STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968261	**03/19/2018**
NAME OF PROVIDER OR SUPPLIER **COVENTRY ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **415 N WILDER RD** **PLANT CITY, FL 33563**	

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

0000 - Initial Comments

Assisted Living Facility

A biennial survey was conducted at Coventry Assisted Living (License 12181), an assisted living facility in Plant City, Florida, on . There were deficiencies identified during the survey. Due to the deficient practice identified, the abbreviated survey was expanded to a full survey on the date of the visit.

License #12181

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the facility failed to review and follow-up with providers to ensure that the resident health assessments were completed accurately for continued residency determination for (#3, #5, #6, #7, #8, #11, #12 and #18) residents of 16 residents that received 24-hour assisted living services in the licensed facility.

Findings included:

The following records were reviewed with the Facility's Administrator and Assistant Administrator on :

Review of Resident #3's health assessment (AHCA Form 1823), dated , revealed that the assessment did not indicate the level of assistance that Resident #3 required with medications.

Review of Resident #6's health assessment (AHCA Form 1823), dated , revealed that the assessment did not indicate the level of assistance that Resident #6 required with medications.

Review of Resident #11's health assessment (AHCA Form 1823) revealed that the undated assessment did not indicate the level of assistance that Resident #11 required with medications.

Review of Resident #5's health assessment (AHCA Form 1823) revealed that the undated assessment was missing information that included page two (sections A, Section C and Section D), and page three (Section A and Section B).

Review of Resident #7's health assessment (AHCA Form 1823), dated , revealed that the assessment did not indicate the level of assistance that Resident #7 required with medications.

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Review of Resident #18's health assessment (AHCA Form 1823), dated , revealed that the assessment did not indicate the level of assistance that Resident #18 required with medications.

Review of Resident #8's health assessment (AHCA Form 1823), dated , revealed that the assessment did not indicate the level of assistance that Resident #8 required with medications.

Review of Resident #12's health assessment (AHCA Form 1823), dated , revealed that the assessment did not indicate the level of assistance that Resident #12 required with medications. The word "No" was circled in answer to the question as to whether the resident's needs can be met at an assisted living facility. Examiner's information was not documented on the assessment.

On at 04:24p.m., the Administrator stated that the AHCA Form 1823 for Resident #12 was not accurate. Administrator stated that he or the Assistant Administrator usually review all AHCA Form 1823s on arrival. He confirmed that the facility did not notice missing information from the residents' health assessments.

Class III

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

Based on record review and interview, the facility failed to provide the level of supervision required for two of two sampled residents (Resident #1 and Resident #17) by placing the two residents in an unlicensed structure, from the licensed facility, that contributed to a that resulted in leg to discharged resident #17.

Findings included:

During interview with Resident #1, on at 10:18 a.m., the resident stated that Resident #17 was discharged from the hospital related to a that resulted in bone at the unlicensed structure where Resident #1 and Resident #17 resided.

During interview with the Administrator on at 10:40 a.m., he confirmed that Resident #17 and broke both legs while walking out of the doorway of the unlicensed structure. The Administrator further confirmed that the facility did not report incident to the Agency.

Review of Resident #1's health assessment (AHCA Form 1823), dated , indicated that

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Resident #1 needed assistance with ambulation, bathing, dressing, transferring and transferring for toileting and was "wheelchair bound".

Review of hospital discharge summary revealed that Resident #17 was admitted to the hospital from the facility on with acute of right femur, left , left diaphysis and left malleolus.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based of observation and interview the facility and failed to honor the rights of two of two sampled residents (Resident #3 and Resident #16) to privacy, dignity and use of their own space. The facility allowed one resident (#16) to sleep in the bed and to another resident (#3) from to without permission or notification.

Findings included:

During a Family interview for Resident #3, on at 11:29 a.m., the family member/ power of attorney, confirmed they were not aware that the facility allowed Resident #16 to use the , bedding and linen that belonged to Resident #3 during Resident #3's hospital stay from to .

During interview with the Administrator and Assistant Administrator, on at 12:33 a.m., they confirmed that Resident #16, who they initially identified as an adult daycare participant, received 24-hour services from to at the facility while family members of the resident were away. The Administrator confirmed that Resident #16 used the to Resident #3.

During interview with Resident #16, on at 12:56 p.m., the resident confirmed that she used Resident #3's bed to sleep in from to . Resident #16 stated that when all beds were occupied, she slept on a recliner located in the common/dining area. The Assistant Administrator, who was present for interview, confirmed that Resident #16 has slept on the recliner (image taken).

On at 01:02 p.m., the by Resident #16 was observed and it was confirmed that the personal belonging of Resident #3.

On at 01:44 p.m., the Administrator confirmed that the facility did not inform Resident #3's family member and power of attorney that Resident #16 was using the Resident #3's

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absence from the facility.

Class III

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

Based on observation and interview, the facility failed to ensure that unlicensed staff provided two of two sampled residents of the facility (Resident #6 and Resident #18) were provided assistance with self-administration of medication per the requirements of 429.256 FS. The facility failed to have unlicensed staff obtain the residents' medications from the original container.

Findings included:

During an observation of the facility's medication system and storage beginning at 5:30 PM, it was revealed that the medications for Resident #6 and Resident #18 were in the facility's locked medication cart in pill organizers.

During an interview with the Assistant Administrator, beginning at 6:00 PM, the Assistant Administrator confirmed that the medications for Resident #6 and #18 were delivered by the residents' families weekly, already in the pill organizers. The Assistant Administrator stated the facility did not have access to the original labels or packaging indicating the medications being provided to the residents in the pill organizers.

Class III

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

Based on record review and interview the facility failed to maintain a Medication Observation Record (MOR) for one resident (#16), and failed ensure that handwritten MORs for four sampled residents (#3, #6, #9 and #18) selected who received assistance with self-administration of medication contained required information.

Findings included:

Record review revealed no evidence that the facility maintained a MOR for Resident #16.

On [redacted], approximately at 12:55 p.m., the Assistant Administrator confirmed that the facility did not maintain a MOR for Resident #16, who received assistance with self-administration of medication.

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Review of the handwritten MORs for Resident #3, Resident #6, Resident #9 and Resident #18, revealed the MORs did not have the name of the residents' healthcare provider. There were no evidence that the facility maintained a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, and the date dispensed for medications in pill organizers for Resident #6 and Resident #18.

Class III

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

Based on record review and interview, the facility failed to provide evidence of a negative examination ( ) documented on an annual basis or documentation that indicated freedom of communicable for one (Staff D) of four employees selected for record review.

Findings included:

A review of employee records conducted on revealed no evidence of a negative examination or documentation that Staff D, with hire date of , had no signs or symptoms of a communicable .

During an interview with Administrator conducted on at approximately 08:00 p.m., the administrator stated that Staff D has not completed a examination and did not have any documentation that indicated that Staff D was free of communicable . The Administrator confirm that Staff D was a full time resident care aide.

Class III

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

Based on observation and interview, the facility failed to ensure that facility menus were reviewed annually by a licensed or registered dietitian to ensure the meals meet the nutritional standards.

Findings included:

Review of the facility scheduled for meals, on revealed that facility menu on display for the residents and original menu, maintained by the facility, was last reviewed on .

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During interview with the Administrator, conducted on at 06:16 p.m., he confirmed that the facility menu was not reviewed and approved since .

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the facility failed to maintain an up-to-date admission and discharge log recording the admission and the discharge date, the reason for discharge, and where the resident was discharged to.

Findings included:

During entrance conference, on at 09:30 a.m., Administrator stated that he has not kept up with the Admission Discharge Log.

On at 10:39 a.m., the Administrator confirmed that the Facility's Admission Discharge Log did not accurately reflect the census. The Administrator then provided a facility map with names of residents in each , which did not accurately reflect the each resident resided.

Admission dates and discharged dates for residents were obtained through review of contracts, review of medication observation record, hospital admission records and interviews. There was no admission/discharge log produced during the survey.

Class III

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

Based on record review and interview, the facility failed to maintain a completed contract for two residents (#10 and #16), and health assessment (AHCA Form 1823) for one resident (#10) of 16 residents who received 24-hour continuous assisted living services.

Findings included:

Record review on revealed that assisted living contract for Resident #10 only contained the resident's name. The undated contact was not signed by the resident, responsible party, nor Administrator. Record review also revealed that health assessment for Resident #10 was documented on AHCA Form 3100-1023 (AFCH-1110) which is used for Adult Family Care homes and not

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Assisted Living Facilities. The health assessment did not indicate whether the resident's needs could be met at an assisted living facility.

Record review revealed no documentation for Resident #16 who received 24-hour services from to .

On at 03:54 p.m., the Administrator confirmed that there was no contract for Resident #16, who stayed at the facility from to and received services that included assistance with medication self-administration.

On at 04:19 PM, the Administrator and Assistant Administrator confirmed that the health assessment for Resident #10 was not documented on the AHCA Form 1823 and that the assisted living contract for Resident #10 was not completed.

The Administrator confirmed that Resident #10 was admitted in 2016.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review, the facility failed to complete an Adverse Incident Report with the Agency following a that resulted in bone to the left and right leg for one discharged resident (#17) of two residents who resided in an unlicensed structure behind the licensed facility..

Findings included:

During interview with Resident #1 on at 10:18 a.m., the resident indicated that Resident #17 was discharged to the hospital related to a that resulted in bone .

During interview with the Administrator on at 10:40 a.m., he confirmed that Resident #17 was an assisted living resident that lived in the unlicensed structure behind the licensed facility, and confirmed that Resident #17 and broke both legs while walking out of the doorway of the unlicensed structure. Administrator confirmed that the facility did not report the incident to the Agency, as required.

Review of hospital discharge summary revealed that Resident #17 was admitted to the hospital on with acute of right femur, left , left diaphysis and left malleolus.

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Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview, the facility failed to submit a Comprehensive Emergency Management Plan (CEMP) to the local emergency management agency for review and approval.

Findings included:

Record review, conducted on , revealed that the facility's latest CEMP approval was on . Record review also revealed documentation addressed to the Department of Elder Affairs, dated , requesting a variance or waiver related to the emergency power requirement. There was no documentation the indicated if the variance was granted.

On at 06:20 a.m., the Administrator confirmed that was the last time the CEMP was approved.

Class III

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Z827 - Unlicensed Activity - 408.812 FS

Based on observation, interview and record review, the licensed assisted living facility provided assisted living services that included housing, meals and assistance with self-administration of medications, to one resident (Resident #1) residing in an unlicensed structure behind the licensed facility. The facility's failure to maintain residents in a licensed facility also resulted in a that resulted in leg to one previous (now discharged) resident (Resident #17).

Findings included:

While conducting a facility tour on , at 09:50 a.m., an additional, , structure, located within the property line of the facility, was observed directly behind the licensed facility. The Assistant Administrator confirmed that the structure was used for Resident #1.

During interview with Resident #1, on at 10:18 a.m., the resident stated that he lived at the unlicensed structure. A tour of the structure confirmed that Resident #1 had a designated his belongings. Resident #1 confirmed that the facility provided meals and assisted him with his medications. Resident #1 indicated that Resident #17 was discharged to a hospital related to a that resulted in bone at the unlicensed structure.

During interview with the Administrator on at 10:40 a.m., he confirmed that Resident #1 currently lives in the additional structure, and Resident #17 was an assisted living resident that lived in the additional unlicensed structure behind the licensed facility. The Administrator confirmed that Resident #17 and broke both legs while walking out of the doorway of the unlicensed structure.

Record review revealed that Resident #1 had a contract, signed and dated , with the Facility for assisted living services. Review of Facility's Medication Observation Report for 2018, revealed that the facility stored and assisted Resident #1 with daily medications.

Review of Resident #1's health assessment (AHCA Form 1823), dated , indicated that Resident #1 needs assistance with leaving facility (page 1), instrumental activities of daily living (pages 1 and 6), Heath support (Page 6), and assistance with self-administration of medication (page 6). The assessment also indicated that Resident #1 needed supervision with shopping, personal affairs, and financial affairs due to .

Unclassified