STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967498	**03/22/2018**
NAME OF PROVIDER OR SUPPLIER **SWAN AT LAKE CONWAY ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **3714 ST MORITZ STREET** **ORLANDO, FL 32812**	

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

0000 - Initial Comments

Complaint Investigation #2018000262 was completed on . Swan at Lake Conway Assisted Living, License #11542, had deficiencies at the time of the visit.

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

Based on resident record review and interview, the facility failed to ensure that 3 of 6 sampled residents had the required information on the AHCA form 1823 Health Assessment completed by the healthcare provider required for residents needing assistance with activities of daily living (#1, 5 & 9).

Findings:

1. Resident #1's 1823 health assessment, dated , did not indicate the type of assistance needed for medication administration. It reflected that the resident needed assistance with self-administration of medications and also needed medication administration. She need assistance with all activities of daily living (ADLs), except for supervision with eating.

2. Resident #5's 1823 health assessment was not dated by the healthcare provider. She needed assistance with dressing and ⌄ ⌄ and supervision with toileting.

3. Resident #9's 1823 health assessment, dated , indicated she was able to take her medications without assistance, needed assistance with ambulation, bathing, dressing, toileting and transferring, needed supervision with ⌄ ⌄ care, and was independent with eating.

On at 4:40 PM, resident #9 confirmed that staff help her and she receives assistance with self-administration of medications. The owner confirmed that staff assists her with self-administration of medications.

On at 6 PM, the Owner confirmed the findings.

Class III

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

Based on record review and interview, the facility failed to determine continued appropriateness of level of care for 1 of 6 sampled residents (#2), and failed to get an updated AHCA form 1823 Health

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Assessment after a significant change for 2 of 6 sampled residents (#1 & 9).

Findings:

1. Resident #1's record revealed an admission date of and an 1823 Health Assessment dated . A significant change occurred on when the physician ordered thickening powder to thin liquids to prevent , , and another physician's order on for at 2 liters via nasal cannula, and to crush medications before giving to the resident.

2. Resident #2's record revealed an admission date of with Hospice care. The Hospice election and interdisciplinary certification began on .

3. Resident #9's record revealed an admission date of and an 1823 Health Assessment dated , indicating she was able to take her medication without assistance but also needed assistance with self-administration of medications by unlicensed staff.

On at 4:40 PM, resident #9 confirmed that staff help her and she receives assistance with self-administration of medications. The owner confirmed that staff assists her with self-administration of medications.

On at 5 PM, the owner confirmed the findings.

Class III

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

Based on observation, record reviews, and interview the facility failed to ensure staff A received the initial required 4 hour training in assistance of self-administration of medication before she was left in sole charge of the residents and allowed 1 of 7 sampled residents to endure pain with no relief until the owner returned to the facility one hour later (#5).

Findings:

On at 1:30 PM, residents #1, #2, #5, #6, #7, #8 and #9 were observed at the facility staff A who is unlicensed.

On at 1:57 PM, resident #5 told staff A that she had pain from her stomach to her feet. Staff A

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did not address resident #5, and said she did not know where the key was to the medication cart. Staff A said usually the owner has the keys.

On . . . . . at 2:07 PM, staff A found the keys to the medications on top of the medication cart. Next, she washed her hands and dried. Open the medication cart to pull out the over-the-counter (OTC) bottle of . . . . . , . . 500 milligrams (mg.). The label had resident #8's name on it, not resident #5. Staff A opened the bottle and was getting ready to pour in a small Dixie cup, when she was stopped. Staff A was asked if she had her medication training, and answered, "Yes, I am a Home Health Aide." Staff A did not check resident #5's MORs log for prescription medication, did not ask the resident more about her pain to possibly identify exact location, did not contact the physician, and did not contact the family member. Staff A was told she was going to give resident's #8 OTC medication to resident #5. Staff A stated that the owner always pulls out the medication for her and puts it in a cup to hand to the residents. Staff A further stated that she just started working at the facility about 1 month ago, and had never been left alone with the residents before. She said the owner is always with her. Staff A was told she you could not be left alone with residents without the required training and knowledge of the facility's policies and procedures. Staff A was asked what to do in an emergency, fire but could not answer.

Resident #5's 2018 MORs were not marked from . . . . to . The MOR revealed a prescription of Hydrocod/Acetam 10-325 mg. as needed for pain 1 tablet by mouth every 6 hours.

Staff A was encouraged to call the owner again to come to the facility as soon as possible. The surveyor called the physician at 2:10 PM, and left voice message to return call back. The surveyor also called the resident's son at 2:15 PM, and left a voice message to return the call back. Resident #5 was told her doctor and family had to be notified first before she could have the medication.

On . . . . . at 2:20 PM, resident #5's record review revealed a dated 1823 Health Assessment indicating needing assistance with self-administration of medications.

On at 2:30 PM, one hour later, the owner arrived back to the facility. The owner explained that she asked resident #5 before she left the facility if she needed any medications and resident #5 said no.

On . . . . . at 2:45 PM, the owner assisted with self-administration of medications to resident #5 handing her prescribed as needed Hydrocod/Acetam 10-325 mg. to take by mouth.

Staff A's personnel file review revealed a hire date of . It did not contain documentation of the required in-service training in reporting incident and adverse incidents, and the completed initial 4-hour assistance in self-administration of medications, and safe practices.

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On . . . . . at 8:30 PM, the owner confirmed the findings.

Class II

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

Based on review of the Medication Observation Record (MORs) log and interview, the facility failed to maintain a daily MOR for 1 of 6 sampled residents who receives assistance with self-administration of medications (#5).

Findings:

Review of resident #5's MORs for month of 2018 revealed missing dates or no documentation of medications given for 10 consecutive days beginning . . . , 2018 through . . . . ., 2018.

On . . . . . at 3 PM, the owner confirmed the findings.

Class III

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

Based on personnel file review and interview, the facility failed to ensure that 2 of 3 sampled staff had the required 1 hour in-service training documentation within 30 days of hire (A & B).

Findings:

1. Staff A's personnel file review revealed a hire date of . The file did not contain documentation of 1 hour training in major incident reporting and Adverse incident reporting.

2. Staff B's personnel file review revealed a hire date of . The file did not contain documentation of 1 hour training in major incident reporting and Adverse incident reporting.

On at 6:30 PM, the Owner confirmed the findings.

Class III

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

Based on personnel file review and interview, the facility failed to ensure that 2 of 3 unlicensed sampled staff providing assistance with self-administration of medications to residents had successfully completed the initial 4 hour training required in self-administration of medications and safe medication practices in an assisted living facility (A & B).

Findings:

1. Staff A's personnel file review revealed a hire date of . . . . The file did not contain documentation of the completed initial 4 hour medication training.

2. Staff B's personnel file review revealed a hire date of . . . . The file did not contain documentation of the completed initial 4 hour medication training.

On . . . . . at 6:30 PM, the owner confirmed the findings.

Class III

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

Based on the review of the Background Screening (BGS) Clearinghouse website and interview, the facility failed to report and update employment status changes for 7 of 9 sampled staff on the employee roster within 10 business days as required (A, B, E, F, G, H & I).

Findings:

On . . at 8 PM, a review on the BGS Clearinghouse website employee roster revealed that:
1. Staff A was hired on . . and not registered on the employee roster;
2. Staff B was hired on . . . . and not registered on the employee roster;
3. Both staff E and staff F no longer worked at the facility as of . . 2017
4. Staff G no longer worked at the facility as of 2017
5. Staff H no longer worked at the facility as of . . 2017
6. Staff I no longer worked at the facility as of 2017

On . . . at 8:15 PM, the Owner confirmed the dates and findings.

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Unclassified