STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968340	**06/18/2018**
NAME OF PROVIDER OR SUPPLIER **NURSING CARE BY ANGELS, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8085 S BABCOCK ST** **PALM BAY, FL 32909**	

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

0000 - Initial Comments

The re-licensure survey was conducted on , 2018. Nursing Care by Angels, LLC, license #12241, had deficiencies at the time of the survey.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record reviews and interview, the facility admitted a resident (#6) who exceeded the admission criteria for an Assisted Living Facility (ALF.)

Findings:

Resident #6's record revealed an admission date of . A health assessment form 1823, dated on , indicated she had diagnoses of with behavioral disturbances, she was at risk for elopement and the question on the form that pertained to whether she posed a danger to herself or others was not answered but rather had a comment that indicated "wandering risk."

On at 10:15 a.m., resident #6 was observed opening the front door. The surveyor alerted the staff, who closed the front door and escorted the resident away from the door.

On at 11:15 a.m., resident #6 was observed opening the front door. The surveyor alerted the staff, who closed the front door and escorted the resident away from the door.

On at 12:35 p.m., resident #6 was observed attempting to open the front door however, it was locked.

On at 12:50 p.m., the owner confirmed the findings.

Observations made on at 5 p.m. revealed the facility's back door that led from the patio to the backyard contained a manual lock that did not require a key or other secure device to open it.

The facility admitted resident #6 despite its inability to meet her safety needs.

Class III

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968340	**06/18/2018**
NAME OF PROVIDER OR SUPPLIER **NURSING CARE BY ANGELS, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8085 S BABCOCK ST** **PALM BAY, FL 32909**	

SUMMARY STATEMENT OF DEFICIENCIES
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Based on record reviews and interview, the facility failed to ensure a health assessment form 1823 was complete and accurate for 2 of 3 sampled residents (#2 and #6) and failed to ensure a health care provider examined 1 of 3 residents (#6) within 60 days before admission or within 30 days following admission.

Findings:

1. Resident #6's record revealed a facility admission date of [redacted] and contained a health assessment form 1823 that was most recently completed on [redacted]. The form indicated that she required both assistance and administration of her medications. In addition, the question that pertained to whether she posed a danger to herself or others was not answered but rather had a comment that indicated she was a "wandering risk."

The record did not contain documentation to indicate the facility contacted a health care provider to obtain the correct and omitted information and to ensure a health care provider within the required time frames examined the resident.

On [redacted] at 12:50 p.m., the owner confirmed the findings.

2. Resident #2's record revealed a facility admission date of [redacted] and contained a health assessment form 1823 that was most recently completed on [redacted]. The question on the form that pertained to whether he required 24-hour nursing or [redacted] care was not answered.

The record did not contain documentation to indicate the facility contacted a health care provider to obtain the omitted information.

On [redacted] at 3 p.m., the owner confirmed the findings.

Class III

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

Based on observations, record reviews, and interviews, the facility retained a resident (#3) who exceeded the continued residency criteria in an Assisted Living Facility (ALF.)

Findings:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968340	06/18/2018
NAME OF PROVIDER OR SUPPLIER **NURSING CARE BY ANGELS, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8085 S BABCOCK ST** **PALM BAY, FL 32909**	

SUMMARY STATEMENT OF DEFICIENCIES
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On at 11:30 a.m. caregiver A said resident #3 required total assistance with her care, that she did not pivot during transferring, and the staff had to lift her up by her pants. Caregiver A said resident #3 required that amount of assistance since she began to work at the facility three months ago.

On at 11:14 a.m. caregiver B said resident #3 required total assistance with her care and transferring. Caregiver B said resident #3 required that amount of assistance since she began to work at the facility two months prior.

Resident #3's record revealed a facility admission date of . A health assessment form 1823, most recently dated on , indicated that at that time, she required assistance with her activities of daily living and transferring. Her diagnoses included Advanced . The record did not contain documentation to indicate she received hospice services.

On at 1:15 p.m. observations made during a transfer of resident #3 from a recliner to a wheelchair revealed caregivers A and B each placed an arm under the resident's arms, they each held onto the back of the resident's pants, then they lifted her into the wheelchair. During a transfer from the wheelchair to her bed, caregivers A and B used the same technique.

Resident #3 did not assist during either transfer, she did not stand, and she did not pivot.

On at 2:25 p.m., the owner said "okay."

Class III

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

Based on observations, record reviews and interviews the facility failed to follow a physician's order for 1 of 3 residents (#2,) failed to adequately supervise a resident (#6) who was at risk for elopement and failed to document when law enforcement was called to the facility to assist with 1 of 4 residents (#7).

Findings:

1. Resident #2's record contained an admission date of . A health assessment form 1823, dated on , indicated he required assistance with self-administered medications.

Observations made during a medication pass for resident #2 on at 10 a.m. revealed unlicensed caregiver B gave the resident one 5 milligram tablet of even though his 2018

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968340	**06/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE BY ANGELS, LLC	**8085 S BABCOCK ST PALM BAY, FL 32909**

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

Medication Observations Record (MOR) indicated the medication was discontinued. On at 10:30 a.m. caregiver B confirmed the findings and said she did not know why the MOR indicated the medication was discontinued.

Resident #2's record contained a health care provider's order, dated on , to discontinue the .

2. Resident #6's record revealed an admission date of . A health assessment form 1823, dated on , indicated she had diagnoses of with behavioral disturbances, she was at risk for elopement, and the question on the form that pertained to whether she posed a danger to herself or others was not answered but rather had a comment that indicated "wandering risk."

On at 10:15 a.m., resident #6 was observed opening the front door. The surveyor alerted the staff, who closed the front door and escorted the resident away from the door.

On at 11:15 a.m., resident #6 was observed opening the front door. The surveyor alerted the staff, who closed the front door and escorted the resident away from the door.

On at 12:35 p.m., resident #6 was observed attempting to open the front door however, it was locked.

Although there was documentation alerting the facility of resident #6's risk for elopement, the facility failed to provide her with adequate supervision.

On at 12:50 p.m., the owner confirmed the findings.

3. On at 11:14 a.m. caregiver B said resident #7 who no longer resided in the facility became unruly a couple of months ago so law enforcement was called to the facility.

Resident #7's record contained a facility admission date of . The record did not contain documentation to indicate law enforcement was ever called to the facility to assist with the resident.

On at 11:56 a.m., the owner said that on resident #7 went outside of the facility with staff. When the resident refused to come back inside the staff called law enforcement to assist them in returning the resident to the facility. She confirmed the resident's record did not contain documentation to indicate law enforcement was ever called to the facility to assist with the resident and said the resident's stay at the facility was only for a respite.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968340	**06/18/2018**
NAME OF PROVIDER OR SUPPLIER **NURSING CARE BY ANGELS, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8085 S BABCOCK ST** **PALM BAY, FL 32909**	

SUMMARY STATEMENT OF DEFICIENCIES
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On . . . . at 12 p.m. caregiver B disputed the owner's recollection of when law enforcement were called. Staff B said the reason for the call was because the resident #7 hit one of the caregivers. Law enforcement responded, ensured the resident calmed down, Law Enforcement left the facility.

Class III

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

Based on observations, record review and interview, the facility failed to make a daily effort to determine that a resident (#6) who was at risk for elopement had Identification (ID) on their person that included their name and the facility's name, address, and telephone number and failed to ensure that same resident had a photo ID within 10 days of admission.

Findings:

Resident #6's record revealed an admission date of . . . . . A health assessment form 1823, dated on , indicated she had diagnoses of with behavioral disturbances, she was at risk for elopement, and the question on the form that pertained to whether she posed a danger to herself or others was not answered but rather had a comment that indicated "wandering risk." The record did not contain a photo identification of the resident.

On . . . . at 10:15 a.m., resident #6 was observed opening the front door. The surveyor alerted the staff, who closed the front door and escorted the resident away from the door.

On . . . at 11:15 a.m., resident #6 was observed opening the front door. The surveyor alerted the staff, who closed the front door and escorted the resident away from the door.

On . . . . at 12:35 p.m., resident #6 was observed attempting to open the front door however, it was locked.

On at 12:40 p.m. observation of the resident revealed, she did not have ID on her person. The resident's record did not contain documentation to indicate the facility made a daily effort to determine the resident had ID on her person.

On at 12:50 p.m., the owner confirmed the findings.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968340	**06/18/2018**
NAME OF PROVIDER OR SUPPLIER **NURSING CARE BY ANGELS, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8085 S BABCOCK ST** **PALM BAY, FL 32909**	

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

Class III

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

Based on observations, record reviews and interview, the facility failed to ensure the unlicensed staff (B) who assisted a resident (#2) with self-administration of medications followed the correct procedure.

Findings:

Observations made during a medication pass for resident #2 on at 10 a.m. revealed unlicensed caregiver B unlocked a medication cart and removed medication packages. While standing at the cart, she poured the medications into a medicine cup. She placed the packages back into the cart then she locked the cart. She took the cup of medications to resident #2, who was in his bed, and told him she was giving his morning medications. The resident placed each pill into his mouth then he drank water. She observed him take the medications. She returned to the medication cart and placed a check mark next to each medication in the Medication Observation Record (MOR.) When questioned as to why she placed a check mark instead of her initials to indicate she gave the medications, she said the facility owner told her she had to use a check mark.

During the medication pass, caregiver B did not take the medications, in their previously dispensed, properly labeled container from where they were stored and bring them to the resident and in the presence of the resident, read the labels, open the containers, remove the prescribed amount of medication from the container, and close the container.

On . . . at 10:30 a.m. caregiver B confirmed the findings.

Class III

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

Based on observations, record reviews and interview, the facility failed to ensure the Medication Observation Record (MOR) was properly updated for 2 of 4 residents (#2 and #6)) who required assistance with self-administered medications.

Findings:

1. Observations made during a medication pass for resident #2 on . . . at 10 a.m. revealed unlicensed caregiver B unlocked a medication cart and removed medication packages. While standing

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968340	**06/18/2018**
NAME OF PROVIDER OR SUPPLIER **NURSING CARE BY ANGELS, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8085 S BABCOCK ST** **PALM BAY, FL 32909**	

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

at the cart, she poured the medications into a medicine cup. She placed the packages back into the cart then she locked the cart. She took the cup of medications to resident #2, who was in his bed, and told him she was giving his morning medications. The resident placed each pill into his mouth then he drank water. She observed him take the medications. She returned to the medication cart and placed a check mark next to each medication in the Medication Observation Record (MOR.) When questioned as to why she placed a check mark instead of her initials to indicate she gave the medications, she said the facility owner told her she had to use a check mark.

Resident #2's record contained a health assessment form 1823, dated on that indicated he required assistance with self-administered medications.

2. Resident #6's record contained a health assessment form 1823, dated on . . . . . that indicated she required both administration of and assistance with her medications.

Rather than initials, resident #6's 2018 MOR contained check marks to indicate she received her medications, which did not allow the reviewer of the MOR to determine which staff member gave the medications.

On at 4 p.m., the owner confirmed the findings.

Class III

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

Based on record reviews and interviews, the facility failed to ensure 1 of 4 staff (B) submitted a written statement from an approved health care provider documenting freedom from communicable within 30 days after beginning employment and failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience allowing unlicensed staff to make a judgement or discretion regarding the dose amount that would be given to a resident (#6) who received assistance with self-administered medications.

Findings:

1. Caregiver B's personnel record revealed a hire date of . The record contained a written statement from a registered nurse documenting freedom from communicable . . . . . and not from a physician or physician's assistant, or an advanced registered nurse practitioner, as required.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968340	**06/18/2018**
NAME OF PROVIDER OR SUPPLIER **NURSING CARE BY ANGELS, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8085 S BABCOCK ST** **PALM BAY, FL 32909**	

SUMMARY STATEMENT OF DEFICIENCIES
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On at 2 p.m., the owner confirmed the findings.

2. Resident #6's record contained a health assessment form 1823, dated on that indicated she required both administration of and assistance with her medications. In addition, the form contained an order for , 0.5-milligram (mg) tablet, give 1/2 to 1 tablet by mouth every 12 hours. The resident's 2018 MOR contained the same order with no documentation to indicate that 1/2 a tablet or 1 tablet was given each time.

On at 2:52 p.m., unlicensed caregiver B said she gave resident #6 one whole tablet of , on that morning and said she knew to give a whole tablet because she followed the prescribed directions.

Due to the dosing parameter of the , , an unlicensed caregiver was not permitted to give the medication.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on review of the facility's staffing schedules and interview, the facility failed to maintain a written work schedule that reflected its 24-hour staffing pattern for a given time period.

Findings:

Review of the facility's staffing schedule revealed caregiver E was scheduled to work on from 7am-7pm.

On at 12:04 p.m., the owner said caregiver E no longer worked at the facility effective on and she forgot to update the staffing schedule to reflect the change.

Class III

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

Based on personnel record reviews and interview, the facility failed to ensure that 1 of 3 unlicensed caregivers (A) received the annual 2 hours of continuing education on providing assistance with self-administered medications and safe medication practices in an Assisted Living Facility (ALF.)

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968340	**06/18/2018**
NAME OF PROVIDER OR SUPPLIER **NURSING CARE BY ANGELS, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8085 S BABCOCK ST** **PALM BAY, FL 32909**	

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

Findings:

Caregiver A's personnel record revealed a hire date of . The record contained a 4-hour certificate of completion, dated on , for assistance with self-administered medications. The record did not contain documentation to indicate caregiver A received the required 2 hours of continuing education on providing assistance with self-administered medications and safe medication practices in an ALF during 2017 and 2018, as required.

On at 3 p.m., the owner confirmed the findings.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on personnel record reviews and interview, the facility failed to ensure certificates of training contained the required information for 2 of 4 sampled staff (A and B).

Findings:

Caregiver A was hired on .

Caregiver B was hired on .

Caregiver A's personnel record contained a certificate of completion, dated on , for training on ( ) however, the certificate did not contain the duration of the training, as required.

In addition, the records for both caregivers A and B contained a certificate of completion, dated on , for training on facility policies and procedures. On at 4:15 p.m., the owner said this training included the topics of facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation and the facility's resident elopement response policies and procedures however, she did not include the subject matter of the training on the certificates.

Class

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

Based on record reviews and interview, the facility failed to maintain an up-to-date admission and

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968340	**06/18/2018**
NAME OF PROVIDER OR SUPPLIER **NURSING CARE BY ANGELS, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8085 S BABCOCK ST** **PALM BAY, FL 32909**	

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

discharge log and did not list 1 of 4 residents (#7).

Findings:

Resident #7's record revealed a facility admission date of . On at 11:45 a.m., the owner said the resident was not listed on the admission and discharge log because she was only at the facility for a respite stay. Review of the facility's records revealed no documentation to indicate the facility maintained a separate list of respite care residents.

Class

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

Based on record reviews and interview, the facility failed to record a semi-annual weight for 1 of 2 residents (#2) who received assistance with the Activities of Daily Living (ADLs).

Findings:

Resident #2's record contained a facility admission date of . A health assessment form 1823, dated on , indicated that he required assistance with his ADLs. The record contained documented weights for the resident on , and .

On at 3 p.m., the owner said the last recorded weight of resident #2 was on .

Class III

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

Based on review of the facility's background clearinghouse employee roster and interview, the facility failed to update the employment status for 1 of 5 sampled staff (E) within 10 business days of a change.

Findings:

Review of the facility's background clearinghouse roster on at 12:28 p.m. revealed caregiver E was hired by the facility on and there was not an end date listed. The facility owner said caregiver E was no longer employed effective on and said she forgot to update the roster to reflect the end of employment.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968340	**06/18/2018**
NAME OF PROVIDER OR SUPPLIER **NURSING CARE BY ANGELS, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8085 S BABCOCK ST** **PALM BAY, FL 32909**	

SUMMARY STATEMENT OF DEFICIENCIES
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Unclassified.