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0000 - Initial Comments

Complaint Investigation #2017014068 was conducted on 2/14/18. Silver Crest Home, License #12867, had deficiencies at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on observation, record review, and interview, the facility failed to ensure a health assessment form (1823) was accurate for 1 of 4 sampled residents (#2).

Findings:

Observations made during an interview with resident #2 on 2/14/18 at 11:05 AM revealed was and able to explain the facility holds medications and brings them to when it's time to take them. stated could put the pills in mouth and swallow them.

Review of the record for resident #2's revealed an 1823 assessment form, dated , which indicated the resident required medication administration.

During an interview with the owner on 2/14/18 at 3:30 PM, he said the resident was able to take the pills on own, and did not realize the form (1823) documented administration of medications.

Class III

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

Based on observation, record review and interview, the facility failed to provide care and services appropriate to the needs of 1 of 4 residents (#3), and did not provide staffing that maintained the general health, safety, and physical and emotional well-being of the residents by allowing a caregiver to work alone with the residents without proper training (A).

Findings:

Observation upon arrival at the facility at 9 AM on 2/14/18 revealed unlicensed caregiver A was the only employee working with the residents at that time.

At 9:10 AM on , caregiver A took a pill organizer for resident #3 from the unlocked medication

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cart and put the pills for Wednesday morning in a small cup and took the pills and a glass of water to the resident who was napping in a chair in the living room. She called name several times to wake up and then said, "your medicines" and handed the cup with the pills. took the medications and caregiver A went on to clean the kitchen. She did not document that medications had been given to the resident. When asked if she had documented in the Medication Observation Record (MOR), caregiver A looked puzzled. When asked, caregiver A did not know what a MOR was or where to find it.

At 9:15 AM on 2/14/18, caregiver A stood in resident #3's doorway holding a laundry basket. She calmly pointed to the adjacent bathroom and where resident #3 sat on the next to the toilet. was able to talk. was dressed in a blouse and said did not , but when stood up from the toilet, were and could not stated lowered herself to the and could not When caregiver A was asked if she was going to help the resident , the caregiver shook her head no, and held up and said Caregiver A continued to gather laundry. She did not call anyone to help the resident. Resident #3 stated had been sitting there about one hour. When the resident was asked if was in any pain, said no, but was uncomfortable and wanted to

At approximately 9:35 AM, the 3rd party , arrived to see this resident and was alerted by the surveyor that the resident was on the floor in the bathroom and the staff working could not help get up. He said he could help, but asked why the caregiver did not call 911 or anyone for help. He assisted resident #3 off the floor and back to room where the resident finished getting dressed. At the end of the , 's visit, he spoke with the owner about the incident and explained it was unacceptable to leave a resident on the floor and not call for help. He said the language barrier with caregiver A was an issue since she did not know how to call for help.

Personnel Record review for unlicensed caregiver A, hired 1/07/18, did not reveal any documentation to confirm she had received any in-service training, including assisting residents with Activities of Daily Living, emergency procedures, First Aid, cardio-pulmonary resuscitation (CPR) and assisting resident with self-administration of medications.

In an interview with the owner on 2/14/18 at 10 AM, he confirmed that caregiver A was alone with the residents. He said the other caregiver had just left to go to an appointment and that he or his mother were usually there when Caregiver A was working because of the training and because of the language barrier. He confirmed that caregiver A had not received training in First Aid, CPR and assisting with medications because they were looking for a trainer who spoke Creole. He said he had explained to her over and over to "call 911, then call me." He acknowledged that the residents care and supervision were neglected with caregiver A working alone.

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Class II

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on observation and interview, the facility failed to provide an activity program that consisted of at least 12 hours of activity, 6 days each week.

Findings:

On 2/15/18 at approximately 9 AM, an undated activity calendar was posted on a bulletin board in the kitchen. Several activities were written on each date in the monthly calendar, such as word games, bingo, puzzle time, and specifically sing-along on 2/15/18. A one-hour duration was noted for each activity. None of the day's activities was observed during the course of the survey. The television in the living room was on all day during the survey.

When asked about activities 2/15/18 at approximately 9:15 AM, resident #2 stated, "We don't do anything here." Resident #3 said, "I'm bored. There's nothing to do here except the TV." Resident #4 sat in front of the TV asleep and in room napping on bed the duration of the survey (2/14/18).

On 2/15/18 at 2:45 PM, the owner said they offer activities every day, but the residents do not want to participate in the activities offered. He said the facility just hired someone to start coming in and doing activities and music with them twice a week. He confirmed that they currently do not offer 2 hours of activities each day.

Class III

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

Based on observation, record review and interview, the facility failed to treat 1 of 4 sampled resident (#2) with consideration and respect and with due recognition of personal dignity and did not provide a safe and decent living environment, free from neglect by not providing staff that was trained and able to provide care and services and a safe environment for the residents (#A).

Findings:

Observation upon arrival to the facility at 9:00 AM on 2/14/18 revealed Staff A, an unlicensed caregiver, was the only employee working with the 4 residents.

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Further observation at 9:15 AM found Staff A, the caregiver, standing in resident #2's doorway holding a laundry basket. She calmly pointed to the adjacent bathroom. Resident #2 was observed seated on the next to the toilet. Further observation revealed was sitting up, and was able to talk. The resident was dressed in a blouse and said did not , but when stood up from the toilet were and could not stated lowered herself to the and could not . When Staff A was asked if she was going to help the resident get up , the caregiver shook her head no, and held up and said Staff A continued to gather laundry. Staff A had not called anyone to help the resident. Resident #2 stated had been sitting there about one hour. When asked again if and replied did not. When asked if was in any pain, said no, but was uncomfortable and wanted to At approximately 9:35am, the third party , arrived to see this resident. I alerted him that the resident was on the in the bathroom and the staff working could not help . He said he could help, but asked why the caregiver did not call 911 or anyone for help. He assisted resident #2 off the and back to room where finished getting dressed. At the end of his visit, the , spoke with the owner about the incident and explained it was unacceptable to leave a resident on the and not call for help. He said the language barrier with the sole caregiver was an issue since she did not know how to call for help.

Personnel Record review for Staff A, an unlicensed caregiver, hired 1/7/18, revealed no documentation to confirm she had received any in-service training, including assisting residents with Activities of Daily Living, emergency procedures, First Aid, CPR or assisting resident with self-administration of medications.

In an interview with the owner on 2/14/18 at 10:00 AM, he confirmed that Staff A was alone with the residents. He said the other caregiver had just left to go to an appointment and that he or his mother were usually there when Staff A was working because of the training and because of the language barrier. He confirmed that Staff A had not received training in First Aid, CPR or assisting with medications because they were looking for a trainer who spoke Creole. He said he had explained to her repeatedly to "call 911, and then call me." He acknowledged that the residents care and supervision were neglected with Staff A working alone.

Class III

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

Based on observations, record review and interview, the facility failed to ensure that a licensed nurse

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managed pill organizers to be used only by residents who self-administer medications, and allowed unlicensed staff to provide assistance with self-administration of medications from a pill organizer for 2 of 2 sample residents (#1 & 2).

Findings:

On 2/14/18 at 9:15 AM, the medication cart was in the kitchen. It was situated against the wall and was unlocked and 2 drawers were partially open. No staff were attending to the cart. Resident #3 was eating breakfast at the kitchen table next to the medication cart.

On 2/14/18 at 9:00 AM, Staff A, an unlicensed caregiver was unable to explain why the cart was unlocked. She did not seem to understand that it should have been locked. She proceeded to take out and show me that each of the residents had a pill organizer or two.

Review of the record for resident #1 revealed a health assessment (form 1823) dated that indicated she required with self-administration of medications.

Review of the record for resident #2 revealed a health assessment (form 1823) dated that indicated she required administration of medications.

In an interview with the owner on 2/14/18 at 10:00AM, he explained that a nurse and his administrator (who is not a nurse) come in once a week, fill the organizers for the residents, and document in the MOR. In addition, he confirmed that none of the 4 current residents was able to medications. He stated he did not know this practice was not allowed.

Class III

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

Based on observation, record review and interview, the facility failed to ensure the unlicensed caregiver who 1 resident (#3) with self-administration of medications followed the correct procedure (A).

Findings:

During observation at 9:10 AM, unlicensed caregiver A took a pill organizer for resident #3 out of the unlocked medication cart and put the pills for Wednesday morning in a small cup. She took the pills and a glass of water to the resident, and handed the cup with the pills. Resident #3 took the

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medications. Caregiver A did not read the medication labels aloud to the resident. When asked what medicines she gave to the resident, she pointed to the empty section in the pill organizer for Wednesday morning and said "Here. I give these. Wednesday AM. See?" When further prompted about what the names of the medications were, she was unable to understand or answer. She did not document that medications had been given to the resident. When asked if she had documented in the Medication Observation Record (MOR), she looked puzzled. Further questioning found caregiver A did not know what a MOR was or where to find it.

Review of the MOR, provided by the administrator at 11:30 AM on 2/14/18, did not reveal any medications documented as given on . . . for any resident.

On 2/14/18 at 9:50 AM, the owner confirmed that caregiver A had not yet received training in assisting residents with self-administration of medications.

Class III

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

Based on observation, Medication Observation Record (MOR) review and interview, the facility failed to maintain an accurate and up-to-date MOR for 2 of 3 sampled residents who require with self-administration of medications (#1 & 3.)

Findings:

Observation of a medication pass for resident #3 was made on . . . at 9:10 AM. Unlicensed caregiver A provided with the medication but did not document in the MOR when the medications were given.

Resident #1' MOR on . . . at 12:30 PM revealed none of the 8 AM medications for resident #1 were marked as given. . . . . cap, one capsule by mouth three times daily was written on the MOR to be given at 8 AM, 12 PM and 5 PM but was not marked as given on . . . , . . . and . . . The MOR was blank for each of these doses. There was no documentation on the back of the MOR to indicate when the medication was not given as ordered.

Resident #3's MOR on . . . at 12:30 PM revealed none of the 8 AM medications for resident #1 were marked as given.

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The MOR for all 4 residents in the facility on found that for every date in February, and every time a dose was ordered, the MOR was initialed by the same staff member. There was no documentation on the MOR indicating which staff person was signed the MOR.

On at 9:10 AM, caregiver A was asked if she had documented in the MOR. She looked puzzled. Upon further questioning, caregiver A did not know what a MOR was or where to find it.

On at 10 AM, the owner explained that a nurse and his administrator, who is not a nurse, come in once a week and fill the organizers for the residents and document in the MOR. He confirmed that none of the 4 current residents were able to medications. He stated he did not know this practice was not allowed.

Class III

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

Based on observation and interview, the facility failed to ensure that all centrally stored medications were locked and secured at all times as required by 58A-5.0185(6) FAC.

Findings:

On 2/14/18 at approximately 8:55 AM, the medication cart was in the kitchen against the wall unlocked and 2 drawers were partially open. No staff attended to the cart. Resident #3 ate breakfast at the kitchen table next to the medication cart.

On 2/14/18 at 9 AM, unlicensed caregiver A was unable to explain why the cart was unlocked. She did not seem to understand that it should have been locked. She proceeded to show me each resident's pill organizers.

On 2/14/18 at 9:50 AM, the owner did not offer an excuse or explanation as to why the cart was unlocked. He confirmed that caregiver A had not yet received training in residents with self-administration of medications.

Class III

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

Based on observation, personnel record review and interview, the facility failed to ensure that staff were

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qualified, and assigned duties were consistent with their level of education, training, preparation, and experience, and allowed an unlicensed caregiver without medication training and certification in First Aid and cardio-pulmonary resuscitation (CPR) to work alone with the residents, and failed to obtain documentation from a licensed health care provider for 3 of 3 sampled Staff (A, B & C) documenting freedom from communicable disease and tuberculosis (TB).

Findings:

Observation upon arrival at the facility at 9 AM on revealed unlicensed caregiver A was the only employee working with the 4 residents at that time. At 9:10 AM, she took the pill organizer for resident #3 out of the unlocked medication cart and put the pills for Wednesday morning in a small cup. She took the pills and a glass of water to the resident who was napping in a chair in the living room. She called name several times to wake up and then said, "your medicines" and handed the cup with the pills. Resident #3 took the medications. Caregiver A did not document that medications were given to the resident. When asked if she had documented in the Medication Observation Record (MOR), she looked puzzled and did not know what a MOR was or where to find it.

On 2/14/18 at 9:15 AM, caregiver A found resident #2 sitting on the bathroom The resident stated was unable to and had been sitting there about one hour. When caregiver A was asked if she was going to help the resident. She held up and said '. Caregiver A continued to gather laundry. She did not call anyone to help the resident.

Personnel Record review for caregiver A, hired 1/07/18, did not reveal any documentation to confirm she was free from communicable disease and TB, had not received any in-service training, including assisting residents with Activities of Daily Living, emergency procedures, First Aid, cardio-pulmonary resuscitation (CPR) and assisting resident with self-administration of medications within 30 days of hire.

Personnel record review for the owner B revealed the last documentation of freedom from TB was dated 2016.

Personnel Record review for the administrator C, hired 12/26/17, did not reveal any documentation to confirm she was free from communicable disease and TB.

On 2/14/18 at 3:10 PM, the owner confirmed that caregiver A was working alone and had not received training. He stated someone else is usually working with her, but today was an unusual occurrence. He also confirmed documentation regarding freedom from communicable disease and TB was not in the records for caregiver A, the owner, and the adminsitstrator.

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Class II

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation, review of staff schedule and personnel records and interview, the facility failed to meet the needs of the residents, and did not maintain an accurate written work schedule that reflected its 24-hour staffing pattern for a given time period. The facility failed to ensure a staff member who had completed courses in First Aid and cardio-pulmonary resuscitation (CPR) and held a currently valid card documenting completion of such courses was in the facility at all times. as required by 58A-5.019(3) FAC.

Findings:

At 9 AM on 2/14/18, unlicensed caregiver A was the only employee working with the four residents at that time. During the tour of the facility at that time, a staff schedule was not posted.

Review of the personnel record for caregiver A, hired 1/07/18, did not reveal any documentation that she had training or certification in First Aid and CPR.

On 2/14/18 at 11:10 AM, the administrator said she had a staff schedule on her laptop but it was broken and she could not print it. When asked to see the previous schedules that had been printed, she was unable to provide any schedules.

On 2/14/18 at 11:45 AM, the owner confirmed there were no schedules for review and confirmed that caregiver A was working alone with the residents and had not yet completed any training in First Aid and CPR.

Class III

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

Based on personnel record review and interview, the facility failed to ensure that 2 of 3 sampled direct care staff received the minimum staff in-service training within 30 days of employment for (A & C).

Findings:

1. Personnel Record Review for unlicensed caregiver A, hired 1/07/18, revealed that she did not have

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documentation to confirm she had received training in infection control before providing personal care to residents. In addition, there was no documentation for training in the following within 30 days of employment: 1) providing assistance with the activities of daily living and resident behavioral needs, 2) the facility's resident elopement response policies and procedures, 3) the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation, 4) reporting adverse and major incidents, 5) residents rights, 6) recognizing and reporting resident abuse, neglect, and exploitation, and 7) safe food handling practices.

2. Personnel Record review for administrator C, hired 12/26/17, did not reveal any documentation to confirm she had received training in the facility's resident elopement response policies and procedures, or facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation within 30 days of employment.

On 2/14/18 at 3:15 PM, the owner confirmed the findings.

Class III

0082 - Training - HIV/AIDS - 58A-5.0191(3) FAC

Based on Personnel Record review and interview, the facility failed to ensure that 1 of 3 sampled staff obtained a one-time education course on HIV and AIDS within 30 days of employment (A).

Findings:

Personnel record review for unlicensed caregiver A, hired 1/7/18 did not reveal any documentation to confirm she had completed the one-time education course on HIV and AIDS.

On 2/14/18 at 3:45 PM, the owner confirmed caregiver A had not completed the trainings.

Class III

0083 - Training - First Aid and CPR - 58A-5.0191(4) FAC

Based on observation, personnel record review and interview, that facility failed to ensure that 1 of 2 sampled staff, who work alone with the residents, had current training in First Aid and cardio-pulmonary resuscitation (CPR) (A).

Findings:

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On 2/14/18, unlicensed caregiver A worked alone with 4 residents in the facility.

Personnel Record Review for caregiver A, hired 1/07/18,did not reveal any documentation of certification in First Aid and CPR.

On 2/14/18 at 2:30 PM, the owner confirmed that he did not have proof of First Aid or CPR training for this employee.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on observation, personnel record review and interview, the facility failed to have evidence that 1 of 2 sampled unlicensed caregivers who was observed providing with a resident's medications had received the required training for providing with self-administered medications and safe medication practices in an Assisted Living Facility (A).

Findings:

On at 9:10 AM of unlicensed caregiver A provided medications in a small paper cup to resident #3. She placed the pills from the Wednesday morning pill organizer box into a small cup and handed them to the resident, saying name and "your medicines".

Personnel record review for caregiver A, hired 1/07/18, did not reveal any documentation to confirm she had completed the required training for Assistance with Self-Administration of Medication for assisting residents with medications.

On 2/14/18 at 12:30 PM, the owner confirmed caregiver A did not have the training.

Class III

0090 - Training - Do Not Resuscitate Orders - 58A-5.0191(11) FAC

Based on personnel record review and interview, the facility failed to ensure that 2 of 3 sampled staff completed the required in-service training in the facility's policies and procedures regarding Do Not Resuscitate Orders (DNRO) within 30 days of hire (A & C).

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Findings:

1. Personnel record review for unlicensed caregiver A, hired 1/07/18, did not reveal any documentation to confirm she had received DNRO training.

2. Personnel record review for administrator C, hired 12/26/17, did not reveal any documentation to confirm she had received DNRO training.

On 2/14/18 at 2:45 PM, the owner confirmed the findings.

Class III

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

Based on observation, dietary record review and interview, the facility failed to post menus dated for the week in use, failed to document substitutions made to the meal served, failed to maintain 6 months of dated menus for review, and failed to have sufficient water for use in an emergency.

Findings:

1. On 2/14/18 at approxiamtely 10 AM, an observation of the menu posted on the bulletin board in the kitchen found it was approved by a registered dietician on 7/01/17. The menu showed week 3 of the 4 week cycle, but was not dated for the week in use.

2. The lunch menu for Wednesday in week 3 was 8 ounces (oz.) of soup of the day, 3 oz. of egg salad on 2 pieces of bread, ½ cup tomato salad, and ½ cup flan.

Observation of the lunch served on Wednesday, 2/14/18, was tuna salad on a hot dog bun and chicken noodle soup. Orange juice was served. No vegetables or dessert were served.

Review of the substitution log did not reveal changes to the menu on 2/14/18 documented. The last substitution documented was from January 2018.

3. Review of the menus from the past 6 months revealed the facility did not have dated copies of the menus served in the previous 6 months.

4. Observation of the emergency food and water supply found the facility had 5.1 gallons of water for

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emergency use. The requirement for 4 residents is a minimum of 12 gallons of water for use by the residents in the event of an emergency. The facility required 6.9 gallons of water more than what they had in the facility.

During an interview on 2/14/18 at 2:45 PM with the owner, he confirmed the findings.

Class III

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

Based on Admission and Discharge Log review and interview, the facility failed to ensure an accurate and up-to-date log was maintained for 2 of 7 sampled resident (#6 & 7).

Findings:

Review of the facility's admission and discharge log revealed that Resident #6 and #7, who no longer lived in the facility, did not have a discharge date or location listed in the log.

On 2/14/18 at 11:30 AM, the owner stated that Resident #6 went to the hospital in [redacted] and never returned to the facility. He said resident #7 was removed by [redacted] in [redacted] without notice. He confirmed the log was not updated to reflect the facility's discharges.

Class III

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

Based on review of the facility's Comprehensive Emergency Management Plan (CEMP) and interview, the facility failed to have documentation the CEMP was approved by the local emergency management agency according to 58A-5.026(2)(c) (1) FAC.

Findings:

Upon request to review the facility's CEMP the owner and administrator were unable to locate the plan or any approval letter from the county. There was no current or previous letter documenting approval or receipt from the Osceola Office of Emergency Management available for review.

On 2/14/18 at 2:50 PM, the administrator confirmed she did not have acknowledgement from the County that the plan was received.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969055	**02/14/2018**
NAME OF PROVIDER OR SUPPLIER **SILVER CREST HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **2151 GRANADA BLVD** **KISSIMMEE, FL 34746**	

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

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on Agency Clearinghouse Website review and interview, the facility failed to register and maintain the employment status of employees within the Agency's Background Screening Clearinghouse for 2 of 3 sampled staff employees (A & C).

Findings:

Review of the Agency's Background Screening website for 3 sampled staff revealed that Staff A, unlicensed caregiver hired on 1/07/18, and C, the administrator, hired on 12/26/17, were not on the clearinghouse roster for the facility.

In an interview with the owner on 2/14/18 at 3:30 PM, he confirmed the updates were not made.

Unclassified