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	AL11965464	**05/10/2018**
NAME OF PROVIDER OR SUPPLIER **M H TENDER CARE I**	STREET ADDRESS, CITY, STATE, ZIP CODE **9 WAINWOOD PLACE** **PALM COAST, FL 32164**	

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

0000 - Initial Comments

A unannounced biennial relicensure survey was conducted at MH Tender Care I from . . . . through . . . . . M H Tender Care I (license #9901) had deficient practice identified during the survey.

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

Based on observation, a review of resident records, and interview with staff, the facility failed to obtain an accurate resident health assessment (AHCA form 1823) for 1 of 2 residents sampled (Resident # 5).

The findings include:

An observation of Resident #5 was conducted at 8:44 am on . . . . . He was seated at the breakfast , and was assisted by Employee A, Caregiver. Employee A retrieved a plastic baggie full of medicine bottles from the medication drawer. She dispensed one capsule from the bottle into a spoon. She then dispensed 2 white tablets from another bottle into the spoon. She then handed the spoon containing the 3 pills to Resident #5, and told him to take the medication. Resident #5 placed the spoon into his mouth and took the pills from the spoon. Employee A returned to the baggie full of bottles, and continued by dispensing 3 additional pills from their bottles. Resident #5 was able to spoon the medication into his mouth, although he dropped one pill onto his lap. Employee A retrieved the pill with the spoon, then assisted him with placing the spoon and 3 pills into his mouth.

Record review for Resident #5 found a resident health assessment (AHCA form 1823) dated and signed by the examining practitioner. Resident #5 was assessed as requiring his medications to be administered, instead of requiring assistance with the self-administration of medications, as was observed at 8:44 am with Employee A on .

An interview was conducted with the Administrator at 12:00 pm on . She confirmed the 1823 for Resident #5 was inaccurate, and that he did not need his medications administered.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on a review of facility records, and interview with staff, the facility failed to conduct and document resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S. on a semi-annual

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basis.

The findings include:

During a review of facility records, the Administrator was asked at 12:15 pm on for the documentation of elopement drills. She stated she would look for them. She was asked again at 12:28 pm on for the semi-annual elopement drills. She said Employee A, Caregiver, was supposed to conduct them once a month. The Administrator stated no elopement drills had been conducted, as required.

Class III

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

Based on observation, interview and record review, the facility failed to provide assistance with self administration of medication in a manner consistent with physician orders and assessment for 2 of 2 residents sampled.

The findings include:

1. Resident #1 was observed at the dining on at 8:35 AM eating her breakfast and drinking from a cup independently. Record review of AHCA 1823 Health Assessment showed Resident #1 needed assistance with self administration of medication.

On at 8:40 AM, Employee A was observed pushing medication from the bubble pack into a small bowl for Resident #1. Ten pills were dispensed. Employee A spooned applesauce on the pills, covering them. She brought the cup to the resident who was sitting at the table. She said "here you have to take these" and spooned the applesauce with the pills into the residents mouth. She did it four times and after each time said "swallow." Resident #1 was not given the opportunity to self-administer her medications, and was not informed of what was being spooned into her mouth. Employee A then gave the resident the drink that was sitting on the table and said "swallow." She then picked up the residents fork and gave her a piece of pancake.

After giving the medication, Employee A did not annotate the medication observation record (MOR). She got out the pills for the next resident. She was not observed checking the MOR before giving Resident #1 her pills, and was not observed documenting after giving the medication.

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During an interview with Employee A on at 9:25 AM, she stated she was not aware she should not spoon feed resident their medications.

2. Resident #5 was observed seated at the breakfast table at 8:44 am on . Employee A, Caregiver, retrieved a plastic baggie full of medicine bottles from the medication storage cabinet, and took them to the the table. Without first reviewing the MOR to determine what medications Resident #5 was scheduled to receive, she open and dispensed one capsule and 2 white tablets into a spoon. She told the resident the 2 pills were his . Employee A then handed the spoon to the resident, and told him to take the medication. Resident #5 placed the spoon into his mouth and took the pills. Employee A then placed a bite of pancake into the resident's mouth. Employee A then proceeded to dispense his remaining medications while telling the resident what he would receive: 1 , 1 , and 1 . Resident #5 fed himself the pills.

Review of the medication observation record (MOR) and the medication bottle labels found Resident #5 had orders for, and received, the following:

1 , (used to treat or) 20 milligram (mg), 2 (for) 500 mg tablets, 1 (for) 100 micrograms (mcg), 1 (used to treat) 10 mg, and 1 , (treats high ,) 5 mg. The physician's instructions on the , were to administer 1 each day, but to HOLD if the was less than 120.

Further review of Resident #5's records found no record of the facility staff checking his , according to the parameters of the , . The only recordings for Resident #5's were in the hospice records, which revealed he was last visited by the Licensed Practical Nurse (LPN) on . His vital signs were documented, reflecting a , ( ) of . The LPN also visited on , and noted a , of .

An interview was conducted with Employee A at 9:00 am on . She stated she rarely took vitals, including , readings, on the residents. The nurse came once a week and did this. When shown the instructions for the , she said she knew what the label said. It instructed to hold the medication if his , was under 120, but Resident #5's nurse came once a week. Employee A said the doctor knew when to change this resident's medication. After some hesitation, Employee A then insisted the hospice certified nursing assistant (CNA) came in every day and took Resident #5's , but did not necessarily document this.

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The hospice CNA arrived at approximately 10:00 am; one hour after the medication was taken. She tended to Resident #5 behind his closed , but departed without notice, and prior to being interviewed.

An interview was conducted with the Administrator at 12:00 pm on . She reviewed the , instructions, the hospice order, and MOR. She confirmed that staff were giving the medication daily without having actual knowledge of his , . She confirmed this required correction.

Photographic Evidence Obtained

Class III

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

Based on observation, resident record review, and staff interview, the facility failed to ensure a licensed staff member was available to administer medications in accordance with a health care provider's order to 1 of 1 residents observed to have her medications administered (Resident #2), out of a total of 3 residents observed for assistance with medications.

The findings include:

An observation of Employee A assisting Resident #2 with morning medications was conducted at 8:50 am on . Employee A retrieved the resident's medications from the medication cabinet, and dispensed two pills into a bowl of oatmeal. Resident #2 was in bed, and did not respond to this surveyor's greetings. Employee A explained Resident #2 needed assistance with medications, and needed to be fed, so she put Resident #2's medications into her food. After raising the head of the bed so the resident sat upright, she fed Resident #2 her pill and oatmeal mixture. Resident #2 opened her mouth for each bite, but at no time in the observation was she seen assisting in the process.

When interviewed at 9:25 am on , Employee A confirmed she was not a licensed nurse. When asked if she was aware that a licensed nurse was required to administer medications to a resident, she said yes. She stated she was aware of the requirement, but the hospice nurse was not always there in the facility. She had no choice but to administer the pills to Resident #2.

Review of the AHCA form 1823 (resident health assessment) dated revealed the examining practitioner assessed Resident #2 as requiring her medications administered.

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An interview was conducted with the Administrator at 11:50 am on . She reviewed the resident's record, and confirmed Resident #2 needed her medications administered. The Administrator confirmed Employee A was not a licensed nurse, and that a nurse was needed to administer medication.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observation, interview, and record review, the Administrator failed to ensure the services provided to 2 of 2 residents met the standards set forth in Chapter 429, F.S., and 58A-35, F.A.C., specific to the lack of oversight provided to staff in training and assignments, the mismanagement of records necessary to verify compliance with standards, and the failure to ensure resident care needs were met.

The findings include:

1. Resident #1 was observed at the dining on at 8:35 AM eating her breakfast and drinking from a cup independently. Record review of AHCA 1823 Health Assessment showed Resident #1 needed assistance with self administration of medication.

On at 8:40 AM, Employee A was observed pushing medication from the bubble pack into a small bowl for Resident #1. Ten pills were dispensed. Employee A spooned applesauce on the pills, covering them. She brought the cup to the resident who was sitting at the table. She said "here you have to take these" and spooned the applesauce with the pills into the residents mouth. She did it four times and after each time said "swallow." Resident #1 was not given the opportunity to self-administer her medications, and was not informed of what was being spooned into her mouth. Employee A then gave the resident the drink that was sitting on the table and said "swallow." She then picked up the residents fork and gave her a piece of pancake.

After giving the medication, Employee A did not annotate the medication observation record (MOR). She got out the pills for the next resident. She was not observed checking the MOR before giving Resident #1 her pills, and was not observed documenting after giving the medication.

During an interview with Employee A on at 9:25 AM, she stated she was not aware she should not spoon feed resident their medications.

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An observation of Employee A assisting Resident #2 with morning medications was conducted at 8:50 am on . Employee A retrieved the resident's medications from the medication cabinet, and dispensed two pills into a bowl of oatmeal. Resident #2 was in bed, and did not respond to this surveyor's greetings. Employee A explained Resident #2 needed assistance with medications, and needed to be fed, so she put Resident #2's medications into her food. After raising the head of the bed so the resident sat upright, she fed Resident #2 her pill and oatmeal mixture. Resident #2 opened her mouth for each bite, but at no time in the observation was she seen assisting in the process.

When interviewed at 9:25 am on , Employee A confirmed she was not a licensed nurse. When asked if she was aware that a licensed nurse was required to administer medications to a resident, she said yes. She stated she was aware of the requirement, but the hospice nurse was not always there in the facility. She had no choice but to administer the pills to Resident #2.

Review of the AHCA form 1823 (resident health assessment) dated revealed the examining practitioner assessed Resident #2 as requiring her medications administered.

An interview was conducted with the Administrator at 11:50 am on . She reviewed the resident's record, and confirmed Resident #2 needed her medications administered. The Administrator confirmed Employee A was not a licensed nurse, and that a nurse was needed to administer medication.

2. During a review of facility records, the Administrator was asked at 12:15 pm on for the documentation of elopement drills. She stated she would look for them. She was asked again at 12:28 pm on for the semi-annual elopement drills. She said Employee A, Caregiver, was supposed to conduct them once a month. The Administrator stated no elopement drills had been conducted, as required.

3. Record review of the Employee file for the Administrator found no evidence of a Level II background screening. The Administrator brought the surveyor a "Live Scan" request form dated on at 11:55 AM and stated she did not know her Level II expired and she was going to get finger printed again. She was notified by the surveyor her last screening in the computer had a date of . She stated she could not recall when she was last screened and confirmed a copy was not in her employee file.

During an interview with the Administrator on at 12:35 PM, she provided the employee schedule for , of 2018. Record review of the schedule found it did not give any times the employees were scheduled to work. The Administrator confirmed the schedule for , 2018 did not have times. She was then asked for the schedules for the last 6 months. She stated she threw them out.

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A review of the facility personnel files revealed Employee B was hired on . . . . . as a Caregiver.

A telephone interview was conducted with Employee B on . . . . . at 10:30 am. She confirmed she worked on the facility over the weekends, and sometimes during the week.

A review of the AHCA background screening website was conducted at 8:21 am on . Employee B was not listed as an employee of the facility on the clearinghouse roster.

An interview was conducted with the Administrator at 12:00 pm on . . . . . She reviewed the roster and confirmed Employee B was not listed as an active employee.

Photographic Evidence Obtained

Class III

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

Based on record review and staff interview the facility failed to ensure 1 of 3 sampled employees received 3 hours of in-service training within 30 days of employment that covered providing assistance with the activities of daily living. (Employee A)

The Findings Include:

Record review for Employee A (hired . . .) found no evidence Employee A received training that covered providing assistance with activities of daily living (ADL).

The findings were confirmed during an interview with the Administrator on at 12:00 pm. The Administrator was asked for documentation of the ADL training for the employee. She could not locate proof of the training and confirmed the employee needed it done.

Class III

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

Based on observation, interview and record review, the facility failed substitutions to the planned menu, and failed to offer 2 of 4 residents (Resident #1 and #5) all of the items on the menu for the day.

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The findings include:

The menu for the week was observed on the refrigerator on at 8:10 AM. Breakfast for was recorded as waffles, margarine, syrup, juice and milk. The milk was at 8 ounces. Two residents sitting at the table Resident #1 and #5 were given pancakes. Juice was not served. The only milk was in coffee.

In an interview with Employee A on at 11:30 AM, she was asked why she did not serve waffles. She stated she does not ever give waffles as the menu states and does pancakes since it is made of the same thing and she has pancake mix and does not have a waffle maker. She was asked if she documents what she substitutes and she stated that she has a substitution log. She stated she had not kept it up to date. Review of the log found it was last documented in on .

Photographic Evidence Obtained

Class III

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

Based on observation, review of facility records, and interviews with staff, the facility failed to maintain an up-to-date admission and discharge log listing the names of all current residents, evidenced by inaccurate documentation for 1 of 5 currents residents (Resident #5) and 2 of 2 former residents (Resident #6 and #7).

The findings include:

A review of the facility's admission and discharge log revealed 6 residents were logged as residing in the home. Resident #1 was noted to be admitted in , 2013, with no discharge date. Resident #2 was listed at admitted in 2013, with no discharge date. Resident #3 was noted as admitted , 2013, with no discharge date. Resident #3 was admitted in 2016, with no discharge date. Resident #4 was admitted 2006, with no discharge date. Resident #6 was admitted 2018, with no discharge date. Resident #7 was admitted , 2009, with no discharge date.

A tour of the facility at 7:55 am on found there were 5 residents in the home at the time of the survey. Residents #1, #2, #3, #4, and #5.

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A second review of the admission and discharge log revealed Resident #5 was not on the log at all.

An interview was conducted with Employee A, Caregiver, 8:00 am on . She confirmed there were only 5 residents living in the facility, Residents #1, #2, #3, #4, and #5, not #6 and #7.

In an interview with the Administrator at 12:35 pm on , she acknowledged the admission/discharge log had not been maintained to accurately reflect the residents' admission and discharge status.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on employee record review and staff interview, the facility failed to maintain a personnel file that contained at a minimum, documentation of compliance with level II background screening for 2 of 3 staff members. (Employee A and the Administrator) and failed to maintain written work schedules for the most recent 6 months.

The findings include:

1. Record review of the employee file for Employee A (hired) found the Level II background screening had a screening date of and a prints retained with an expiration date of .

The Administrator was asked if she had a new Level II screening for Employee A on at 11:55 AM. She could not locate it and on at 12:00 pm she provided a new print out.

Record review of the Employee file for the Administrator found no evidence of a Level II background screening. The Administrator brought the surveyor a "Live Scan" request form dated on at 11:55 AM and stated she did not know her Level II expired and she was going to get finger printed again. She was notified by the surveyor her last screening in the computer had a date of . She stated she could not recall when she was last screened and confirmed a copy was not in her employee file.

2. During an interview with the Administrator on at 12:35 PM, she provided the employee schedule for , of 2018. Record review of the schedule found it did not give any times the employees were scheduled to work. The Administrator confirmed the schedule for , 2018 did not have times.

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She was then asked for the schedules for the last 6 months. She stated she threw them out.

Photographic Evidence Obtained

Class III

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

Based on a review of facility records, the AHCA background screening website and staff interview, the facility failed to register with the clearinghouse and maintain the employment status of 1 of 3 employees whose files were reviewed within the clearinghouse (Employee B).

The findings include:

A review of the facility personnel files revealed Employee B was hired on [redacted] as a Caregiver.

A telephone interview was conducted with Employee B on [redacted] at 10:30 am. She confirmed she worked on the facility over the weekends, and sometimes during the week.

A review of the AHCA background screening website was conducted at 8:21 am on [redacted]. Employee B was not listed as an employee of the facility on the clearinghouse roster.

An interview was conducted with the Administrator at 12:00 pm on [redacted]. She reviewed the roster and confirmed Employee B was not listed as an active employee.

Photographic Evidence Obtained

Unclassified

Z827 - Unlicensed Activity - 408.812 FS

Based on observations, resident and staff interviews, and resident record reviews, the facility's controlling interest was found to be operating as an assisted living facility by providing assistance with activities of daily living (ADLs) and assistance with self-administration of medication for 5 of 5 residents observed in the home (Residents A,B,C,D, and E).

The findings include:

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On at 7:45 am, an unannounced closure monitoring visit was conducted at 9 Ponderosa Lane in Palm Coast, FL. Review of the Final Order showed the location at Ponderosa Lane did not have a currently valid license to operate. On arrival to 9 Ponderosa Lane, Employee D, a caregiver answered the door. At 8:00 am on , she stated there were 5 residents living in the facility. In an interview with Employee D at 8:15 am on , she stated she had worked in the facility for a couple of years. When asked who the Administrator was, she named the same Administrator as M H Tender Care I.

When asked about the assistance the residents required with activities of daily living (ADLs), she said Resident C required assistance. Resident B received hospice services, and required total care by staff. She was also dependent on staff for all transfers. Resident E received assistance with showers. Employee D stated all 5 residents required assistance with the self-administration of medications.

An observation of Resident A was conducted at 8:00 am on . He was seated in a wheelchair in the living . When greeted and questioned, he stated he had lived here approximately one year. He stated received assistance with anything and everything he needed, explaining the facility staff provided assistance with his medications, and his meals.

The medication observation record (MOR) was reviewed, and revealed assistance with self-administration of medication was being documented for all 5 residents. Inspection of the medication drawer confirmed medications for all 5 residents were centrally stored.

A staff schedule was posted on the wall in the common area of the facility, dated , 2018. It reflect scheduled work days for several employees.

A record review for Resident A revealed he was admitted on . Resident A had a Medicare number documented on his demographic sheet. An AHCA form 1823 (resident health assessment) completed noted diagnoses including and . Resident A required assistance with ambulation, bathing, dressing, eating, self care/, toileting, transfers and the self-administration of medications.

Resident A signed Resident contract on for a monthly rate of $2100.00 for the following services: board, 24 hour care, laundry, snacks, telephone and cable TV, assistance with bathing and other ADLs, assisting with securing healthcare, supervision with self-administration of medications, assistance in providing transportation to the doctors, and scheduled activities. The contract was co-signed by the individual with controlling interest, the Administrator.

A Record review for Resident B revealed an admission date of . The record contained a durable

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power of attorney/designation of health care surrogate designation (dated) appointing a family member as her legal representative. Resident B had an AHCA form 1823 dated that listed diagnoses of , , and . She was assessed as being , and required the services of a hospice nurse every 14 days, with as-needed hospice services. Resident B was at risk for , and was assessed to require total care with ambulation, bathing, dressing, , toileting, transferring, eating, and with self-administration of medications. Resident B's legal representative executed a Resident Contract on for a monthly amount of $2200.00. A review of hospice records confirmed an admission date of . Resident B had Medicare part A and B and private supplemental insurance.

Record review for Resident C revealed an admission date of . She had an AHCA 1823 dated , which noted diagnoses including and hip replacement. Resident C was assessed with mobility limitations, and was oriented only to herself. She required assistance with ambulation, bathing, dressing, , toileting and transfers, self-administration of her medications, and supervision with eating. Resident C had Medicare/Medicaid. A durable power of attorney appointment to a family member was dated . The legal representative and resident executed a Resident Contract on for $2300.00/month.

In an interview with Resident D on at approximately 8:30 am, she said she came in (2017). Employee D gave her medications, and her doctor told her she should not stay alone. Employee D assisted her with anything she needed. Review of facility and resident records found she was admitted on . She had an AHCA 1823 dated that assessed Resident D as alert and oriented, but at risk for . Diagnoses included multiple , , unsteady gait, , , , , , left hand and low back pain. She required assistance with self-administration of medication. Resident D had a Resident Contract signed for a monthly rate of $2000.00.

An interview with Resident E was conducted on at 8:45 AM. He stated he had lived at the facility for several years, and needed help dressing and with showers. Record review for Resident E revealed he was admitted to the facility on . The AHCA 1823 dated listed diagnoses including of lung, and . He was oriented to person and place, and required assistance with transfers by one person. He was "Not Ambulatory" , and required assistance with bathing, dressing self-care ( ), toileting, transferring and with self-administration of medication. A Resident Contract was signed by Resident E on for a $2,300.00 a month.

An interview was conducted with the Administrator on . She stated she owned this property.

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The surveyor team retrieved the facility license, and provided a letter of Unlicensed Activity (ULA) to the Administrator/controlling interest at 9:25 am on [redacted] for operating without a license.

Photographic Evidence Obtained.

Unclassified