for 2 (Staff A and B) of 2 staff.

The findings included:

1. A review of the administrator Staff A's personnel record found a statement about dated 11/ in the file. The statement said "Final and reviewed" it did not say the test was positive or negative, or that the staff person was free of communicable .

A review of caregiver Staff B's personal record found a negative test result dated . There was no freedom from communicable statement from a health care provider present.

2. On at 10:00 a.m., the administrator reviewed her results and could not believe it. She said I did not read it. I just grabbed it and went. She further verified Staff B only had a negative test and did not have a freedom of communicable statement.

Class III

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0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview, the facility failed to insure each caregiver was minimally trained before providing care for 1 (Staff B) of 2 staff.

The findings included:

Record review on revealed Staff B had no documentation for training in control, or medications in the personnel file.
Staff B did have an on-line course reportedly for a home health aide 120 hour course. She did not have any information about the course content, hours for each topic taught or competency demonstration.

On at 9:30 a.m., caregiver Staff B said she had worked for the administrator since the last part of , 2017. She said she had taken an on-line home health aide course, but had not demonstrated competency to a nurse at a home health agency. She said she had worked all her life, including in 1980-1984 for Lee Memorial Hospital and private duty caregiving for many years. She verified she had not had training from an ALF qualified trainer to date.

On at 9:30 a.m., the administrator Staff A verified she had the Assisted Living Facility CORE training in 2017, but did not pass the test and had not retaken the test. She verified she could not train her employees until she had passed the test.

Class III

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

Based on observation and interview, the facility did not ensure the menu provided by the registered dietitian was followed for the noon meal observed.

The finding included:

On at the noon meal, Resident #2 and Resident #1 were observed to be eating a sandwich and soup. Resident #2 said he had a ham and tomato sandwich and beef and vegetable soup and Resident #1 was eating a turkey sandwich with soup. He also said they had corn bread muffins which were very good.

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On at noon, caregiver Staff B said she made the soup from left overs which included a cup of ground beef and many vegetables and broth. Caregiver Staff B said she writes down what each resident eats at each meal on papers she keeps in a folder.

On at noon, the administrator Staff A said the two residents are the only ones there. She said she has a 5 week cycle of menus and was on week 4. She verified she did not follow the menu, but rather served what ever the residents wanted to eat. The administrator also verified she did not have a substitution log to note what was served instead of what was on the menu, item by item. She did not know she was to keep it, to allow the dietitian to review the substitutions for nutritive equivalency.

A review of week 4 Wednesday lunch showed the facility was supposed to serve:
3 oz. "sweetish" patty;
1/2 cup twice baked potato casserole;
1/2 cup cauliflower and carrots;
1 baked roll and
1 fudge crinkle.

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

Based on record review, and interview, the facility failed to ensure the demographic data sheet contained all required information, and the consent form to be utilized when the facility had unlicensed staff assisting with medications for 2 (Residents #1 and #2) of 2 resident records reviewed.

The findings included:

1. A review of the Demographic Data Sheet revealed it was missing the following;
a. The address of the next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; b. The address for the health care provider or case manager, if applicable;
c. The informed consent form to be used for facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract.

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2. On at 2:30 a.m., the administrator Staff A verified the demographic form did not contain a place for address of required parties. She stated she had gotten it from a friend who ran a facility and did not look to see it was complete. She also verified she did not have the informed consent information in the contract or a separate form.

Class III

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0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record review, and interview, the facility's contract did not contain all information required under 429.24 Florida Statute (F.S.) and 58A-5.0125 Florida Administrative Code (F.A.C.).

The findings included:

1. A review of the facility contract revealed the contract did not contain the following required information :
a. The accommodations to be provided by the facility;
b. A list of additional services or charges, even though the contract included:
"Payment for services not covered by the daily/monthly rate. You agree to be responsible for payment for any services or convenience items not specifically included by this contract in the daily/monthly rate. Those by the Provider will be billed directly to you at the end of each month in addition to the daily/monthly rate;"
c. The 30 day notice of rate increase, included the language, "The thirty (30) days notice will not be required if you are the one requesting additional service not already included in the rate you pay pursuant to this contract;" however, no ancillary charge list was available to provide the resident or the representative with a list of additional services and charges for those services;
d. Any rights, duties, or of residents, other than those specified in Section 429.28, F.S.;
e. A refund policy that must conform to Section 429.24(3), F.S.;
f. The bed hold policy did not contain the way to terminated the bed hold if a resident became unable to return to the facility which was holding a bed, unless the resident's medical condition prevented the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf;
g. A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility;
h. A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those that the facility is licensed to provide, the resident or the resident's

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representative, or agency acting on the resident's behalf, must be notified in writing that the resident must make arrangements for transfer to a care setting that is able to provide services needed by the resident. In the event the resident has no one to represent him or her, the facility must refer the resident to the social service agency for placement;
i. A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule;
j. The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule;
k. The facility's policies and procedures related to a properly executed Department of Health Form 1896, ;
l. The provision for the resident to terminate the contract with no more than 30 days notice to the provider, and the provision under which the provider will terminate the contract with 45 days written notice, or what conditions a provider would give less than 45 days written notice of termination.

2. On . . . . . at 2:30 p.m., the administrator Staff A said she had developed her own contract with the help of her husband. She said she did not know it was missing information, even though she had attended Assisted Living CORE Training.

Class III

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0168 - Resident Refund Policy - 429.24(3)(a) FS

Based on record review, and interview, the facility failed to include the required refund policy per 429.24 Florida Statute was in the facility's contract.

The findings included:

1. On . . . . . a review of the contract revealed under Security Deposit: "The following costs maybe deducted from the security deposit: Intentional or unintentional damages to facility property."
Under . . . . . of Refund: "You are entitled to a refund for any advanced payments you make on a prorated basis when you are discharged. The will include a refund for the day in which you are discharged. Your refund is . . . . . from the date your apartment unit is vacated or from the last day of any required notice period, whichever is later. The refund is . . . . . by multiplying the amount you paid per day times the remainder of days in the month, including the date your unit is vacated or the last

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day of any required notice period whichever is later.

The contract refund language did not include the language: "that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal use, have been paid to the licensee. For the purpose of this paragraph, the termination date shall be the date the unit is vacated by the resident and cleared of all personal belongings. If the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident or his or her estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed 20 percent of the regular rate for the unit, provided that 14 days' advance written notification is given. If the resident's possessions are not claimed within 45 days after notification, the facility may dispose of them. The contract shall also specify any other conditions under which claims will be made against the refund due the resident. Except in the case of or a discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract. However, a resident may not be required to provide the licensee with more than 30 days' notice of termination. If after a contract is terminated, the facility intends to make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond. The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident."

2. On at 2:30 p.m., the administrator Staff A said she had developed her own contract with the help of her husband. She said she did not know it was missing information, even though she had attended Assisted Living Facility CORE Training.

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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on record review, and interview, the facility did not ensure all staff employed had an "Eligible" background screening for 1 (Staff B) of 2 staff.

The findings included:

A review of caregiver Staff B's personnel record revealed she had no background screening.

On at 11:00 a.m., Staff B verified she had never had a level II background screening. She said she had been working for the administrator since the last part of , 2017.

Unclassified

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

Based on record review, and interview, the facility did not ensure all staff employed had an "Eligible" background screening without a break in service for 1 (Staff A) of 2 staff.

The findings included:

1. A review of administrator Staff A's personnel record revealed an eligible level II background screening dated .

On at 11:00 a.m., the administrator said she had closed her adult family care home in 2013. She had health issues and was unemployed for 1 year. She then went into private duty care. She further stated she has not worked for some years until she opened her home in 2017. The administrator verified she had not worked at a facility required by law to have background screening since she was screened.

Unclassified

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