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	AL11968664	**05/10/2018**
NAME OF PROVIDER OR SUPPLIER **M H TENDER CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **29 PRINCE JOHN LN** **PALM COAST, FL 32164**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

An unannounced biennial licensure survey was conducted at M H Tender Care on , , 2018 through , , 2018. M H Tender Care (License #12522) had deficiencies found at the time of the visit.

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

Based on observations, resident record review and staff interviews, the facility failed to obtain an updated resident health assessment (AHCA form 1823) following a significant change in condition 1 of 1 resident reviewed who received hospice supports (Resident #1), out of 2 sampled residents whose records were reviewed.

The findings include:

A record review revealed Resident #1 was admitted to the facility on . She had an AHCA 1823 dated and signed by the examining practitioner that listed diagnoses including , of knees, wheelchair dependency, dyslipidemia, and . She was assessed as being at risk for , with memory loss, and unable to stand or walk.

Further review of the resident record revealed that on , Resident #1 commenced hospice services. The record contained no updated resident health assessment following a significant change is the resident's condition that warranted hospice support.

An interview was conducted with the Administrator on at 12:25 pm. She confined no new 1823 was completed after Resident #1 had a change in condition. She confirmed she had not yet gotten a new 1823 following the hospice enrollment.

Class III

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

Based on observation, facility record review, and staff interview, the facility failed to provide an ongoing diversified activities program keeping with each resident's needs, abilities, and interests for 2 of 2 sampled residents observed (Resident #1 and #2), and failed to maintain a current activities calendar that reflected at least 12 hours of scheduled activities per week.

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The findings included:

A tour of the facility was conducted on [redacted] at 8:05 am. An activity calendar dated [redacted], 2018 was posted on the kitchen wall, and reflected activities such as folding laundry, assist with garbage, exercise, senior center, walks, and ball time. There were no times on the calendars to reflect when the activities should be offered.

At 9:00 am, during the survey on [redacted], the Administrator was obserred going into the office, and produced an activity calendar dated [redacted], 2018.

The survey team did not observe any organized activity on [redacted] between 8:00 am and 1:00 pm, other than from approximately 9:00 am to 9:45 am. During that time, Employee A, caregiver, placed a magazine on the table in front of Resident #1. She sat with the resident and turned the pages of the magazine. Resident #1 did not appeared to look at the magazine. She leaned forward over the table and stared out the window. She was left at the table at approximately 9:45 am, staring at the wall, where she remained for much of the survey. Resident #2 napped in a recliner chair throughout the duration of the survey.

An interview was conducted with Employee A at 11:40 am on [redacted]. She stated she did not go by the posted calendar, she just did whatever activity she wanted.

Class III

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

Based on record review and staff interview, the facility failed to maintain photo identification of 1 of 2 residents assessed to be at risk for elopement (Resident #2), and failed to ensure the safety of residents by conducting elopement drills at the facility twice a year with direct care staff.

The findings include:

Record review of the AHCA Form 1823 Resident Assessment for Resident #2 that was based on a [redacted] exam found the physician documented on page one of the assessment that the resident was an elopement risk. Further record review for Resident #2 found a written statement from a caregiver

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documenting the resident's elopement at another facility on . There was not a picture of the resident in the record at the time of the review on .

On at 10:30 AM, the Administrator was asked to provide evidence of the elopement drills conducted at the facility since the last biennial survey. The Administrator left the facility on at 11:34 AM and did not provide the information prior to exit.

During an interview with Employee A on at 11:34 AM, she stated she does elopement drills on her own. The Administrator and other employees were not present. She was not able to give any details of when and state she did not have anything in writing to show she did them.

During a telephone call with the Administrator on at 12:25 PM, the Administrator was notified of the missing elopement drills . She did not have any additional information to provide. She was also asked about the missing photograph of Resident #2, but she did not have any additional information to provide on the photograph either.

Class III

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

Based on observation, a review of resident records, and interviews with staff, the facility failed to provide adequate assistance with the self-administration of medication for 1 of 2 residents observed (Residents #2)

The findings include:

1. An observation was conducted of Employee A, caregiver, providing assistance with self-administration of medications at 8:10 am on . She retrieved a plastic bin containing Resident #2's medications from a storage drawer and took them to the table where he was seated. Without reviewing the medication observation record (MOR) to determine what medications he should receive, she dispensed the following pharmacy-labeled medication into a plastic cup: 50 milligrams (MG), tablet 40 MG, tablet, 1 tablet, .5 MG tablet, 250 MG capsul, 10 MG tablet and Douscate 100 MG capsule.

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Without telling him what he would receive, Employee A poured the pills into Resident #2's mouth. She said "drink the juice", which he did.

Record review of Resident #2's AHCA 1823 Resident Health Assesment based on a examination found Resident #2 had diagnoses of and . He required assistance with self administartion of medication and was independent with all acivites of daily living.

Without telling him what he would receive, Employee A poured the pills into Resident #2's mouth. She said "drink the juice", which he did.

An interview was conducted with Employee A at 11:00 am on . She explained she did not know she had to give verbal prompting.

Class III

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

Based on observation, a review of resident records, and interviews with staff, the facility failed to ensure that only licensed staff administered medications to 2 of 2 residents observed to have their medications administered (Residents #1).

The findings included:

1. An observation was conducted of Employee A, caregiver, providing assistance with self-administration of medications at 8:10 am on , for both Resident #1 and #2. When she began assisting Resident #1, Employee A retrieved Resident #1's medications, and per surveyor's review of the labels, dispensed the following into a cup: One 1000 microgram (mcg) tablet, one 20 milligram (mg) tablet, one Centrum -162-1 supplement tablet, and one 1 mg tablet. She did not provide the medication information to Resident #1.

Employee A poured the contents of the cup into an opened napkin on the kitchen counter, folded the napkin over the top of the pills, then attempted to pulverized the tablets by banging them with a bottle. Plumes of powder-like crushed tablets puffed out of the sides of the napkin, and were observed landing and coating the surface of the kitchen counter when she lifted the napkin. Employee A poured the crushed pills into a bowl, and added 2 ounces of ensure to the bowl. She spoon fed the liquid and

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crushed medication mixture to Resident #1.

Observation of Resident #1 throughout the survey on from 8:00 to 12:40 pm, she was observed to be non-verbal, and was not observed communicating any of her needs. She required total assistance with wheelchair mobility and with meals (she had to be fed by staff), and was not seen engaging with others.

Closer review of the MOR and pharmacy label revealed Resident #1's (an) 1 mg tablet was ordered to be given "as needed", every 6 hours for agitation.

In an interview at 8:20 am on , Employee A was asked if she was a licensed nurse. She said she was. When asked again to confirm she was a licensed practical nurse, she hesitated, then replied "yes." The Administrator, who was in the same , corrected her at this time and said, "No, you are a CNA (certified nursing assistant)." She said she gave Resident #1 her whenever she became agitated, and started moving around in her wheelchair and taking off her clothing. It calmed her down. Employee A stated Resident #1 was not capable of asking for the medication, she just gave it when she was agitated.

A telephone interview was conducted with the Administrator at 12:25 pm on . She confirmed she knew that unlicensed staff should not be administering medications to residents.

A review of the personnel file for Employee A revealed she was hired as a caregiver. There was no indication she was a licensed nurse.

Class III

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

Based on resident record reviews and staff interview, the facility failed to (1) Maintain a daily medication observation record (MOR) that recorded each time medication was taken immediately after the medication was offered or administered for 2 of 2 residents who received assistance with self-administration of medications or medication administration (Residents #1 and #2).

The findings include:

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At 8:10 am on , the survey team requested Employee A provide the MORs for both Residents #1 and #2. Employee A provided the MORs at this time, and commented "I need to write in it some."

Review of the MOR for Resident #1 revealed she received the following medications on a daily basis: 1000 micrograms (mcg) once a day at 8:00 am, , (anti-depressant) 20 milligrams (mg) a day 8:00 am, Centrum -162-1 daily (supplement) at 8:00 am, , (a used for) 15 mg daily at 8:00 pm, , (an ,) 1 mg every 6 hours as needed (prn) agitation.

The entries on the , 2018 MOR for Resident #1 revealed the , the , , the Centrum and had not been signed out as taken since , 6 days ago. The , had not been signed out as given all month, 8 days. There were no explanations whether the medications had been held, were unavailable, refused, or why the medications were not signed out as taken. , was signed as given "as needed" two times on , and 2 times on , , but there were no notes as to what time the medication was administered.

Review of the , 2018 MOR for Resident #1 revealed none of her scheduled medications (listed above) had been signed out as taken on , 29 or , , with no explanation. The was signed out 2 times daily from , 1-23, with 2 additional doses signed out (to total 4 doses) on , 7 and 8.

A record review for Resident #1 revealed an AHCA 1823 (resident health assessment) dated , which indicated she had diagnoses of , wheelchair dependency, and . Resident #1 was assessed with memory loss, and required assistance with the self-administration of medication.

Review of the MOR for Resident #2 revealed the following medications had not been signed out as taken since : DOK (, a stool softener)100 mg every day at 8:00 am, , 81 mg daily at 8:00 am, , (an anti-depressant) 50 mg daily 8:00 am, , (used in treatment of) 40 mg daily at 8:00 am, (used to treat) 10 mg daily 8:00 am, , ( ) 250 mg daily for prophylaxis (, prevention) 8:00 am, Tamulosin , (for , retention) 0.4 mg daily 8:00 am, (to lower lipids) 20 mg daily at 8:00 pm, 1000 micrograms (mcg) daily 8:00 am, , (,) 15 mg daily 8:00 pm, Quietapine (anti-,) 50 mg daily 8:00 pm, , (anti-) 0.5 mg twice daily 8:00 am and 8:00 pm, , (for function) 5 mg twice daily at 8:00 am and 8:00 pm. The MOR for , 2018 consisted of only one page, and reflected the above orders for , , , , and one hand-written order for , Hydro (an anti- rmedication) 1 tab 3x a day for 7 days. The

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signature boxes for the , , , and were blank from 4/1-18 to . The was also blank from to , then the boxes for through had been initialed, as taken, but then lined through, with no explanation. The remainder of the month was blank with no discharge instructions or additional information. The and was not signed as taken on - , then after , the , was blank with instructions to "D/C" (discontinue), but no discontinue date. The , was signed from , 17, and 18, then a large "D/C" written across the page, with no discontinue date.

An interview was conducted with Employee A at 9:40 am on . She looked at the MORs for Residents #1 and #2, and confirmed the multiple blanks/ missing initials. She admitted she had forgotten to initial the MORs for both residents.

Photographic Evidence Obtained

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. Record review for Employee A (hired) revealed no evidence Employee A received training reporting major incidents, resident rights or in the facility emergency procedures including chain of command and staff roles relating to emergency evacuations.

Further record review of the employee record for Employee A found no evidence of , , ( ) training. An interview was held with Employee A on at 11:12 AM. She was not aware if she had training. On entrance to the facility at 7:55 AM, Employee A stated she works alone at the facility from 8:00 AM to 8:00 PM and at times will work a 24 hour shift alone. She did not know the names of the other employees that work at the facility.

Record review for Employee B (hired) found no evidence of current First Aid or training

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located in the file. Record review for Employee C (hired) found no evidence of current First Aid or training located in the file.

Employee C's record showed the most recent medication administration training Employee C was a 6-hour training on , with no annual updates available for review.

During an interview with the Administrator of the facility on at 8:15 AM, she was asked for the employee schedules. The Administrator was asked a second time for the employee schedule on at 9:03 AM. She stated she did not think she needed to rush to get them.

The Administrator was asked for her employee file on at 9:03 AM and again at 10:30 AM.

The findings were confirmed during an interview with the Administrator on at 10:30 AM. She was asked for more information on the employee files and schedules. She left the facility on without finding the information, and did not provide her own file for review prior to leaving. During a telephone call on at 12:25 PM she still did not have any information related to the missing training to provide.

2. Record review of the background screening system found Employee C was not listed as an employee on the facility's roster.

Record review of the employee file for Employee C found she was hired on .

During a telephone interview with Employee C on at 11:45 AM, she stated she has worked at the facility as a relief person for years. She stated she is on call and last worked at the facility the weekend before last Sunday.

The findings were confirmed during a telephone interview with the Administrator on at 12:25 PM. She stated she would add her.

3. On at 10:30 AM, the Administrator was asked to provide evidence of the elopement drills conducted at the facility since the last biennial survey. The Administrator left the facility on at 11:34 AM and did not provide the information prior to exit.

During an interview with Employee A on at 11:34 AM, she stated she does elopement drills on her own. The Administrator and other employees were not present. She was not able to give any details

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of when and state she did not have anything in writing to show she did them.

During a telephone call with the Administrator on at 12:25 PM, the Administrator was notified of the missing elopement drills . She did not have any additional information to provide. She was also asked about the missing photograph of Resident #2, but she did not have any additional information to provide on the photograph either.

4. An observation was conducted of Employee A, caregiver, providing assistance with self-administration of medications at 8:10 am on , for both Resident #1 and #2. When she began assisting Resident #1, Employee A retrieved Resident #1's medications, and per surveyor's review of the labels, dispensed the following into a cup: One 1000 microgram (mcg) tablet, one 20 milligram (mg) tablet, one Centrum -162-1 supplement tablet, and one 1 mg tablet. She did not provide the medication information to Resident #1.

Employee A poured the contents of the cup into an opened napkin on the kitchen counter , folded the napkin over the top of the pills, then attempted to pulverized the tablets by banging them with a bottle. Plumes of powder-like crushed tablets puffed out of the sides of the napkin , and were observed landing and coating the surface of the kitchen counter when she lifted the napkin. Employee A poured the crushed pills into a bowl, and added 2 ounces of ensure to the bowl. She spoon fed the liquid and crushed medication mixture to Resident #1.

Observation of Resident #1 throughout the survey on from 8:00 to 12:40 pm, she was observed to be non-verbal, and was not observed communicating any of her needs. She required total assistance with wheelchair mobility and with meals (she had to be fed by staff), and was not seen engaging with others.

Closer review of the MOR and pharmacy label revealed Resident #1's , (an ,) 1 mg tablet was ordered to be given "as needed", every 6 hours for agitation.

In an interview at 8:20 am on , Employee A was asked if she was a licensed nurse. She said she was. When asked again to confirm she was a licensed practical nurse, she hesitated, then replied "yes." The Administrator, who was in the same , corrected her at this time and said, "No, you are a CNA (certified nursing assistant)." She said she gave Resident #1 her , whenever she became agitated, and started moving around in her wheelchair and taking off her clothing. It calmed her down. Employee A stated Resident #1 was not capable of asking for the medication, she just gave it when she was agitated.

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She retrieved a plastic bin containing Resident #2's medications from a storage drawer and took them to the table where he was seated. Without reviewing the medication observation record (MOR) to determine what medications he should receive, she dispensed medications for Resident #2.

Without telling him what he would receive, Employee A poured the pills into Resident #2's mouth. She said "drink the juice", which he did.

Record review of Resident #2's AHCA 1823 Resident Health Assessment based on a examination found Resident #2 had diagnoses of [illegible] and [illegible]. He required assistance with self administration of medication and was independent with all activities of daily living.

An interview was conducted with Employee A at 11:00 am on [illegible]. She explained she did not know she had to give verbal prompting.

Class III

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

Based on employee record review and staff interview, the facility failed to ensure 1 of 3 employees submitted a written statement from a health care provider documenting freedom from signs or symptoms of communicable within 30 days of employment (Employee A), and failed to ensure 2 of 3 employees had annual [illegible] screening completed (Employee A and B).

The findings include:

Record review for Employee A (hired [illegible]) revealed no evidence of a written statement from a health care provider documenting that Employee A did not have any signs or symptoms of communicable [illegible]. The only information found in the employee record was a lab test for [illegible] ( ) dated [illegible]. The lab test was not dated or signed that the findings had been confirmed by a health care provider.

Record review for Employee B (hired [illegible]) found no evidence of an annual test. The last evidence of negative was from , 2016.

The findings were confirmed by the Administrator on at 10:30 AM. She did not provide any of the missing information and left the facility at 11:18 AM without returning. During a telephone call with

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the Administrator on at 12:25 PM, she did not have any additional information to provide.

Class III

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

Based on employee record review and staff interview, the facility failed to ensure 1 of 3 employees (Employee A) received training in reporting major incidents, resident rights in an assisted living facility, and the facility emergency procedures including chain of command and staff roles relating to emergency evacuations within 30 days of employment.

The findings include:

Record review for Employee A (hired) revealed no evidence Employee A received training reporting major incidents, resident rights or in the facility emergency procedures including chain of command and staff roles relating to emergency evacuations.

The findings were confirmed during an interview with the Administrator on at 10:30 AM. She was asked for the missing training. She looked in the employee file and could not locate it. She left the facility on without finding the information. During a telephone call on at 12:25 PM she still did not have any information related to the missing training to provide.

Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on record review and staff interview, the facility failed to ensure there was one staff member working at all times holding a valid card documenting completion with courses in First Aid and ( ).(Employee A, B and C)

The findings include:

Record review of the employee record for Employee A (hired) found no evidence of ( ) training. An interview was held with Employee A on at 11:12 AM. She was not aware if she had training. On entrance to the facility at 7:55 AM, Employee A stated she works alone at the facility from 8:00 AM to 8:00 PM and at times will work a 24 hour shift alone. She did not know the names of the other employees that work at the facility.

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Record review for Employee B (hired) found no evidence of current First Aid or training located in the file.

Record review for Employee C (hired) found no evidence of current First Aid or training located in the file.

The Administrator was notified of the missing training on at 10:30 AM. She left the facility on at 11:18 AM and did not return. During a telephone call with the Administrator on at 12:25 PM, she was notified again of the missing information. She stated she did not have any additional information to provide.

Class III

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

Based on staff interview and record review, the facility failed to ensure 1 of 3 employees that assist with self-administering of medications received annually a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. (Employee C)

The findings include:

Record review for Employee C (hired) found the most recent medication administration training Employee C was a 6-hour training on .

The Administrator was notified of the missing training on at 10:30 AM. She left the facility on at 11:18 AM and did not return.

During a telephone interview with Employee C on at 11:45 AM, she stated she works as relief at the Administrators four facilities and has done so for years. She is on call and worked the weekend before last on a Sunday. She also stated that she gives medication to the residents.

During a telephone call with the Administrator on at 12:25 PM, she was notified again of the missing medication training for Employee C. She did not have any additional information to provide.

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

Based on employee record review and staff interview, the facility failed to ensure 3 of 3 sampled employees received a minimum of 1 hour of training in the facility's policy and procedures regarding Do No Orders ( ), within 30 days of employment. (Employee B)

The findings include:

Record review for Employee A (hired) revealed a certificate dated for training did not indicate the training she received was 1 hour in length.

Record review for Employee B (hired) found no evidence of facility specific training.

Record review for Employee C (hired found no evidence the employee received a minimum of 1 hour of training in the facility's policy and procedures regarding .

The findings were confirmed during an interview with the Administrator on at 10:30 AM. She was asked for the missing training. She left the facility at 11:18 AM and had not provided the information. During a telephone call with the Administrator on at 12:25 PM, she still did not have any additional information to provide.

Class III

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

Based on observation, facility record review, and interviews with staff, the facility failed to provide menu substitutions with comparable nutritional value for 2 of 2 residents observed at breakfast (Residents #1 and #2), or to maintain a log when meal substitutions were made, and keep it on file for 6 months.

The findings include:

An observation of the breakfast meal was conducted at 8:00 am on . Employee A, Caregiver, prepared and served a bowl of oatmeal and cup of juice to Residents #1 and #2. Resident #2 also received a slice of white bread covered with a thick coating of butter. There was no observation of Resident #1 receiving bread.

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Observation of the refrigerator revealed the week's menu was posted on the door. It was signed by the Registered Dietician, and called for 2 slices of toast, 1 egg, margarine, 4 ounces of juice, and 8 ounces of milk on the day of the survey.

When asked for the substitution log at 11:15 am on , the Administrator produced an alternate menu that listed potential substitutions for various food groups. The list was not signed by the dietician, and did not include a space for noting what substitutions were made on any given day. The Administrator acknowledged the meal served today did not follow the Registered Dietician's menu recommendation for breakfast.

In a second interview with the Administrator at 12:38 pm on , she insisted she had a book for noting substitutions. When asked at this time if she had ever seen or used this book, Employee A shook her head "No."

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 residents and each resident's date of admission, the facility or place from which the resident was admitted, the date and reason for discharge, and identification of the facility or address to which the resident was discharged for 3 of 3 discharged residents (Residents #3, #4 and #5).

The findings include:

1. During a tour of the facility at approximately 8:00 am on , 2 residents were observed in the home. Interview with Employee A, Caregiver, at this time confirmed there were only 2 residents in the facility, Resident #1 and #2.

A review of the facility's admission and discharge log reflected 5 residents still living in the facility at the time of survey. Resident #3 was listed as being admitted in ; however, there was not date, reason for, or location of discharge. Resident #4 was noted with an admission date . There was no discharge information. Resident #5 had no admission or discharge date, and no reason for or location of discharge.

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SUMMARY STATEMENT OF DEFICIENCIES
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An interview was conducted with Employee A at 11:30 on . She reviewed the admission and discharge log and confirmed it was not up to date. She said Resident #3 was discharged, but came back to visit recently. Resident #4 was no longer here, as she was .

In an interview with the Administrator at 12:25 pm on . She acknowledge admission and discharge log was not up to date to reflect the required information.

Photographic Evidence Obtained

Class III

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

Based on record review and staff interview, the facility failed to maintain employee schedules for the facility and failed to maintain personnel records for each staff member which contain, at a minimum, documentation of background screening for 1 of 3 employees (Employee A) and failed to maintain any records for the Administrator at the facility.

The findings include:

During an interview with the Administrator of the facility on at 8:15 AM, she was asked for the employee schedules. The Administrator was asked a second time for the employee schedule on at 9:03 AM. She stated she did not think she needed to rush to get them. She left the facility on at 11:18 AM and never came back. She did not provide the employee schedules prior to leaving.

Record review for Employee A (hired) found no evidence of a level II background screening in the employee file. The Administrator was notified of the missing background screening on at 10:30 AM. She then provided one with a date of print of .

The Administrator was asked for her employee file on at 9:03 AM and again at 10:30 AM. She left the facility at 11:18 AM and had not provided her employee file. During a telephone call with the Administrator on at 12:25 PM, she was notified her file was still not able to be reviewed. She did not have any additional information to provide.

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and staff interview, the facility failed to maintain weight records for 1 of 2 residents. (Resident #1)

The findings include:

Record review for Resident #1 revealed she was admitted to the facility on . She had a resident health assessment (AHCA form 1823) dated , which noted diagnoses including , , and wheelchair dependency. She was unable to stand or walk, and had memory loss. Resident #1 was assessed as requiring assistance with ambulation, bathing, dressing, eating, toileting, , and transfers, and self-administration of medications. Section 3 of the assessment, Services Offered or Arranged indicated Resident received daily assistance with all of these activities of daily living from the facility.

Only one weight was noted on the AHCA 1823 , which was 120 pounds on . Further review of the resident's record found no semi-annual weights, as required.

An interview was conducted with the Administrator at 9:40 am on to request weight records for Resident #1. She said the weights should be in the resident charts. When shown the records did not contain semi-annual weights, she could not explain.

In a second telephone interview with the Administrator at 12:25 pm on , she said she could not find the weights. She said Employee B did the weights, but she could not find them.

Class III

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

Based on record review and staff interview, the facility failed to ensure a contract was offered to the resident or the resident's legal representative before or at the time of admission for 2 of 2 sampled residents. (Resident #1 and #2)

The findings include:

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Record review of the admission/discharge log for the facility found Resident #2 was not listed and Resident #1 was admitted to the facility on .

1. Record review for Resident #2 revealed a AHCA 1823 Resident Health Assessment form signed by a physician based on a examination, with noted diagnoses of and Nursing/treatment/ services requirements of needing assistance with medication, or behavioral status of memory loss, and nursing for wandering. Further record review found no evidence a contract was obtained from the resident or his legal representative.

2. Record review for Resident #1 revealed a AHCA 1823 Resident Health Assessment signed by the resident's medical provider based on a examination, , which noted diagnoses including , and wheelchair dependency. Resident #1 was assessed as requiring assistance with ambulation, bathing, dressing, eating, toileting, , and transfers, and self-administration of medications. Section 3 of the assessment, Services Offered or Arranged indicated Resident received daily assistance with all of these activities of daily living from the facility. Further record review found no evidence of a facility contract.

An interview was conducted with the Administrator at 9:40 am on to request contracts for Residents #1 and #2. She stated she would look for the contracts.

In a second telephone interview with the Administrator at 12:25 pm on , she said she could not locate the contracts for both residents.

Class III

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

Based on record review and staff interview, the facility failed to update the agency background screening clearinghouse for 1 of 3 sampled employees currently working at the facility (Employee C).

The findings include:

Record review of the background screening system found Employee C was not listed as an employee on the facility's roster.

Record review of the employee file for Employee C found she was hired on .

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During a telephone interview with Employee C on at 11:45 AM, she stated she has worked at the facility as a relief person for years. She stated she is on call and last worked at the facility the weekend before last Sunday.

The findings were confirmed during a telephone interview with the Administrator on at 12:25 PM. She stated she would add her.

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:

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 .

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.

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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 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.

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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.

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 for operating without a license.

Unclassified