STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967874	**06/18/2018**
NAME OF PROVIDER OR SUPPLIER **ANGEL CARE AT VERO BEACH INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1130 7 AVENUE** **VERO BEACH, FL 32960**	

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

0000 - Initial Comments

An unannounced licensure Complaint investigation, CCR#2018004618, was conducted on , 2018 at Angel Care At Vero Beach, Inc., License #11859. The facility had deficiencies identified at the time of the investigation.

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

Based on record review and an interview, the facility failed to ensure health assessments (AHCA Form 1823) were completed as required for 3 out of 3 sampled residents (Residents #1, #2 and #3).

The findings included:

1) On , the health assessments for Resident #1 were reviewed. The resident was admitted to hospice on , requiring a new assessment to be completed for this significant change. The initial assessment dated was completed and on file. A second assessment, with no date of examination documented, was found in the resident's record. During interview with the Administrator on at 1:00 PM, she stated that this assessment was the one required for the hospice admission on . The assessment had the following omissions and errors identified:

a. No date of examination documented.
b. "Bedridden" was marked "Y" (yes) with no explanation to indicate that the resident would discharged after the allowed amount of days (14) he could be bedridden with a plan of care coordinated with hospice.
c. No "hospice" services were noted on the assessment.
d. Documentation that the resident required "administration" of medication instead of "assistance with self-administration" of medication for this facility that does not provide licensed nurses to provide administration of medication.

2) On , the health assessment dated for Resident #2 was reviewed. The following omission was noted:

a. No diet instructions were documented on page 2, section 1. B.

3) On , the health assessment dated for Resident #3 was reviewed. The following omission was noted:

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a. Documentation whether the resident required "administration" of medication or "assistance with self-administration" of medication was left blank.

These findings were discussed during interview with Staff A on at 1:10 PM. The facility provided no additional documentation for review at this time.

Class III

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

Based on record review and an interview, it was determined the facility failed to ensure residents were provided medication as ordered for 2 out of 2 sampled residents (Residents #1 and #9) who required assistance with self-administration of medication.

The findings included:

1) On at 11:00 AM, the 2018 MOR for Resident #1 was requested from Staff A and the Administrator. Both stated that the MOR was not available for review and could not be found. During review of the nursing notes for this resident, the following documentation showed that the resident was not provided and every 4 hours "ATC" (around the clock) as ordered on .

a. : Staff reports yesterday ( ) was the last time the resident was given , or . Nurse discussed with staff that the resident was to receive , and every 4 hours. Staff explained that these medications were discontinued on . Nurse clarified that these medications were not discontinued.
b. : Staff A was noted as stating the weekend nurse had said she would speak with the Care Manager about "DCing/discontinuing" , and . Nurse documents that Staff A was notified not to stop medication unless the nurse "writes it" on an order.

The facility could not show that the , (5mg) and (.5mg) were provided as ordered to Resident #1 on and . There was no documentation available for review to show the resident received medication as ordered.

2) During review of the 2018 MOR for Resident #9, the following errors were identified:

a. ( ), 3mg to be given "every evening, 4 times a week" was noted on the

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MOR. The MOR was initialed every evening at 5:00 PM from through , indicating that staff had given the resident this medication every day.

During interview with the ARNP (Advanced Registered Nurse Practitioner) on at 11:15 AM, she confirmed that the current order for this medication is for the 3mg dose to be given 4 times a week on Monday, Thursday, Saturday and Sunday. She clarified this by writing the specific days of the week on a new order dated .

Staff A stated at 1:00 PM on that she understood the ( ) schedule for Resident #9, and would create a separate MOR for this medication to ensure the 3mg doses and 5mg doses were given on the correct dates. There was no system in place to check medication errors and ensure documentation was accurate. The facility provided no additional information for review at this time.

Class III

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

Based on record review and an interview, it was determined the facility failed to ensure the Medication Observation Record (MOR) was charted each time the resident was provided medication for 5 out of 10 sampled residents (Residents #4, #5, #6, #7 and #8) who required assistance with self-administration of medication.

The findings included:

During review of the 2018 MOR's, the following omissions and errors were identified:

1) Resident #4
a. - , was not doucmented as given on at 8:00 AM. The MOR was reviewed at 11:00 AM on .

2) Resident #5
a. D, to be given once weekly, was not documented as given on at 8:00 AM.

3) Resident #6
a. ( ) was not documented as given "every other day", as the MOR instructs, from - .

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b. Clearlax Powder was not documented as given "every other day", as the MOR instructs, from [redacted].

There was no documentation on the MOR to show that the medication was discontinued or that there were any changes in the health care provider's order to take these medications every other day.

4) Resident #7
a. 12:00 PM dose on [redacted] was not initialed as given at the time it was provided to the resident for [redacted].

5) Resident #8
a. 12:00 PM dose on [redacted] was not initialed as given at the time it was provided to the resident for C.

Staff A stated at 1:00 PM on that she had finished giving all medications to residents who required medications. She was asked why the noon medications for these residents were not documented as given yet. She stated she had given them the medication but had not documented this on the MORs. The facility provided no additional documentation for review at this time.

Class III

0164 - Records - Inspection Availability - 58A-5.024(4) FAC

Based on record review and an interview, the facility failed to ensure residents' records were kept for a minimum of 2 years for 1 out of 1 sampled residents (Resident #1).

The findings included:

On [redacted] at 11:00 AM, the [redacted], 2018 MOR for Resident #1 was requested from Staff A and the Administrator. Both stated that the MOR was not available for review and could not be found.

The facility could not show that medication was provided as ordered to Resident #1 in , 2018. There was no documentation available for review to show the resident received medication as ordered.

The facility provided no additional documentation for review at this time.

Class III