STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968719	**07/12/2018**
NAME OF PROVIDER OR SUPPLIER **IMMACULEE HOME CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **5758 OAK HILL MANOR DR** **ORLANDO, FL 32839**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

Relicensure survey was conducted on . . . Immaculee Home Care, License #12912, had deficiencies found at he time of the visit.

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

Based on record review and interview the facility did not obtain an accurate Resident Health Assessment form (AHCA form 1823) for 1 of 2 sampled residents (#1).

Findings:

Resident #1's health assessment report 1823 dated . . . listed diagnoses of mental . . . . . and . Per the 1823 form, she needed administration of medications, total care with transfers, ambulation, toileting, bathing , dressing and . . . , and needed 24-hour nursing or . . care.

On at 2:30 p.m., the owner said at the time of admission, the resident only needed assistance with activities of daily living. She was not total care.

Class III

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

Based on observations, record review and interview, the facility failed to ensure it provided care and services appropriate to the needs of 2 of 3 sampled residents and did not ensure medications were given as ordered (#1 & 2).

Findings:

Observation on at 8:45 AM noted 3 residents #1 and #2 gathered at the table to eat breakfast.

1. On at 9 AM, during the medication pass, unlicensed staff B assisted resident #1 with self-administration of medications in the following manner. She took a medication basket from the unlocked medication cart and brought it to where the resident sat in the dining . She opened the medication bottles, poured the pills in a cup, and signed the Medication Observation Record (MOR). She poured 5 pills in the cup. She told the resident, "Take these for me". She handed 5 medication

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bottles to the Agency representative. The medication bottles had the following prescription labels:
a label, dated , for , 1 milligram (mg.) take one tablet twice daily as needed for ,
a label, dated , for , 500 mg. one tablet twice daily
a label, dated , for 10 mg. in the evening
2 bottles with labels, dated and , for , 25 mg. one tablet twice daily - Staff D did not proceed with the medication pass until the resident's medications were clarified
a label, dated , for , 5 mg. half tablet twice daily inside the bottle there was a pill cut in half
a label, dated , for 10 mg. daily
a label, dated , for 50 micrograms (mcg.) one spray to each nostril daily (bottle).

The Agency representative informed staff B that there were 2 bottles with , . She had given the resident , 1 mg. as needed for , and had not poured , and .

On at 9 AM, staff B stated she thought she had an order for , twice daily. She said resident #1 did not ask for , , as she was unable to do so because of her , . She then took all of the resident's medication and started the medication pass again. She discarded the medications previously poured. Staff B did not answer when asked if resident #1 had been given 2 , pills before.

The MOR listed , 1 mg. one tablet twice daily as needed for , , and was given twice daily the entire month of at 8:30 AM and 5:30 PM, and from to at 8:30 AM and 5:30 PM.

Resident #1's health assessment report 1823 dated listed diagnosis of mental and . Per report, she needed administration of medications. There was no evidence to confirm a healthcare provider's order for , 1 mg. twice daily.

On at 3 PM, staff B stated she was unable to locate the order for , twice daily.

2. On at 9:20 AM, staff B gave resident #2 , 112 mcg. The prescription label, dated , indicated , 112 mcg. every morning on an empty stomach. Resident #2's 2018 MOR listed , at 8:30 a.m. as well as in , 2018. The resident was given the medication after she ate breakfast.

On at 9:30 M, when asked about , staff B offered no comment.

Class II

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0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on observations and interview, the facility failed to ensure the unlicensed staff (A) who assisted 1 of 3 residents (#1) with self-administration of medications followed the correct procedure.

Findings:

Observations on at 9 AM noted unlicensed staff B assisted resident #1 with self-administration of medications in the following manner: She took a medication basket from the unlooked medication cart and brought it to where the resident sat in the dining . She opened the medication bottles, poured the pills in a cup, and signed the Medication Observation Record (MOR). She poured 5 pills in the cup. She told the resident "take these for me".

Staff B did not retrieve the medication from the locked medication storage; bring the medications in their properly labeled containers to where the resident was. Staff B did not in the presence of the resident read the container aloud; take out the prescribed amount and give it to the resident and observe the resident take the medication. Further observation revealed she did not return the medications to the locked medication area and sign the Medication Observation Record (MOR).

The facility did not have a policy for Self-administration of medication.

Class III

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

Based on observations and interview, the facility did not make sure that all medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times.

Findings:

Observations on at 8:45 AM noted 3 resident at the dining table. The medication cart was located to the left of the dining table and was unlocked. The drawers were opened, its content were visible, and anyone could easily access any of the medications inside. The owner was made aware of the unlocked medication cart. Continued observation noted the cart remained unlocked until 3 PM when the exit was conducted.

At 3 PM on , the owner was again notified that the medication cart was still unlocked. The

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owner offered no response.

Class III

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

Based on observations and interview, the facility did not make ensure prescription drugs for self-administration or administration were properly labeled and dispensed in accordance with Chapters 465 and 499, FS, and 64B-16-28.108 FAC for 1 of 3 sampled residents (#3).

Findings:

Observations during the medication pass on at 9:30 AM for resident #3 noted tears without a box or label, and a Pro-Air inhaler and a inhaler both without a prescription label with instruction for use. At that time, staff B said the resident moved in with the inhalers as they were, without directions for use.

Class III

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

Based on personnel record review and interview, the facility failed to ensure the 2 of 3 personnel record (B & D) contained a healthcare provider statement that indicated freedom from communicable including ( ), and failed to ensure freedom from was documented yearly (B).

Findings:

1. Staff B's personnel record revealed a negative test result, dated . There was no evidence to confirm she obtained a healthcare provider statement that indicated freedom was obtained yearly thereafter. Staff B was the owner and caregiver.

2. Staff D's personnel record did ot reveal any evidence to confirm she obtained a healthcare provider statement that indicated freedom from communicable including and that freedom from was obtained yearly thereafter. Staff D was the administrator, hired in 2016.

On at 3 PM, the owner said she could not find the information paperwork.

Class III

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

Based on observations and interview, the facility failed did not maintain a written work schedule that reflected its 24-hour staffing pattern for a given time period.

Findings:

On . . . at 9:45 AM, the staff schedule was requested and the owner stated her son took the schedules to do payroll, and she did not have them available.

Class III

0080 - Training - Core & Competency Test - 429.52(1-2) FS; 58A-5.0191(1) FAC

Based on personnel record review and interview, the administrator (staff D) failed to have evidence to confirm completion of 12 hours of continuing education in topics related to Assisted Living every 2 years.

Findings:

Staff D, the administrator's personnel record did not reveal any evidence to confirm she attended a total of 12 hours as required. She attended the ALF Core in 11/ . The administrator was hired in . . . . 2016.

On . . . at 3 PM, the owner said the administrator still worked at the facility but could not find the paperwork.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC

Based on observations and interviews, the facility did not provide or arrange for 3 of 3 sampled staff (A, B & C) to receive the mandated in-services training.

Findings:

1. Personnel record review for staff A, a caregiver hired , did not reveal any evidence she attended a 1-hour in-service training in . . . . control, including universal precautions and facility

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sanitation procedures, before providing personal care to residents; 3- hours of in-service training within 30 days of employment for resident behavior and needs and providing assistance with the activities of daily living. There was no evidence she was a nurse, certified nursing assistant, or home health aide, therefore exempt from the above in-service training.

The review did not reveal any evidence she attended an in-service training regarding the facility's resident elopement response policies and procedures, a 1-hour in-service training regarding reporting adverse incidents and facility emergency procedures, including chain-of- command and staff roles relating to emergency evacuation.

There was no evidence she attended a 1 hour in-service training for resident rights in an assisted living facility and recognizing and reporting resident , neglect, and , (The facility must use its prevention policies and procedures when offering this training), a 1-hour-in-service training in safe food handling practices, and ALF Core training, which would make her exempt from these trainings.

2. Personnel record review for staff B, the owner and caregiver, did not reveal any evidence she attended in-service training regarding the facility's resident elopement response policies and procedures, a 1-hour in-service training regarding reporting adverse incidents, and facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.

There was no evidence she attended a 1-hour in-service training regarding resident rights in an assisted living facility and recognizing and reporting resident , neglect, and , (The facility must use its prevention policies and procedures when offering this training.) There was no evidence staff B attended ALF Core training, which would exempt her from this in-service training.

3. Personnel record review for staff D, the administrator, hired 2016, did not reveal any evidence to confirm she attended in-service training regarding the facility's resident elopement response policies and procedures.

On at 2:45 PM, the owner said all the training was done on the Internet. She said her son was the only one with access to the account. She was given an opportunity to contact her son to make arrangements to review the documentation but said at 3 PM her son was at work and unable to help at this time.

Class III

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0082 - Training - / - 58A-5.0191(4) FAC

Based on personnel record review and interview, the facility did not provide or arrange for 2 of 3 sampled staff (A & B) to attend the required education course on / (/).

Findings:

1. Personnel record review for staff A, a caregiver and hired , did not reveal any evidence she attended a one-time education course on and .

2. Personnel record review on for staff B, the owner and caregiver, did not reveal any evidence she attended a one-time education course on and .

There was no evidence staff A or B were licensed nurses, therefore exempt from the requirement.

On at 2:45 PM, the owner said all the training was done on the Internet. She said her son was the only one with access to the account. She was given an opportunity to contact her son and make arrangements to review the documentation but at 3 PM, she said her son was at work and unable to help at this time.

Class III

0083 - Training - First Aid and - 58A-5.0191(5) FAC

Based on record review and interview, the facility failed to ensure a staff member who had completed courses in First Aid and and held a currently valid card documenting completion of such courses, was in the facility at all times when residents were present.

Findings:

In an interview on at 9:32 AM, staff A said she worked 24-hour shifts from Saturday at 6:45 AM to Sunday at 9 AM. She said she worked alone.

On at 9:45 AM, when asked for the staff schedule, the owner stated that her son had taken the schedules to do payroll and she did not have them available.

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Personnel record review for staff A, a caregiver, did not reveal any evidence to confirm she held a current First Aid certification.

On at 3 PM, the owner said she could not find the paperwork.

Every time staff A worked alone, there was no staff with a current First Aid and certification.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC

Based on observations, interview and record review, the facility failed to ensure unlicensed staff who assisted residents with self-administration of medications met the training requirements before they provided such assistance (Staff A & B).

Findings:

Observations on at 9 AM noted staff B assisted residents #1, #2 and #3 with self-administration of medications.

1. On at 10:30 AM, staff A said she assisted the residents with self-administration of medication.

Personnel record review for staff A, a caregiver hired on , revealed a certificate of training dated that indicated she attended 6 hours of medication administration training according to Chapter 65 G-7 in compliance with the agency for person with . There was no evidence she attended a 6 hour training regarding the provision of assistance with self-administration in an assisted living facility.

2. Personnel record review for staff B, owner and caregiver, revealed she attended a 4-hour medication class on and attended an additional 2 hours on . The review did not reveal any evidence she attended a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility.

On at 3 PM, the owner said she could not find the paperwork.

Class III

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

Based on personnel record review and interview, the facility did not provide or arrange for 3 of 3 sampled staff (A, B & D) to attend a 1 hour in-service training regarding the facility's ( ) policies and procedures.

Findings:

Individual personnel record review for staff A, hired , staff B, the owner/caregiver, and staff D, hired 2016, did not reveal any evidence to confirm they received an in-service training regarding the facility's policies and procedures.

On at 2:45 PM, the owner said all the training was done on the Internet. She said her son was the only one with access to the account. She was given an opportunity to contact her son and make arrangements to review the documentation but at 3 PM, said her son was at work and unable to help at this time.

Class III

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

Based on record review and interview, the facility failed to ensure that regular and therapeutic menus as served, with substitutions noted before or when the meal was served and kept on file in the facility for 6 months, failed to ensure a 3-day supply of nonperishable food that included milk was on hand at all times, and failed to ensure menus were dated for the week in use.

Findings:

Observations on at 8:45 a.m. noted the facility census was 3 residents. The owner confirmed the findings.

Observations on at 12:15 noted the menu served was mashed potatoes, chicken, corn and apple sauce. The menu was not posted in the common areas or dining , and was not available for review. On at 12:15 p.m., the owner said she had the menu posted but did not know what happened to it.

Review of the menus revealed week 3 of a 4 week menu was not available. The menus and subtitutions

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dated for , , . . . and , 2018 were not available for review.

Observations of the emergency food supply on at approximately 1 p.m noted there was only 12 ounces of evaporated milk to use in the event of an emergency.

On . . . at 3 PM, the owner could not find the paperwork for the menus and substitutions.

Class III

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

Based on record review and interview, the facility failed to ensure that facility records included all the required components including 1. All fire safety inspection reports issued by the local authority or the State Fire Marshal issued within the last 2 years 2. All sanitation inspection reports issued by the county health department issued within the last 2 years, and 3. An up to date admission and discharge log.

Findings:

On . . . . at 1:30 PM, the administrator said she was unable to locate the fire and sanitation inspection reports.

Review of the facility's admission and discharge log revealed the log was blank. All the pages were blank, no entries had been made since the facility's licensure in . . . . . .

On . . . . . at 2 PM, the owner said she had inspections by the Fire and County Health but could not locate the reports.

Class III

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

Based on observations, record review and interview, the facility failed to ensure that 2 of 2 sampled resident records (#1 & 2) contained all the required components that included a completed resident contract and a completed informed consent form.

Findings:

1. Resident #1's record revealed an admission date of and did not contain evidence to confirm

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that an informed consent form regarding assistance with medications from unlicensed was completed.

2. Resident #2's record revealed an admission date of and contained an informed consent regarding assistance with medications from unlicensed staff dated . . . . However, the form did not indicate whether the unlicensed staff, who provided the assistance, would be or not be supervised by a licensed staff. The resident's agreement was not signed or dated.

On . . . . at 2:30 PM, the owner said the resident's family took the resident agreement and they had not finish reviewing it.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on interview and record review, the facility failed to submit the Comprehensive Emergency Plan (CEMP) to the local emergency management within 30 days of obtaining the initial licensure and yearly thereafter.

Findings:

On . . . . at 9:30 AM, the administrator said she had been granted an extension for the power plan and her CEMP had been approved. The Agency representative requested the last letter of approval for the facility's CEMP. The owner was given to opportunity to locate the letter of approval. After searching on her desk and all cabinet drawers, she was unable to locate any letter of approval for any time period for the facility's CEMP. At 11:30 AM, she stated was unable to locate the letter of approval.

Class III

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

Based on record review and interview, the facility failed to maintain the employment status of all employees within the background screening (BGS) clearinghouse.

Findings:

Review of the facility's assisted living facility (ALF) roster on at 9:42 AM revealed the roster did not list any staff. It revealed an assistive care services BGS log with the same address and name as the ALF. The assistive care services log listed staff B, the ALF owner.

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On at 9:50 AM, the owner said she did not do anything about the assistive care services and was not aware of the BGS log. She said that currently she worked as a caregiver and staff A. Staff C was no longer working at the facility, and had stopped working on . Staff D was the administrator.

Unclassified

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

Based on personnel record review, record review and interview, the facility failed to ensure 1 of 2 staff (B), in a role that required a background screening (BGS), did not have any disqualifying offenses, and was allowed to continue to work without a current screening, and failed to have a printed copy of the BGS result for 1 of 2 staff (B).

Findings:

1. On at 10:30 AM, staff A said she had worked in the facility since , 2018. Staff A's personnel record revealed a job application dated that indicated her last employer and she worked from to . She had a break in employment greater than 90 days.

2. Staff B's personnel record did not contain a BGS result in her personnel record. The Agency for Health Care Administration's BGS website indicated on at 9:25 AM, she was eligible to work .

On at 2:45 PM, the owner said she thought the staff did not need to be re-screened.

Unclassified