STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967919	**04/18/2018**
NAME OF PROVIDER OR SUPPLIER **AMBITIOUS QUALITY-CARE ASSISTED LIVING LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3939 COUNTRY PL** **WINTER HAVEN, FL 33880**	

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

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

Based on record review and interview, the facility failed to maintain the employment status of personnel within the employee roster listed in the AHCA background screening clearinghouse (Employee Roster), within 10 business days of initial employment, for one (Staff B) of three employee records reviewed.

Findings included:

A review of employee records conducted on . . . showed that Staff B had a date of hire of . . . .

A review of the facility's Employee Roster conducted on . . . showed that Staff B was not entered (photographic evidence obtained).

The Administrator was interviewed on at 1:07 PM and acknowledged that Staff B was not entered in to the Employee Roster as required.

Unclassified

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0000 - Initial Comments

Assisted Living Facility

A complaint investigation (CCR 2018002306) was conducted at Ambitious Quality Care Assisted Living on . Ambitious Quality -Care Assisted Living had deficiencies at the time of the investigation.

(License #11988)

0004 - Licensure - Requirements - 58A-5.016 FAC

Based on observation and interview, the facility failed to ensure that they did not hold themselves out as providing any service other than services for which it was licensed to provide.

Findings included:

A sign was observed in the window of the facility stating that it had a limited nursing services (LNS) specialty license. A review of the facility's license revealed it had a limited mental health (LMH) specialty license, not a LNS license.

An interview was conducted with the Administrator at 4:06 PM on concerning the observation of the sign representing that they had a LNS specialty license. The Administrator acknowledged that they did not have a LNS specialty license and stated that they would remove the sign.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, record review and interview the facility failed to provide licensed staff to conduct a glucose test for one resident (Resident #5) of one sampled resident.

Findings Included:

On , Staff A was observed at 11:45 PM administering a glucose test to Resident #5. Staff A asked Resident #5 to please go to their it was time to check their sugar before lunch. Staff A administered the glucose check and recorded the glucose level on clip board in the resident's .

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A record review for Staff A on revealed that they were an unlicensed medical technician (med tech) trained, not a licensed professional qualified to administer a glucose test.

During the exit interview at 5:00 PM on with the Administrator, they acknowledged and confirmed that Staff A was not licensed to administer a glucose test. They stated that they were told by a registered nurse (RN) that provided training in assistance with self-administered medication for Staff A, that since an RN taught the class, Staff A could take sugars.

Class III

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

Based on observation, interview, and record review, the facility failed to ensure that medication observation records (MORs) were immediately updated after a medication was provided and charted for a medication error for one (Resident #1) of five residents observed taking medication.

Findings included:

On at 11:45 AM, Staff C was observed giving Resident #1 two pills. When asked what medication was provided to Resident #1, Staff C stated that it was .

A review of Resident #1's MORs showed the medication , 500 MG Tablet- Take 1 tablet by mouth every 6 hours as needed. A review of the MORs showed that Resident was given 500 MG of , at 8:00 AM on .

Staff A was interviewed at 12:15 PM on concerning the observation at 11:45 AM of Resident #1 being given the , . Staff A reviewed the MORs which showed that the 11:45 AM dosage was not documented (photographic evidence obtained) and that the 8 AM dosage was provided. Staff A acknowledged that it was less than 6 hours between dosages, contrary to physician's orders.

Class III

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

Based on observation, record review, and interview, the facility failed to maintain a log of menu substitutions, noted before or when a meal was served. Additionally, the facility failed to maintain a 6-month file of dated menus.

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Findings Included:

A lunch meal observation conducted on . . . . . at 12:05 PM showed that the facility served BBQ pork on a , coleslaw, seasoned corn, applesauce or Jello and beverage of choice.

During a review of the approved menu conducted on at 1:30 PM, it was revealed that the facility was to serve BBQ chicken on a . . , coleslaw, seasoned corn, mandarin oranges and milk.

The Administrator was asked for a 6-month file of dated menus after they arrived at the facility on . The Administrator was interviewed at 12:37 PM on and they stated that they don't put a date on the menu, and that if it's week 5, they put up week 5. There was no proof presented that weekly menus were alternated.

During an interview with the administrator conducted on at 2:40 PM, they stated that the facility did not keep a substitution log for menu substitutions.

Class III

0125 - Fiscal - Surety Bonds - 429.27(2) FS; 58A-5.021(3) FAC

Based on record review and interview, the facility failed to obtain a surety bond as required when they served as representative payee and/or power of attorney (POA) for residents.

Findings included:

An interview was conducted with the Administrator at 12:05 PM on . . . . . The Administrator stated that they acted as POA for Resident #2 and representative payee for Resident #2 and Resident #3. A review of Resident #2's and Resident #3's record revealed documentation concerning appointments as POA and representative payee for the two residents.

The Administrator was asked for proof of a surety bond and they provided a copy of a declarations page from their insurance company. The declarations page did not state that it was a surety bond.

A phone interview was conducted with an Assistant Underwriter with the facility's insurance company at 3:05 PM on . . . . . A policy number was provided to the Assistant Underwriter to research the status of coverage. The Assistant Underwriter stated that this was not a surety bond and explained that surety

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bonds were specific to resident trust funds.

An interview was conducted with the Administrator at 4:07 PM on and the phone interview with the Assistant Underwriter from the facility's insurance company was discussed, including the statement that the facility's policy presented was not a surety bond. The Administrator stated that they thought it was a surety bond.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to make necessary repairs in order to provide a safe living environment, free of hazards. Additionally, based on observation and interview, the facility failed to use universal precautions to prevent the spread of during a medication observation for four Residents (#1, #3, #4, and #5) of four sampled residents.

Findings included:

A tour of the facility beginning at 9:58 AM on showed a residential cracked linoleum peeled away from the floor and sticking up between the toilet and shower (photographic evidence obtained). The showed cracked ceramic tile leading in to and within the shower (photographic evidence obtained).

An observation of Resident #2's the lack of a threshold covering the gap between the tiled hallway and the wooden floor in the resident's , creating a potential tripping hazard (photographic evidence obtained).

An observation of Resident #1's an electrical outlet without a protective cover (photographic evidence obtained).

Staff C was interviewed at 10:11 AM concerning the tile, threshold, and electrical outlet safety hazards. Staff C observed the hazards and stated that they would get them fixed.

During an observation of a medication pass on , Staff A was observed passing medications wearing the same pair of gloves for Residents #1, #3, #4, and #5 without washing or sanitizing their hands between residents.

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During an interview with the Administrator and Staff A on at 1:00 PM they both acknowledged that they were not aware that wearing the same pair of gloves during a medication pass could spread to other residents.

Class III