STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967254	**04/20/2018**
NAME OF PROVIDER OR SUPPLIER **ARK CENTER OF BREVARD**	STREET ADDRESS, CITY, STATE, ZIP CODE **1574 MANZANITA STREET** **PALM BAY, FL 32907**	

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

0000 - Initial Comments

A Biennial Relicensure survey with Limited Nursing Service (LNS) was conducted on . . . . and . . . . . Ark Center of Brevard, License #11359, had deficiencies at the time of the survey.

0004 - Licensure - Requirements - 58A-5.016 FAC

Based on record review and interview, the facility failed to have a satisfactory health inspection.

Findings:

Review of the facility's most recent health department group home inspection that was completed on . . . . revealed the results were unsatisfactory.

On . . . . at 4:10 p.m., the administrator confirmed the findings and said she did not know the facility had to have the information outlined as missing on the health inspection until the inspection itself was done.

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 ensure 1 of 6 sampled residents had a face-to-face medical examination by a health care provider that was recorded on a health assessment form 1823 after experiencing a significant change (#1), and failed to ensure 1 of 6 sampled residents had face-to-face medical examination by a health care provider at least every 3 years (#5).

Findings:

1. Resident #1's record revealed a facility admission date of and a hospice admission date of . Resident #1's most recent health assessment form 1823 was dated on . The record did not contain a health assessment form 1823 to indicate a face-to-face medical examination by a health care provider was conducted when resident #1 was admitted to hospice, which was a significant change.

2. Resident #5's record revealed a facility admission date of and a health assessment form 1823 that was dated most recently on . The record did not contain a health assessment form 1823 to indicate a face-to-face medical examination by a health care provider was conducted every 3

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years.

On at 11 a.m., the administrator confirmed the findings.

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 follow a medication list for 2 of 2 sampled residents who received assistance with self-administered medications (#1 & 5).

Findings:

1. Review of a health assessment form 1823, dated on , revealed resident #1 required assistance with self-administered medications.

Resident #1's record contained a most recent medication list that was dated on . The medications on the list included 8.6 milligram (mg.) tablet, 1 tablet by mouth daily, and 50 mg. tablet, 1/2 tablet by mouth every 8 hours.

Resident #1's , 2018 Medication Observation Record (MOR) revealed two listings for tablets. Both listings were for 8.6 mg. daily, both were scheduled every day at 9 am, and both were signed as given from through .

The was scheduled on the , 2018 MOR to be given daily at 9 a.m. and 9 p.m. and not every 8 hours as was indicated on the medication list.

On at 3:37 p.m., the administrator confirmed the findings and said she believed hospice had a more recently dated medication list for resident #1. The administrator was provided the opportunity to email the surveyor a copy of a more recent medication list.

On at 12:21 p.m., an email received from the administrator included a medication list for resident #1 that was dated on . However, the newer medication list contained the same information related to the and as was on the medication list that was dated on .

2. Review of a health assessment form 1823, dated on , revealed resident #5 required assistance with self-administered medications.

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Resident #5's record contained a most recent medication list that was dated on . The medications on the list included Caltrate 600 plus D plus 600-400 mg.-unit tablet, give 2 tablets once daily.

Resident #5's , 2018 MOR revealed the entry for the Caltrate was to give 1 tablet once daily and not 2 tablets as was indicated on the medication list.

Resident #5's record did not contained any documented evidence to indicate the facility contacted a health care provider to clarify the discrepancy.

On at 3:45 p.m., the administrator confirmed the findings.

Class III

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

Based on observations and interview, the facility failed to post an activities calendar in a common area where residents normally congregated.

Findings:

Observations made on at 10:09 a.m. did not reveal an activities calendar posted in the facility. The administrator confirmed the finding and said the calendar off of the wall and had not yet been replaced.

Class

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

Based on record review and interview, the facility failed to ensure the Medication Observation Record (MOR) was updated for 1 of 6 sampled residents who required assistance with self-administered medications (#5).

Findings:

Review of a health assessment form 1823, dated on , revealed resident #5 required assistance with self-administered medications.

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Resident #5's record contained a most recent medication list that was dated on . The medications on the list included 75 micrograms (mcg.) by mouth daily on Monday through Saturday, and 150 mcg. by mouth daily only on Sunday.

Resident #5's 2018 MOR contained only an entry for the 75 mcg. dose which was signed as given every day, including on Sundays.

On at 3:48 p.m., the administrator confirmed the findings and said resident #5 did receive the 150 mcg. every Sunday as prescribed. She said the MOR was not updated properly to reflect it. Review of resident #5's medication containers revealed the presence of both 75 mcg. and 150 mcg. tablets were available to be given.

Class

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

Based on observation and interview, the facility failed to ensure that centrally stored medications were properly secured.

Findings:

Observations made on at 9 a.m. revealed a cup that contained 3 pills was left unattended on the dining . Caregiver A confirmed the finding and said she placed the pills there for resident #5 to take but the resident did not feel well, left the pills there, and went to her .

Caregiver A said the cup contained 1 Centrum tablet and 2 Propanolol tablets. Caregiver A picked up the cup of pills, placed them on the kitchen counter, and walked away leaving the pills unattended again.

On at at 9:16 a.m., the pills remained unattended on the kitchen counter. Upon further questioning by the surveyor, caregiver A secured the pills.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on review of a medication container, record review and interview, the facility failed to ensure a medication container was properly labeled for 1 of 6 sampled residents who received assistance with

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self-administered medications (#2).

Findings:

Observations made during a medication pass for resident #2 on at 8:56 a.m. revealed caregiver A gave the resident one tablet from a Centrum Silver over the counter bottle and one tablet from an , 81 milligrams over the counter bottle. Neither of the bottles contained the name of resident #2, as required.

On at 9:15 a.m., caregiver A confirmed the findings.

Class III

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

Based on record review and interview, the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience, and allowed unlicensed caregiver (A) to set the dose on an pen for a resident who received (#4).

Findings:

During an interview with caregiver A on at 10:11 a.m., she identified resident #4 and said the resident received . Caregiver A said resident #4's husband checked her sugar, told the caregiver what the results were, the caregiver dialed the pen to the prescribed dose, then resident #4's husband injected her with the .

Review of resident #4's , 2018 Medication Observation Record (MOR) revealed entries for 30 units every morning and 20 units every night at bedtime. On at 11:50 a.m., caregiver A identified staff initials on the MOR as her own.

On at 11:55 a.m., the administrator confirmed that caregiver A did dial resident #4's pen to the prescribed dose, as was reported by the caregiver. That task could not be performed by an individual who was not licensed to do so.

Resident #4's health assessment form 1823, dated on , indicated the resident required assistance with self-administered medications. Her diagnoses included Dependant .

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Class III

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

Based on record review and interview, the facility failed to maintain the minimum staffing hours per week.

Findings:

On at 8:30 a.m., caregiver A said the facility's census was six.

Observations made on at 8:45 a.m. revealed there were six residents in the facility. Therefore, the facility required a minimum of 212 hours per week.

Review of the facility's staffing schedule for the week of through revealed the facility had only 184 scheduled staffing hours.

On at 9:42 a.m., a request was made of the administrator as to whether any additional documentation was available to review for compliance. She said "No", the schedule was the only document used to determine staffing hours.

Class III

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

Based on personnel record review and interview, the facility failed to ensure an unlicensed caregiver (A) who provided assistance with the resident's medications received the initial 4 hour training on providing assistance with self-administered medications in an assisted living facility from a registered nurse or licensed pharmacist.

Findings:

Observations made on at 9:56 a.m. revealed caregiver A provided assistance with self-administered medications to resident #2.

Caregiver A's personnel record revealed a 4-hour certificate of completion, dated on , in

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"assisting the patient with self-administration of medications." However, the certificate did not indicate the training was provided by a registered nurse or licensed pharmacist.

On at 12 p.m., the administrator confirmed the findings.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on personnel record review and interview, the facility failed to have documented evidence that direct care staff (A) received at least one hour of training in the facility's policies and procedures regarding ( ) that included information in 58A-5.0186, Florida Administrative Code within 30 days after employment.

Findings:

Caregiver A's personnel record revealed a hire date of . The record contained a 1-hour certificate of completion in reporting major incidents and but caregiver A did not receive at least one hour of training in itself.

On at 12 p.m., the administrator confirmed the findings.

Class III

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

Based on observation and interview, the facility failed to have at least one gallon of water per resident, for three days of stored water.

Findings:

On at 8:30 a.m., caregiver A said the facility's census was six.

Observations made on at 8:45 a.m. revealed there were six residents in the facility. Therefore, the facility required a minimum of 18 gallons of stored water.

On at 2:40 p.m., the administrator confirmed the findings. She said she did not have a plan for obtaining water in an emergency.

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Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record reviews and interview, the facility failed to ensure the residency contract for 2 of 6 sampled residents contained all of the required information (#1 & 5).

Findings:

Review of the facility's posted license on revealed the facility held a Limited Nursing Service specialty license.

Review of the contract for residents #1 and #5 revealed the contracts did not contain a list of the specific Limited Nursing Services to be provided by the facility and any associated charges.

On at 3:07 p.m., the administrator confirmed the findings.

Class

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

Based on record reviews and interviews, the facility failed to employ or contract with a nurse who was available to meet the needs of residents who required a Limited Nursing Service (LNS.)

Findings:

Review of the facility's posted license on revealed the facility held a Limited Nursing Service specialty license.

On at 10 a.m., the administrator said the facility did not employ a nurse but rather had a contract with a home health agency to provide the services of a nurse to meet the needs of residents who required a LNS. Review of the contract revealed it was dated on .

During a phone interview with the home health administrator on at 1:43 p.m., she said the contract was no longer valid and that the home health agency moved out of the county in 2017.

On at 3:08 p.m., the administrator said she did not know the home health agency moved and

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the contract was no longer valid.

Class III