STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969273	**06/04/2018**
NAME OF PROVIDER OR SUPPLIER **FAITHFUL FRIENDS INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1902 49TH AVE E** **BRADENTON, FL 34203**	

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

0000 - Initial Comments

ASSISTED LIVING FACILITY

A complaint investigation (CCR#2018006099) was conducted at Faithful Friends assisted living facility on . . . . Faithful Friends had deficiencies at the time of the investigation.

(License #13096)

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

Based on record review and interview, the facility failed to ensure that residents were examined by a health care provider within 60 days prior to admission or 30 days following the date of admission for 1 of 3 resident records reviewed (#1).

Findings Included:

A review of Resident #1's record was conducted on . The record did not contain the required 1823 Assessment form completed by a licensed physician, licensed physician assistant or licensed nurse practitioner. The facility's Admission and Discharge Log identified Resident #1 as having been admitted to the facility on and showed that the resident had been living in the facility for over 1 year. Photographic evidence obtained.

In an interview with the Administrator at 10:15am on , she seemed surprised that the 1823 assessment was not in Resident #1's record, but did not produce an assessment during the course of the survey. The Administrator stated that the facility would contact the resident's physician to provide an 1823 assessment of Resident #1.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record reviews and interviews, the facility failed to provide daily observations by designated staff of the health, safety and physical and emotional well-being of a resident and failed to maintain a written record, updated as needed of any significant changes or illnesses that resulted in the need for medical attention for 1 of 3 residents (Resident #1).

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Findings Included:

During an observation of Resident #1 at 10:00am on . . . . . , it was observed that the resident's lower left leg was very , red and warm to touch. Resident #1 complained about the leg being painful. The skin on the resident's left foot appeared to be very dry with cracks in the skin. There was an open skin on the interior of the resident's left calf. The was covered with a bandage that had become twisted and blackened with dirt. The resident stated that the leg had become . . . . and painful over the past 4 days and during that time, no one at the facility had been notified about it or had noticed it.

In an interview with the Administrator at 10:15am on . . . , she stated that Resident #1 had put the bandage on without anyone from the facility's knowledge or assistance. The resident "put it (the bandage) on". The Administrator affirmed being aware of the resident having a skin issue on the left foot about a week or so ago, but was unaware of any pain or . The Administrator recalled taking the resident to the doctor about a week or so prior to this interview on . . . . . The doctor had requested an x-ray, but the resident had not received an x-ray because, the administrator stated the resident's insurance would not pay for it. The Administrator was not aware that the resident's leg had become , red, and painful or that there was an open on the inside of the resident's left ankle.

A review of Resident #1's record on revealed only an appointment record for a follow up visit to the resident's primary care physician scheduled for . . . . . No other documentation regarding the resident's well-being or current health status was found in the record.

Based on the interview with Resident #1 and the observations of the leg that were made during the survey, the resident was sent to the hospital

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

Based on record reviews and interview, the facility failed to maintain daily medication observation records (MOR) for each resident who receives assistance with self-administration for 9 of 9 resident records reviewed. 6 of 9 resident records did not contain a MOR (#6, #7, #8, #9, #10, # 11) and 3 of 9 records contained MORS that were not documented with medications having been given for the month of 2018. (#1, #3, #4).

Finding included:

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A record review of Resident #1's MOR was conducted on . The MOR showed the resident's medication orders included the following types of medications: an anti-tremor medication, an anti-convulsant, an anti-, , a high , medication, a and a , supplement. The record showed that from to , no medications were documented as given.Photographic evidence obtained.

A record review of Resident #4's MOR was conducted on . The MOR showed the resident's medication orders included the following types of medications: a , treatment, an anti-convulsant, and an anti-, medication. The record showed that from to , no medications were documented as given.. Photographic evidence obtained.

A review of Resident #3's record was conducted on . The MOR showed the resident's medication orders included the following types of medications: 2 for the treatment of high , and 2 anti-, , medications. The record showed that from to , no medications were documented as given.

The Administrator was interviewed at 12:30 pm on . She was asked to provide the MORs for the month of 2018 for the other residents in the facility who received assistance with medication self-administration (#6, #7, #8, #9, #10 and #11). The Administrator failed to provide the requested MORs.

When asked why none of the MORs reviewed had been signed that medications were given between and , the Administrator admitted they had no qualified Medication Technician (Med Tech) since when the only Med Tech working at the facility suddenly quit. The facility staff had not documented in the MORs between and because they were not qualified to provide assistance with medication self-administration.

A review of the medications observed in the medication cart, revealed that the medications in the bubble packs identified for each resident were not there, therefore, they had been given. Staff was just not documenting it.

Class III

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

Based on record reviews and interview, the facility failed to provide trained staff to assist residents who require assistance self-administration of medications. 2 of 2 staff members working at the facility

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(Administrator and Staff A) did not have the required medication training.

Findings Included:

The Administrator was interviewed at 12:30 pm on . She was asked to provide the Medication Observation Records (MORs) for the month of 2018 for all of the residents in the facility who received assistance with medication self-administration (#1, #3, #4 , #6, #7, #8, #9, #10 and # 11). The Administrator stated that the facility had not documented any medications were given to any of the residents from to because they had no qualified Medication Technician (Med Tech). The only qualified Med Tech working at the facility suddenly quit on . Since that day, the facility has been allowing Staff A, an untrained, unqualified and unlicensed employee, to assist with the self administration of medications to the residents.

In addition, the Administrator stated she has not received the required training, and has been assisting with self administration of medications.

Class III

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

Based on observations and interview, the facility failed to honor residents' rights for a clean and safe living environment

Findings included:

During the facility tour on the following issues were observed:

contained laundry hampers sitting empty and dirty clothes were on the floor next to the hamper. There were clothes scattered all over the floor in piles, making it a safety hazard to walk around in the .

The administrator stated on at 11:45 am that both residents in # will not pick up anything. They get undressed and throw the clothes on the floor beside the hamper and instead of putting their clothes in the dresser, they throw them into piles on the floor. She stated the staff try to pick up the clothes but the residents complain.

The dining water damage on the ceiling and on the wallpaper above the pantry door. The knob

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to the pantry was missing.

The 1 and 2 had missing tile by the tub. There was a hole by the baseboard. The knob on the water faucet was missing making it difficult to turn the water off and on. The water was leaking from the faucet because it could not be turned totally off. The towel holder had no bar to hang the towel on. There was no toilet paper holder. The toilet paper was sitting on the sink. The chair rail by the sink was partially gone.

The # had a dirty stain on the bottom of the tub and the tiled floor was dirty. There was no toilet paper holder. The toilet paper was inside the sink cabinet.

The back porch area where the residents went to smoke was made of concrete and tiles. The tiles were broken. The pathway was uneven as a result. This could be considered a safety hazard for residents with balance issues or residents could trip over the uneven edges.

The administrator stated on at 2:15 pm that she was aware of these issues and would start fixing them right away.

Class III.

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

Based on observations, record reviews and interview, the facility failed to maintain an accurate and up-to-date admission and discharge log.

Findings Included:

On at 9:30am, upon entry to the facility, 10 residents were observed. The Administrator confirmed in an interview at 10:15am that they had 10 residents currently in house. (Resident #'s 1,3,4,5,6,7,8,9, 10 and 11) The admission and discharge log was reviewed and it revealed that out of the 10 residents in residence, only residents #1, #4, # 5 and #8 were listed on the admission and discharge date with a date of admission into the facility. Residents #3, #7, #10 and # 11 were listed on the admission and discharge log, however there was no date of admission recorded on the log. The names and admission dates of Residents #6 and #9 did not appear on the log at all. Photographic evidence obtained.

In an interview with the Administrator at 1:30pm, she confirmed that an up-to-date admission and

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discharge log is required, but did not explain why the task had not been done.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observation, record reviews and interview the facility failed to maintain resident records to include resident demographic data and the resident health assessment AHCA form 1823 self-administration of medications for 3 of 3 resident records reviewed (#1, #2, and #3).

Findings included:

A review of Resident #1's record on . . . . revealed the following documention was not maintained for review: no demographic sheet, no resident health assessment AHCA form 1823, and no informed consent form for a resident requiring the assistance for medication self-administration. An interview with the Administrator at 10:15am on . . . . revealed that the resident does require assistance with self-administration of medications

A closed records review was conducted on . . . . of Resident #2's record. Resident #2's record contained an unsigned informed consent form for residents requiring the assistance for medication self-administration. Resident #2's AHCA 1823 form dated . . . . . indicated that the resident required assistance with medication self-administration.

A review of Resident #3's record was conducted on . . . . . Resident #3's record was missing an informed consent to assist with medication by unlicensed personnel on file in resident record. The resident's AHCA 1823 form dated . . . . stated that Resident #3 required assistance with medication self-administration.

In an interview with the Administrator at 10:15am on . . . . , the Administrator could not explain why the facility did not have Resident #1's demographic data or resident health assessment AHCA form 1823.

In an interview with the Administrator at 12:30pm on . . . . , she seemed surprised that the signed informed consent forms for Residents #1, #2 and #3, consenting to unlicensed personnel assisting with medication self-administration were not in the resident's records.

The Administrator attempted to locate the documents in the facility but was unable to produce the signed documents.

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

Based on record review and interview, the facility failed to maintain an up-to-date Background Screening Clearinghouse Employee Roster for 2 (Staff A and Staff B) of 3 staff selected for record review.

Findings included:

Record review on . . . revealed that Staff A had a documented hire date of and was working as a direct care staff. Staff B had worked at the facility since . . . . as direct care staff.

Review of the Agency for Health Care Administration Clearinghouse Employee Roster, on . . . . . , revealed that Staff A who was currently working at the facility, and Staff B, who had left the facility on . . . . . , were not included on the Clearinghouse Employee Roster for the facility.

When interviewed on . . . . . at 12:00 pm, the Administrator confirmed that Staff A had been employed at the facility since . . . . and Staff B had left the facility on . . . . She verified that both Staff A and Staff B had not been added or deleted from the Employee Clearinghouse roster.

Unclassified

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on record review, observation and interview, the facility failed to ensure that 1 (staff A) of 3 staff who provided direct care to the residents had a Level II background screening.

Findings included:

A review of the Agency for Health Care Administration Clearinghouse Employee Roster, on . . . . . , revealed that Staff A was not included on the Employee Roster for the facility. Further search of Staff A on the Agency for Health Care Administration Background Screening website revealed that staff A was not listed as having a Level II background screening stating she was eligible for work in a health care facility.

Record review on . . . . . of Staff A's personnel file revealed that staff A had a documented hire date of

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and was working at the facility as direct care staff. Staff A's personnel file did not contain documentation for a completed Level II background screening.

Staff A was observed working at the facility on at 9:30 am by herself. The administrator did not arrive at the facility until 10:15 am.

When interviewed on at 12:15 pm, the administrator confirmed that Staff A is a direct care staff that has worked at the facility since and that she worked by herself on the second and third shifts. The Administrator confirmed that she did not initiate a level II background screening.

Unclassified