STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968693	**04/23/2018**
NAME OF PROVIDER OR SUPPLIER **LILY'S PROMISE, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1958 ROLLING GREEN CIRCLE** **SARASOTA, FL 34240**	

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

0000 - Initial Comments

An unannounced biennial survey was conducted on at Lily's Promise, LLC., an assisted living facility (license #12553) in Sarasota, FL.

The following is description of the deficiencies cited.

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

Based on observations, record reviews and staff interviews, the facility failed to provide a safe and sanitary environment as evidenced by an invalid ( ) for Resident #1 and failed to adhere to control procedures during administration of medications for Residents' #2 and #4 from a sample of 4 residents reviewed.

The findings include:

1. Observation of Resident #1 on found the resident alert, pleasant and .

Review of the health assessment dated included a diagnosis of and .

Record review showed Resident #1's contract was signed by her husband on who was listed as the resident's Durable Power of Attorney (DPOA). The DPOA document stipulated Resident #1's husband could serve as her agent for financial affairs.

A ( ) was signed by Resident #1's DPOA for the date of .

There was no indication in the record the DPOA could make healthcare decisions for Resident #1.

In an interview on at 11:00 a.m., the Administrator (ADM) was unaware the DPOA document did not include provisions for providing informed consent and treatment for health care. The ADM said he would call Resident #1's son to see if there were any other documents that would permit the DPOA to make decisions related to health care for Resident #1.

After consulting with Resident #1's son, the ADM received a fax of Resident #1's Advanced Directives and Health Care Surrogate.

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Review of the document titled, "Designation of Health Care Surrogate" pages 4 and 5 included the following: "...I hereby designate my spouse...as my health care surrogate pursuant to Florida Statute...My health care surrogate designated herein shall serve subject to the following: ...My health care surrogate named herein shall have the authority and power to act on my behalf during such time as I shall not have the capacity to make health care decisions for myself or provide informed consent, as determined by (1) my attending physician and (2) treating physician or another consulting physician..."

On at 11:30 a.m., the ADM confirmed through telephone interview with the DPOA there was no evaluation by any physician related to Resident #1's capacity to make health care decisions for herself and therefore the was invalid.

2. Review of the guidelines for assisting with , (eye drops) medications and hand washing in an assisted living facility (https://www.falausa.com/Files/DOEA MED GUIDE 5th Edition [, 2016]) included the following: "...2. Wash hands and obtain necessary items (eye medication with label, MOR [Medication Observation Record], warm cloth, gauze, tissues, barrier as disposable tray, etc.)...3. Triple check the medication label with the medication observation record...5. Identify which eye (right, left, or both) to receive medication...9. Explain procedure. Tilt resident's head slightly back and with gloved finger assist resident to pull down gently on the lower eyelid to form a "pouch," while instructing the resident to look up...Hold inverted medication container between the thumb and index finger, and press gently to instill prescribed amount into "pouch" near outer corner of eye. 10. IF DROPS, place drops in "pouch" in the lower eye lid...15. If administering medication to BOTH eyes, use a different gloved finger to apply pressure to other eye tear duct...19. Remove and dispose of gloves...Discard barrier...20. Wash hands thoroughly..."

Hand Washing Procedure: "...Wet the wrists and hands thoroughly, keeping them below elbow level to keep microorganisms from moving up your arms. 6. Dispense soap. 7. Lather hands and wrists by rubbing palms together for at least 20 seconds. 8. Wash each hand and wrist and between the fingers for one to two minutes...Underneath the fingernails can be cleaned by rubbing the fingertips against the palm of the other hand...9. Dry hands with clean paper towel and use paper towel to turn off faucet. Dispose of paper towel in wastebasket..."

Observation on at 1:50 p.m. showed Licensed Practical Nurse (LPN) Staff A obtain a bottle of eye drops from the medication . After washing her hands and putting on gloves, she entered Resident #5's . Resident #5 was in a reclined position on top of her bed. Staff A knelt on the floor beside Resident #5 and removed her glasses. Staff A rested her gloved hands on top of Resident #5's lower abdomen. Staff A used her left thumb to elevate Resident #5's left upper lid and inserted a drop into her left eye. She used the same thumb to elevate the right upper eyelid to insert an eye drop.

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Staff A placed the cap on the eye drops, exited the resident's , and walked into the kitchen. Staff A removed her gloves, washed her hands less than 10 seconds, turned the spigot off with her wet hands, then dried her hands.

Observation on at 4:10 p.m. showed LPN Staff A remove medication from a pill pack and crush the medication. Staff A went into the kitchen and mixed the medication with applesauce and poured a small cup of water. Staff A went into the common area and knelt down on the floor in front of Resident #2. Staff A placed the cup of water on the floor and assisted Resident #2 with self-administration of the medication. Staff A picked up the cup of water off of the floor and handed the cup to Resident #2. After Resident #2 consumed the water, Staff A removed her gloves and walked into the kitchen. Staff A washed her hands less than 10 seconds, turned off the spigot with her wet hands and dried her hands.

In an interview on at 4:30 p.m., the Administrator said he could not find a policy on hand washing techniques and admitted Staff A should have not knelt on the floor while assisting residents with their medications. When asked if LPN Staff A had completed the requirement for control when hired, he said he could not find documentation she had attended the in-service.

Class III

N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on observation, record review, and staff interview, the facility failed to clarify physician orders for treatment to an injury to the left foot of 1 (Resident #4) of 2 sampled residents. Failure to clarify the physician's orders placed the resident at risk for the injury to worsen.

The findings include:

1. On at 9:30 a.m., Resident #4's left anterior and , foot, toes, and ankle showed significant with purple and red discolorations ( ). A large fluid filled , the size of a quarter, was observed on the anterior left foot at the bottom of the second and third left toe. Licensed Practical Nurse (LPN) Staff A asked Resident #4 to move her left foot and the resident was unable to respond to the question.

Review of the resident observation log dated documented, "[Resident #4] last night, see report. Left foot and , [founder, Registered Nurse, responsible party] notified, [Advanced Registered Nurse Practitioner] saw her, podiatrist, x rays taken, no broken bones..."

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Review of the podiatrist's progress notes dated documented, "LPN states , last night and , has and left foot...LPN states they ordered X-rays with [X-ray company] ...PLAN: Left orders with LPN to rest, ice, elevate and compression to left foot ...applied wrap to left foot ...advised , to fax X-ray results to our office, should , have a I will have , come into the office for follow up. Will follow up PRN [as needed]..."

Review of the podiatrist's undated orders, documented, "Evaluated , [patient], please fax x ray report. Make sure patient does not ambulate, elevate left leg rest, ice and wear compression wrap : Foot , with ."

The podiatrist's order did not include the duration for elevating the left leg, how often to ice the affected area, or for how long the compression wrap was to remain on Resident #4's left foot.

Review of the limited nursing services notes between and documented application and removal of ice to Resident #4's foot every 20 minutes. There was no order for this treatment.

On at 1:06 p.m., the Advanced Registered Nurse Practitioner (ARNP) said LPN Staff A sent him a picture of Resident #4's foot and he told her to remove the compression dressing and to continue to ice the foot and elevate the leg. He admitted he did not write an order for the treatment. LPN Staff A admitted she did not call the podiatrist or ARNP for clarification orders for the duration of elevating Resident #4's leg or icing the foot. In addition, she never placed Resident #4 on the LNS (Limited Nursing Services) log.

Class III