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0000 - Initial Comments

Assisted Living Facility

A Biennial Survey was conducted in conjunction with a Complaint Survey (CCR#: 2018004824, 2018005133, 2018006859, and 2018007111) and a Revisit to a 03/29/2018 Complaint Survey (CCR#: 2018003226) at Walton Place Assisted Living Facility from 05/31/2018 to 06/01/2018. Deficient practice was identified during the survey.

(License#: 12859)

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the Facility failed to obtain a completed Agency for Health Care Administration Form 1823 (AHCA 1823) for two Residents (Resident #1 and Resident #36) of three sampled residents who had a significant change in condition necessitating admission to Hospice services.

Findings Included:

During a review of Resident #1 AHCA 1823, conducted on , revealed that the Facility did not obtain a new AHCA 1823 when Resident #1 had a significant change in condition necessitating admission to Hospice services. Resident #1's most recent AHCA 1823 dated did not include required data related to Hospice as a Nursing/Treatment/ , , Services required by Resident #1 on page 1 (See Photographic Evidence12). Resident #1 was admitted to the Facility on . Resident #1 was admitted to Hospice services on . Resident #1's most recent AHCA 1823 did not have any Special Precautions listed on page 1. Hospice notes on stated that, "resident with ongoing declines and decreased safety awareness evidenced by non-injury on [with a] history of four within last six months." Resident #1's most recent AHCA 1823 did not list services offered or arranged by the facility for the resident on page 5 section 3.

During a review of Resident #36's AHCA 1823, conducted on , it revealed that Resident #36's most recent AHCA 1823 dated did not contain all required data. Resident #36 had a significant change in condition necessitating admission to Hospice services. Resident #36's most recent AHCA 1823 did not include required date related to Hospice as a Nursing/Treatment/ , , Services required by Resident #36 on page 1 (See Photographic Evidence 11.) Resident #36 was admitted to Hospice services on . Resident #36's most recent 1823 did not specify the type of diet the

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resident required. Resident #36's most recent AHCA 1823 did not include a list of medications and stated 'see attached' but no medication list was attached. Resident #36's most recent AHCA 1823 did not list services offered or arranged by the facility for the resident on page 5 section 3.

During a staff, interview with the Resident Care Director, conducted on at 04:34pm, the Resident Care Director acknowledged and confirmed that both Resident #1 and #36's AHCA 1823 was missing required data.
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 maintain awareness of residents' health and safety, for weight loss and , appropriate to the needs of residents accepted for admission for seven Residents (#1, #3, #5, #29, #30, #35, and #37) of fifteen sampled residents who need assistance with activities of daily living.

Findings included:

An interview with the Resident Care Director conducted on at 10:08am, revealed that the Facility does not have a means to track or log . The Resident Care Director stated that the incident reports "are kept in each residents' record."

A record review for Resident #1 conducted on , revealed that Resident #1 had multiple . Resident #1 tripped and and sustained a cut to hand on . There was no documentation that the Health Care Provider was notified. Resident #1 was found on the floor on and sustained a hematoma to the back of the head. Resident #1's legs gave out while walking and the resident on . Resident #1 sustained to the forehead. No documentation was found that Hospice was notified. On , Hospice notes stated that Resident #1 has 'ongoing declines and decreased safety awareness'. Resident #1 on and sustained to the right eye and a cut to the right jaw near earlobe. Resident #1 was not sent to the Emergency Department. Hospice was not notified of the . No documentation found in Resident #1's record indicating what safety intervention and prevention measures the Facility put in place as precautions. Resident #1's Agency for Health Care Administration Form 1823 (See Photographic Evidence12) did not include the following required data:
- Hospice as a Nursing/Treatment/ , , services required
- Special Precautions as or risk
- Services offered or arranged by the facility for the resident (Page 5 Section 3)

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A record review for Resident #30 conducted on . . . . . , revealed that Resident #30 . . on . Resident #30 was sent to the Emergency a head injury. No documentation was found in Resident #30's record indicating what safety intervention and prevention measures the Facility put in place as precautions.

A record review for Resident #3 conducted on , revealed that resident #3 had an incident on . . . . . (suspected .) sustaining head and facial injuries and . . . . . to knees (See Photographic Evidence14 and 15). There was no documentation that the Facility sent Resident #3 to the Emergency Department or notified Resident #3's Health Care Provider or Power of Attorney of the injury. No documentation was found in Resident #3's record indicating what safety intervention and prevention measures the Facility put in place as . precautions.

A record review for Resident #5 conducted on . . . . . , revealed that Resident #5 was found on the floor lying face down on . When Resident #5 stood up, staff observed a noticeable limp. Two incident reports were found (See Photographic Evidence5 and 6) and one stated that Resident #5 would not stand on left leg. The Facility sent Resident #5 to the Emergency Department on . No documentation was found in Resident #5's record indicating what safety intervention and prevention measures the Facility put in place as precautions.

A record review for Resident #37 conducted on , revealed that Resident #37 'lost balance in . . . . . caught arm on metal frame' on . . . . . . Resident #37 sustained a laceration to the right . The Facility sent Resident #37 to the Emergency Department. On , Resident #37 was 'found on floor.' Resident #37 sustained a laceration to both the left arm and right leg. The Facility did not send Resident #37 to the Emergency Department. No documentation was found that Resident #37 Power of Attorney notified. No documentation was found in Resident #37's record indicating what safety intervention and prevention measures the Facility put in place as precautions.

A record review for Resident #29 conducted on , revealed Resident 29 had a significant weight loss. The weight log showed that Resident #29 weighed 147 pounds on . . . . . . On , Resident #29 weighed 120 pounds. No documentation was found that Resident #29's Health Care Provider was notified regarding the 27-pound weight loss. Resident #29's charting notes dated stated that the resident's responsible party came to the facility two days after taking Resident #29 to their physician. It stated that tests were taken as part of the doctor's visit. The notes stated that the resident's responsible party informed the facility that the resident's medical doctor indicated that the resident was . . . . . , and very weak and needed to go to a higher level of care immediately.

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A record review for Resident #35 conducted on [redacted], revealed Resident #35 had a significant weight loss. The weight log showed that Resident #35 weighed 157 pounds on [redacted]. On [redacted], Resident #35 weighed 127 pounds. No documentation found that Resident #35 Health Care Provider notified regarding the 30-pound weight loss.

The Resident Care Director was interviewed at 12:23 PM on [redacted] concerning the weight log reviews for Resident #29 and Resident #35. The Resident Care Director recognized that, for some unexplained reason, Resident #29 had a separate weight log for their [redacted] weight entry. This log was not present in the resident's closed record when initially requested by the surveyor. The Resident Care Director stated that the staff would have notified them if they saw this weight loss. As for Resident #35, the Resident Care Director acknowledged that the resident had a significant weight loss. The Resident Care Director stated that they were not aware that the resident lost so much weight and could not explain why. In a further interview at 04:34pm, the Resident Care Director confirmed that the Facility does not have a Policy and Procedures concerning [redacted].

Class III

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

Based on observation, interview, and record review, for eight Residents (#7, #8, #9, #10, # 11, #12, #31 and #35) of eight sampled residents who need assistance with self-administration of medication, the Facility failed to:

1. Follow Medication Technician training guidelines for [redacted] control standards during medication pass
2. Appropriately prompt or cue resident with proper administration of an inhaler
3. Follow Facility medication policy and procedures
4. Return unneeded or unused medication back to pharmacy for proper disposal
5. Observe residents take prescribed medication
6. Notify Health Care Provider for suspected noncompliance

Findings Included:

Anobservation conducted on [redacted] at 12:30pm, revealed a pill lying on the floor in Memory Care (See Photographic Evidence9). Staff G picked up the pill and called Staff K to assist in identifying the medication and which resident it belonged. Staff K went through the medication cart. Staff K identified that the medication capsule was [redacted] 100mg and belonged to Resident #35 (See Photographic

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Evidence8 and 10). Staff K stated that Medication Technicians observe the residents swallow medication by having the resident "open their mouth."

During a staff interview with the Administrator, conducted on at 03:00pm, the Administrator stated that staff has been told "to always check so the resident does not hide" the medication in the cheek.

A medication pass observation with Staff K, conducted on at 07:35am, revealed that the Facility pre-preps Resident medication for medication pass (See Photographic Evidence1). Staff K was observed crushing and pre-prepping medication for medication pass upon entry into the Memory Care Unit's Medication . Resident #11's medications were crushed and in a small container of yogurt with Resident #11's name handwritten on it. Resident #12's medications were crushed and in a small container of applesauce with Resident #12's name handwritten on it. When Staff K noticed the Agency Surveyor, Staff K placed multiple small containers with applesauce into the second drawer of the medication cart. No cooling device was noted in the medication cart including the second drawer for yogurt or applesauce, which require refrigeration.

A medication pass observation with Resident #7, conducted on at 07:40am, revealed that the Facility does not follow the Medication Technician four-hour Training. Staff K did not wash or sanitize hand before or after assisting Resident #7 with medication including administering a prescribed nasal spray and a prescribed inhaler. Staff K did not state the medications Resident #7 was receiving out loud in the presence of the resident. Staff K did not wash or sanitize hands during the procedure of administering Resident #7 prescribed , Nasal Spray nor wear gloves during the procedure. Staff K did not wipe or cleanse the nasal spray nozzle before returning the medication back to the central storage medication cart. Staff K did not wash or sanitize hands before or after administering Resident #7 prescribed HFA Inhaler nor wear gloves during the procedure. Staff K did not instruct Resident #7 to keep mouth open during administration of inhaler. Staff K gave Resident two quick puffs with a two to three second wait time between puffs. Staff K did not wipe or clean mouthpiece before returning the medication back to the central storage medication cart.

A medication pass, observation with Resident #8, conducted on at 07:50am, revealed that Staff K did not wash or sanitize hands before or after giving medications to Resident #8. Staff K did not state the medications given to Resident #8.

A medication pass observation with Resident #9, conducted on at 07:55am, revealed that Staff K did not report Resident #9's medication refusal, which Staff K stated that this is "unusual for him."

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A medication pass observation with Resident #10, conducted on [redacted] at 08:00am, revealed that Staff K did not wash or sanitize hands before or after giving medication to Resident #10. Staff K removed the medication , 400mg from Resident #10's medication dose pack. Staff K disposed of the unneeded medication in the medication cart's trash receptacle. Staff K did not state the medications Resident #10 was receiving. Staff K left the medication cart for two minutes with the computer screen displaying Resident #10's medication information.

A medication pass, observation with Resident #11, conducted on [redacted] at 08:05am, revealed that Staff K did not wash or sanitize hands before or after giving medication to Resident #11. Staff K retrieved the small container of medication with Resident #11's hand-written name on it from the second drawer of the medication cart that Staff K pre-prepped at 07:35am from the start of medication pass. Staff K was not observed comparing the medication label to MORs. Staff K did not state the medications given to Resident #11. Staff K walked away from the medication cart to assist with another resident leaving Resident #11's medication information displayed on the computer screen.

During a staff interview with Staff K, conducted on [redacted] at 08:10am, Staff K indicated that unneeded or unused medications were not returned to the medication container. Staff K stated, "I only threw that in the trash because you were watching [and] I usually throw unneeded medication down the toilet." Staff K stated, "Yes, I usually pre-prep residents' medications so I don't have to crush the meds when I am giving them" to save time.

During a staff interview with Staff B and Staff C, conducted on [redacted] at 01:07pm, both staff stated that they "never" clean inhaler mouthpieces and there is no schedule for cleaning them.

Areview of the Medication Technician Training that the Facility uses as part of the Medication Policy and Procedures (See Photographic Evidence2), conducted on [redacted], revealed that Medication Technician taught on page 79:
1. Part 2: to wash their hands and put on gloves before and after administering inhalers.
2. Part 10: to use the inhaler one to two inches away or place inhaler under top and keep mouth open.
3. Part 14: to, if necessary, wash and thoroughly dry mouthpiece (See Package Insert or Facility Policy)

During are review of the Facility's Medication Policy and Procedures (See Photographic Evidence4), conducted on [redacted], revealed that the Facility requires Medication Technicians to receive the Medication Technician training on medications and "each staff is responsible to follow that training and [not] deviate from it."

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A review of Resident #7's prescribed medication HFA Inhaler package insert for Manufacturer's Instructions for cleaning (See Photographic Evidence3), conducted on , revealed that the Manufacturer instructs for the Inhaler cleaned "at least once a week, wash the actuator with warm water and let it air dry completely." The Manufacturer's instruction for direction of use is to shake the inhaler, administer one dose, "wait one minute and shake the inhaler again" before administering second dose.

A , 2018 Medication Observation Record review for Resident #31 conducted on , revealed that Resident #31 refused medications frequently. Resident #31 refused prescribed , Inhaler 27 days of 31 days in , 2018. Resident #31 refused prescribed Polyethylene Powder every day in , 2018. Resident #31 refused prescribed Sucralfate tablets seven days of 31 days in , 2018. Resident #31 refused tablets eight days of 31 days in , 2018. No documentation was found in Resident #31's record that the Health Care Provider was notified.

A staff interview with the Resident Care Coordinator, conducted on at 09:45am, revealed that unneeded or unused medications are to be sent back to pharmacy for disposal. A further staff interview with the Resident Care Coordinator at 10:45am revealed that Medication Technicians should wash their hands before and after every three residents during a medication pass. The Medication Technicians should sanitize between residents. The Resident Care Coordinator stated that the Medication Technicians should remove the medication vial from the inhaler mouthpiece and wipe or rinse the mouthpiece before placing it back in the central storage medication cart. The Resident Care Coordinator stated that the Facility does not allow pre-prepping/crushing of medications and that the Medication Technicians "should be pulling residents' medications one resident at a time." The Resident Care Coordinator denied that Staff K notified anyone regarding Resident #9's unusual medication refusal at 07:55am. In a further staff interview with the Resident Care Coordinator at 02:47pm, the Resident Care Coordinator was unable to provide documentation that Resident #31 Health Care Provider or Primary Care Physician was notified related to Resident #31 frequent medication refusals.

Class III

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

Based on observation, record review, and interview, the Facility failed to follow it's Medication Policy and Procedure to send all unneeded or unused medication to the pharmacy for proper disposal for one Resident (#10) of one sampled residents.

Finding Included:

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During a medication pass observation of Resident #10, conducted on at 08:00am, Staff K removed a , 400mg capsule from Resident #10's medication dose pack and placed the capsule in the medication cart's trash receptacle.

During a staff interview with Staff K, conducted on at 08:05am, Staff K stated that, "I only threw that in the trash because you were watching [and] I usually throw unneeded medication down the toilet."

During a staff interview with the Resident Care Director, conducted on at 09:45am, the Resident Care Director stated that unneeded or unused medication sent back to pharmacy for proper disposal. The Resident Care Director stated that Staff K, "should have brought them (referring to the medication) to me" in order to alert "pharmacy that this medication should be removed from the resident's medication dose pack."

A review of the Facility's Medication Policy and Procedure, conducted on , revealed that the Facility did not follow its own Medication Policy and Procedure regarding the disposition of unneeded or unused medication (See Photographic Evidence4). The Facility's Medication Policy and Procedure stated that, "all meds to be returned to Pharmacy for disposal per agreement with Pharmacy."

Class III

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

Based on record review and interview, the Facility failed to:
1. Make every reasonable effort to ensure that prescription medications were filled or refilled within a timely manner
2. Obtain an order to crush medication
3. Obtain an order to hold medications for a resident who was sleeping during a medication pass for two Resident (#4 and #11) of eight, sampled resident who need assistance with self-administration of medication.

Findings Included:

A Medication Observation Record (MORs), review for Resident (#4)'s , 2018 and , 2018 MORS, conducted on , revealed that Resident #4's prescribed medication 28mg capsules were circled as not given. Both months of Resident #4's MORs stated that the medication

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was not given due to 'not available, on order from pharmacy'. The medication is used to treat moderate to severe . Resident #4's Agency for Health Care Administration Form 1823 lists a diagnosis of . Resident #4 resides in the Facility's Memory Care Unit. Resident #4's MORs documented medications not given on and due to Resident #4 'sleeping'. No notifications to Resident #4 Health Care Provider regarding missed doses of medication due to Resident #4 sleeping were found in the resident's record. No orders in Resident #4 record to hold medications while not awake were found in the record.

An observation of the medication pass for Resident #11, conducted on at 08:05am, revealed that the Medication Technician crushed Resident #11's medications. Resident #11 MORs did not reflect an order to crush medication.

A phone interview with the Pharmacy Technician, conducted on at 11:30am, revealed that Resident #4 has not had prescribed medication . The Pharmacy Technician stated, "that reorder was called in today [and an attempt to refill occurred] on , fourth but the insurance company declined to refill it at that time because it was too soon to be filled. There were no other attempts to refill it before today."

A review of the Facility's Medication Policy and Procedure (See Photographic Evidence4), conducted on , revealed that 'staff will report discrepancies to their immediate supervisor' and 'reorder medication from the Pharmacy 2 days prior to running out'.

A staff interview with the Resident Care Director, conducted on at 04:30pm, revealed that all orders for crushing medications would be on the residents' MORs. No orders were provided to crush Resident #11's medications.

Class III

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation, record review, and interview, the Facility failed to obtain medication labels for prescribed over-the-counter medications, which include the resident's name, the manufacturer's label or the health care provider's directions of use for use for one Resident (#7) of one sampled resident who has over-the-counter and needs assistance with self-administration of medication.

Findings Included:

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An observation of the medication pass for Resident #7 conducted on , revealed that two medication bottles did not have medication labels for Staff K to check against Resident #7's Medication Observation Records (MORs). Resident #7's medications Alive Women's -50 tablets and Bayer Low Dose 81mg tablets medication bottles did not contain labels.

A review of the Facility's Medication Policy and Procedure, conducted on revealed that, 'Staff will report discrepancies to their immediate supervisor [and] the order written on MOR msut match the prescription label exactly'.

During a Staff interview with the Resident Care Director, conducted on at 09:45am, the Resident Care Director stated that "yes", the Facility requires all medication bottles and packets to have a medication label.

Class III

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

Based on record review and interviews the facility failed to maintain job descriptions for two of ten employees (Resident Care Manager and Staff K).

Findings include:

On at 9:20 AM, in an interview with the Resident Care Manager, the Resident Care Manager was requested to provide the current copy of requested employee files for review.
On , in an employee file review for the Resident Care Manager's record, the file did not contain documentation of a job description as required. The file documented the Resident Care Manager has been employed at the facility since .

On , in an employee file review for Staff K's, the file for Staff K did not contain documentation of a job description for Staff K as required. The file documented Staff K has been employed at the facility since .

On at 5:20 PM, in an interview with the administrator, the administrator was presented with the missing job descriptions for the Resident Care Manager and Staff K and was unable to provide any documentation.

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

Based on record review and interviews the facility placed residents at risk by failing to ensure one of ten staff (Staff G) had completed the required training for assistance with the self-administration of medication for staff who provide medication assistance to residents.

Findings include:

On at 9:20 AM, in an interview with the Resident Care Manager, the Resident Care Manager was requested to provide the current copy of requested employee files for review.
On , in a record review of Staff G's employee file, the file did not contain documentation Staff G had completed the required training for assistance with the self-administration of medication. Staff G's file documented Staff G started employment on .
On at 2:43 PM, in an interview with the Resident Care Manager, the Resident Care Manager stated Staff G provides assistance with the self-administration of medication to facility residents.
On at 5:20 PM, in an interview with the administrator, the administrator was presented with the missing training for Staff G related to assistance with the self-administration of medication. The administrator was unable to provide any additional documentation.

Class III

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

Based on record review and interviews the facility failed to maintain an accurate admissions and discharge log.
Findings include:
On at 9:20 AM, in an interview with the Resident Care Manager, the Resident Care Manager was requested to provide the current copy of the resident census and admission and discharge log for review by the agency.
On , in a record review of the admission and discharge log, the log documented five residents listed on the current census but not listed on the admission and discharge log. The log included Residents #3 (admitted), Resident #14 (admitted), Resident #15 (admitted), Resident #16 (admitted) and Resident #17 (admitted).
On , in a record review of the admission and discharge log, the log documented eleven residents listed on the log but not listed on the census. The residents included Resident #18, 19, 20, 21, 22, 23, 24, 25, 26, 27 and 28.
On at 11:50 AM, in an interview with the administrator, the administrator stated the admission

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and discharge log being reviewed by the surveyor was the current log used by the facility.
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