STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969063	**07/03/2018**
NAME OF PROVIDER OR SUPPLIER **EVERLASTING FAMILY HOME CARE SERVICES LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2722 OKLAHOMA ST** **WEST PALM BEACH, FL 33406**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

An unannounced Relicensure survey was conducted on [redacted] at Everlasting Family Home Care Services, LLC, License #12980. The facility had deficiencies at the time of the visit.

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

Based on interview and record review, it was determined the facility failed to ensure Residents' health assessments (AHCA Form 1823) were completed in their entirety at the time of admission for 1 of 2 sampled residents (#3).

The findings include:

During review of Resident #3's health assessment, the following issues were noted:
a) The facility name listed on page 1 of the assessment was not the current facility where the resident was now residing;
b) Elopement Risk was not indicated on the bottom of page 1 of the assessment;
c) No date of examination recorded under physician's name and credentials.
d) Section 3: Services Offered or Arranged by the Facility for the Resident was missing

During interview with the Administrator on [redacted] at 2:00 PM, he acknowledged the missing information on Residents #3's AHCA Form 1823.

Class III

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

Based on observation and staff interview, the facility failed to ensure that 1 of 1 resident diagnosed with [redacted] and assessed as being an elopement risk (Resident #2); 1) had identification on their person that includes their name and the facility's name, address, and telephone number; and 2) had a photo identification of this resident on file, within 10 days of admission, that is accessible to all staff and law enforcement as necessary.

The findings included:

On [redacted] at 9:00 AM, an interview was attempted with Resident #3. Resident #3 was not able to answer any questions related to her name, how long she had resided in this facility, or how she liked

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living at the facility. The response to any question posed was either a giggle or silence. Also at this time, an observation was made of the resident while seated in her wheel chair in the living room watching television. No visible identification was seen on her person.

A review of Resident #2's Health Assessment, dated , documents Resident has a diagnosis of with behavioral disturbance and requires assistance with all Activities of Daily Living (ADLs) because she will forget to do them if not reminded. Resident #3 is assessed as being an elopement risk. There was no photo identification, other than a photocopy of an old driver's license, contained within Resident #2's file. The photocopy of the Driver's License did not reflect the way the resident currently looked, nor was the photograph able to be clearly seen.

On at approximately 10 AM, Staff A confirmed that Resident #2 does not wear any identification on her person.
On at 2:00 PM. the Administrator acknowledged the requirements related to identification being worn on person identified as an elopement risk and the need for current photograph of Resident #2 to be placed in her file.

Class III

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

Based on observation and staff interview, the Administrator failed to ensure staff was providing medications in accordance with procedures described in Section 429.256, F.S. for 1 of 1 resident (Resident #3).

The findings included:

1) On during the lunch meal at 12:00 Noon, Staff A removed Resident #2's Medications from pharmacy packaged medication card, and placed medications into a small cup.
Staff A did not verify the medications against the Medication Observation Record (MOR).
Staff A did not read the medication label in the presence of the resident; instead, Staff A handed the cup to Resident #2 and said, "Here's your medication."
Staff A walked away from the table before verifying Resident #2 had swallowed all of her medications.
After several minutes, the Administrator, who was looking through cabinets for documents was next to the resident. The Administrator happened to notice the resident had not taken her medications, and he encouraged the resident to swallow the pills, which she did.
Staff A did not record the giving of the medication to Resident #2 in the MOR immediately following the

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provision of the medication.

2) On during the lunch meal at 12:00 Noon, Staff A removed Resident #3's Medications from pharmacy labeled medication bottles, and placed medications into a small cup.
Staff A did not verify the medications against the Medication Observation Record (MOR).
Staff A did not read the medication label in the presence of the resident; instead, Staff A handed the cup to Resident #2 and said, "Here's your medications."
Staff A walked away from the table and out of the a brief time before verifying Resident #3 had swallowed all of his medications.
At the time of the lunch meal, Staff A handed Resident #3 a syringe filled with 32 units of . The resident took the Syringe and injected it into his stomach. Staff A did not observe the injection.
Staff A did not record the giving of the medication to Resident #2 in the MOR immediately following the provision of the medication.

The procedures described in Section 429.256, F.S are as follows:
(a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident.
(b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container.
(c) Placing an oral dosage in the resident's hand or placing the dosage in another container and helping the resident by lifting the container to his or her mouth, if needed.
(e) Returning the medication container to proper storage.
(f) Keeping a record of when a resident receives assistance with self-administration under this section.

State Regulation states, "Trained staff must observe the resident take the medication."

Staff A confirmed on at 9:30 AM that he has completed the Assistance with Self-Administered Medication training.

On at 2:00 PM, the administrator acknowledged Staff A's failure to follow the proper procedure for assisting with self administered medications.

Class III

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

Based on observation, interviews and record review, the facility failed to ensure only licensed staff

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participated in the administration of and glucose monitoring, for 1 of 1 resident who requires administration and glucose monitoring (Resident #3).

The findings include:

Record Review conducted on revealed Resident #3 was assessed as having a diagnosis of II and requiring Medication Administration. Resident #3's Medication Observation Record (MOR) and pharmacy-labeled container documents Resident #3 requires 32 units of injected twice a day before meals. A review of the and MOR showed Staff A's initials on the MOR next to the times of administration, and on the Glucose Monitoring Log for - . No copies of the actual physician's orders were found within the resident's record.

On at 9:10 AM, Resident #3 confirmed he gets daily injections. He stated Staff hand him a pre-filled syringe, and he injects himself.

During interview with Staff A on at 9:30 AM, Staff A stated that he sometimes draws up the into the syringe for Resident #3, but Resident #3 injects himself with the syringe. Staff A also confirmed that he will perform the glucose monitoring test for Resident #3. When Staff A was asked if he was a licensed nurse or health care professional, he answered, "No, I am a Home Health Aide."

On at 12:00 Noon, Staff A handed Resident #3 a pre-filled syringe, and Resident #3 injected the into his stomach. Staff A stated the syringe had been pre-filled by the nurse that visits the facility.

On at 2:00 PM, the Administrator acknowledged the current Health Assessment for Resident #3 documented that Resident #3 required Medication Administration. The Administrator also acknowledged that Medication Administration such as injections, drawing up medication into a syringe, and Glucose Monitoring was to only be completed by licensed staff. The administrator confirmed that Staff A was not a licensed staff member.

Class III

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

Based on observation and staff interview, the facility failed to secure refrigerated medication for 1 of 2 residents by keeping the medication in a locked container within the refrigerator or by keeping the medication in a locked refrigerator (Resident #3).

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The findings included:

At 9:20 AM, an observation was made of 8 boxes of [redacted] placed within a plastic ziploc bag and stored, unsecured, in open compartment on the inside of the refrigerator door. There was also a syringe which was pre-filled with [redacted] in the covered compartment on the inside door of the refrigerator. There was no lock on the refrigerator which would prevent any resident from opening the door and accessing anything inside of the refrigerator.

On [redacted] at 1:50 PM, the Administrator confirmed that Resident's have access to the kitchen and the refrigerator. The Administrator acknowledged the requirement for all medications to be secured, and medications stored in the refrigerator must be in a locked box.

Class III

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

Based on observation, interview and record review, the facility failed to:
1) Ensure prescription drugs for self-administration assistance is not transferred from one storage container to another container for storage [i.e. from [redacted] bottle to syringe for later use] unless by a licensed pharmacist.
2) Ensure the timing of medications were followed as ordered, and staff were not are to be given to prevent unlicensed staff from deciding the timing of the medication on their own (i.e. [redacted] - "Inject [#units] under the skin twice a day before meals;" or "take twice a day)

The findings included:

On [redacted] at 12 Noon, the following medications were given to Resident #3:
1) [redacted] D3, 1,000 Units, 2 tablets (2,000 Units total)
2) [redacted] 400 mg, 2 tablets (800 mg total)
3) [redacted], 36 units in pre-filled syringe

A review of the handwritten Medication Observation Record and the medication label on the medication container showed the following instructions for the medications given:
1) [redacted] D3 (Cholecaliferol) 1000 units, take 2 tablets daily by mouth. In the "Hour Due" column, it had the following times: 8:00 AM and 12:00 PM.
Staff A's initials were next to the 8:00 AM and 12:00 PM dosage times for all of [redacted] 2018.

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For , of 2018, Staff A's initials were only recorded next to the 8:00 AM dose for , , 2, and 3
On at 12:00 PM, an observation was made of Staff A providing 2 tablets of , to Resident #3.
Staff A did not initial the dosage for 12:00 PM..

2) , 400 mg, take 1 every morning, take 2 every evening by mouth. In the "Hour Due" column it had the following times:
8:00 AM and 5:00 PM.
Staff A's initials are next to the 8:00 AM and 5:00 PM dosage times for all of 2018.
For , of 2018, Staff A's initials are nest to the 8:00 AM and 5:00 PM dosage times for , 1 and 2, but only the 8:00 AM dosage time for is initialed.
Observation was made of 2 tablets given at 12:00 PM on . Staff A did not document/initial that the mediation was given at 12:00 PM on .

3) , inject 36 units under the skin twice (2) a day before meals. In the "Hour Due" column it had the following times: 8:00 AM, 12:00 PM, 4:00 PM, and 8 :00 PM.
Staff A's initials are next to the 8:00 AM and 12:00 PM dosage times for all of 2018.
On , 1 and , 2 of 2018, Staff A's initials are recorded at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM.
On , , Staff A's initials are only recorded at 8:00 AM.
Staff A was observed giving pre-filled syringe to Resident #3 at 12:00 PM, and Resident #3 injected the into his stomach at this time.
Staff A did not initial the 12:00 PM dosage time for , , 2018.

During interview with Staff A on at 12:15 PM, he stated, "I give this [D3] two times a day. The [,] I usually give to [Resident #3] at lunch....The I give at 8:00 AM with breakfast and 12:00 PM with lunch. That's the only time." Staff A was misreading the label on the D3; he stated he thought this medication was to be given "2 tablets, 2 times a day."
Staff A was asked about his initials next to 4:00 PM and 8:00 PM dosage times on and , and he stated he did not give the at these times. He did not provide an explanation as to why his initials were there.
According to the the Glucose Log and Staff A, the glucose is monitored at 8:00 AM and 12:00 PM and the is provided after the glucose levels are tested. On , Resident #3's glucose level was not tested at 12:00 PM prior to giving the .

On at 12:30 PM, the Administrator acknowledge that Staff A was not following the MOR as it relates to times medication is to be provided. A copy of the written physician orders or a Summary of the

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Physician Orders printed by the Pharmacy was requested for the above medications and the glucose monitoring. No copies of these physician orders were provided.

The administrator was instructed to notify Resident #3's physician regarding medication errors. The Administrator contacted Resident #3's physician at approximately 12:45 PM on and notified the physician's office of the dosage errors, and requested orders specifying exact times for the Resident #2's medications.
On at 12:55 PM, the Administrator stated that Resident #2's medications come from the VA and cannot be prepackage together according to the times the medications are to be given.

Class III

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

Based on employee record review and staff interview, the Administrator failed to provide written documentation verifying 1 of 3 sampled staff was free from any signs and symptoms of communicable , including , within 30 days of hire (Staff A).

The findings included:

On , Staff A's written health statement from a health care provider documenting Staff A did not have any signs or symptoms of communicable , including , could not be located. Staff A was hired on and provides direct care to the residents living in the facility.

On at 1:30 PM, the Administrator stated the file containing the written health statement could not be found.

Class III

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

Based on observation, employee record review, and staff interview, the Administrator failed to provide documentation verifying 1 of 3 sampled staff completed courses in First Aid and holds a currently valid card documenting completion of such courses from an approved provider (Staff A).

The findings included:

On at 9:00 AM, Staff A was observed to be alone in the facility with the 2 residents currently

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residing in the facility. Staff A is a Home Health Aide who provides direct care to the current residents.

On , at 10:50 AM, a request was made to the Administrator to provide documentation that Staff A had completed an approved course in First Aid and held a currently valid certification card. A valid certification card was provided, but the training did not include First Aid training in its curriculum. A staff member holding a currently valid and First Aid certification card must be in the facility at all times.

On at 1:30 PM, the Administrator stated the documentation verifying completion of an approved First Aid Course by Staff A could not be found.

Class III

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

Based on record review and an interview, the facility failed to ensure that 1 out of 3 sampled staff (Staff A) who provides direct care to residents had received training in the facility's policies and procedures regarding ( ) within 30 days of hire.

The findings included:

On at approximately 10:50 AM, a request was made to the Administrator for documentation showing completion of training in the facility's policies and procedure regarding 's by Staff A within 30 days of hire ( ). Staff A provides direct care to residents currently residing in the facility.

On at 1:30 PM, the Administrator stated the documentation verifying completion of Training in the facility's policies and procedures by Staff A could not be found.

Class III

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

Based on observation, interview and record review, the facility failed to:
1) Follow posted lunch menu with substitutions noted before or when meal was served;
2) Substitute food items of a comparable nutritional value;
3) Provide a 6 month copy of the facility's food substitution log.

The findings included:

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On . . . . . at 12 Noon, during lunch observation, Resident #2 and Resident #3 were served tuna salad, lettuce and tomato wrapped in a flour tortilla, multi-grain chips, and fresh watermelon and sliced apples.

A review of the approved dietary lunch menu for this date lists 1 cup of Spaghetti, 4 oz. meatballs, 1/2 c. green beans, 1 cup tossed salad, 1 T. salad dressing, 1/2 c. Gelatin/Sugar Free Gelatin.

The lunch served did offer substitution of the flour Tortilla wrap for the cup of spaghetti , 4 oz tuna for the meatballs, lettuce and tomato for the 1 c. tossed salad, 1 T. mayonnaise for the salad dressing, and fresh fruit for the Gelatin. The multi grain chips was not a comparable substitute for the 1/2 c. of green beans. The substituted meal items were not recorded as substitutions prior to or at the time of the lunch meal.

On at 1:30 PM, a copy of the 6 month food substitution log was requested from the Administrator. He stated the substitution log could not be located, and was not produced for review.

Class III

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

Based on record review and staff interview, the Administrator failed to maintain personnel records for 1 of 3 sampled staff (Staff A).

The findings included:

On . . . . . at approximately 10:45 AM, a request was made to review the employment record for Staff A. The Administrator began searching for Staff A's personnel file, but was unable to locate it.
On . . . . . at 2:00 PM, the Administrator was unable to produce Staff A's copy of Background Screening, Employment Application with References, and a written health statement regarding freedom from communicable . . . . . , including . . . . The Administrator stated he could not explain what happened to the file, but he would work on replacing all the missing documentation.

Class

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

Based on resident record review and staff interview, the Administrator failed to maintain a copy of the

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signed resident contract executed at the time of admission, which contains all regulatory required provisions for 1 of 2 residents (Resident #2).

The findings included:

On . . . . . while reviewing Resident #2's record, no signed contract between the assisted living facility and Resident #2 or Resident's Legal Representative could be found.

A request for a copy of Resident #2's contract was made to the Administrator on at 10:45 AM . The Administrator stated he gave the contract to Resident #2's legal representative, and he did not keep a copy for the facility's file. No contract for Resident #2 was produced at the time of the Relicensure survey to be reviewed.

Class

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on record review and an interview, the facility failed to ensure that 1 out of 3 sampled staff (Staff A) who has direct contact with mental health residents completed a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses within 6 months of hire. Training must be provided or approved by the Department of Children and Families.

The findings included:

On . . . . . at approximately 10:50 AM, a request was made to the Administrator for documentation showing completion of Limited Mental Health training by Staff A within 6 months of hire ( ). Staff A provides direct care to residents with mental health diagnosis currently residing in the facility .

On . . . . . at 1:30 PM, the Administrator stated the documentation verifying completion of LMH Training by Staff A could not be found.

Class III