STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967628	**07/25/2018**
NAME OF PROVIDER OR SUPPLIER **HAMMOCK MANOR, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3366 PENINSULA CIRCLE** **MELBOURNE, FL 32940**	

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

0000 - Initial Comments

The re-licensure survey was conducted on . Hammock Manor, Inc., license # 11611, had deficiencies at the time of the visit.

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

Based on record reviews and interview, the facility failed to ensure 1 of 2 sampled residents (#4) who experienced a significant change had a face-to-face medical examination by a licensed health care provider that was recorded on a health assessment (form 1823).

Findings:

Observation on at 8:10 AM revealed resident #4 in a hospital bed with half rails raised. Staff were getting her cleaned and dressed for the day. She was observed to be moved to a wheelchair, brought into the living , and transferred into a recliner. Staff A cut up her food, crushed her medications, and fed breakfast to the resident, who was unable to hole a spoon or fork to feed herself.

Resident #4's record revealed a facility admission date of . The most recent health assessment form 1823 was dated on . She was admitted to hospice services prior to her admission to the facility. The 1823 documented the resident required assistance with self-administration of medications and "assistance" with all her ADLs (Activities of Daily Living).

On at 9:45 AM, staff A stated they do have to provide "almost total" care for resident #4 and that she was receiving hospice services.

On at 2:00 PM, the house manager confirmed they had not obtained a new health assessment for resident #4.

Class III

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

Based on observation, record review and interview the facility failed to ensure the unlicensed caregiver (A) who assisted a resident (#3) with self-administration of medications followed the correct procedure.

Findings:

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During observation of the medication pass at 9:10 AM, staff A unlocked medication closet in the living removed the box of medications for resident #3. While still in the closet, staff A popped the morning pills into a small cup labeled with the resident's name. She poured the powder into another small cup, measuring the dose using the bottle's cap as directed. She put the medication bottles and cards back into the box and locked the closet. She brought the medications in the cups to the resident who was finishing her breakfast. She told resident #3, "I have medicine for you," and placed the cups on the table in front of the resident. Resident #3 picked up the cup containing the powder and poured it into her juice. Then she picked up the cup with the pills, took one pill out at a time, and swallowed them. She took all of the pills this way. She drank the juice containing the powder. Then she left the breakfast table and went back to her second floor . After all the pills were swallowed, staff A marked the Medication Observation Record for the morning medications.

Staff A did not, in the presence of the resident, read the labels aloud prior to providing the medications to the resident.

On at 9:30 AM, Staff A, when asked if she read the labels aloud, she confirmed she did not and said she did not know she was supposed to do that.

On at 2:15 PM, the house manager said the procedure for medications would be reviewed.

Class III

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

Based on personnel record review and interview the facility failed to obtain an annual statement from a licensed health care provider documenting freedom from communicable and ( ) for 2 of 3 sampled staff (B & C). The facility also failed to ensure that staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience, and allowed an unlicensed caregiver (A) to administer medications to a resident who was unable to feed herself (#4).

Findings:
1. Personnel Record review for Staff B (caregiver, hired), revealed no documentation to confirm she was free from communicable or within 30 days of hire.

2. Personnel Record review for Staff C (administrator), revealed no documentation to confirm she was

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free from communicable . . . . . or .

3. Observation on at 9:30 AM, found Staff A (unlicensed caregiver) feeding resident #4 her breakfast. The resident was in a recliner in the living . . . Resident #4 was unable to feed herself or hold a spoon or fork. Staff A cut the food into small bites and fed her. Then she crushed all her medications, stirred them into the resident's food, and fed her the meds along with feeding her the meal.

On . . . . . at 9:45 AM, Staff A confirmed she fed resident #4 her medications and stated the resident was unable to put the spoon in her mouth on her own. She further stated she was not aware unlicensed caregivers did not allow this.

Review of the residency agreement for resident #4 revealed the following passage, " ...Assistance with self-administration of medications does not include ... putting medications in a resident's mouth ..." (photo)

On . . . . . at 12:10 PM, staff D (the registered nurse for the facility) arrived to assist another resident. He identified himself as the administrator for the facility. When informed that unlicensed staff could not administer medications, he stated, "Yes they can. I teach the assistance with self-administration of medications class and I know they can."

Class III

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

Based on observation, record review and interview, the facility failed to 1) follow the menu approved by a licensed dietician, 2) note substitutions to the menu before or at the time a meal is served, 3) maintain a list of substitutions to the menu for a minimum of 6 months, 4) provide a maximum 14 hour interval between the end of dinner and the start of breakfast.

Findings:

On . at 8:40 AM, as staff A was preparing breakfast for the residents, she stated the meals times for the facility were breakfast at 9:00 AM, lunch at 12:00 PM and dinner at 5:00 PM. As per 58A-5.020(2) FAC, the interval between the end one meal containing protein and the start of another meal containing protein cannot exceed 14 hours. The interval between the end of dinner and the start of breakfast was 15.5 hours.

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Review of the posted menu, approved on by a licensed dietician, revealed the lunch for was to be sweet & sour chicken, rice, vegetable, banana pudding and milk.

Observation of the lunch meal served to the residents on revealed beef stroganoff, egg noodles and a beverage. There were no vegetables served and dessert was not offered.
There was no substitution log posted in the facility.

On at 1:20 PM, staff A stated the residents do not like sweet & sour chicken and they did not have any banana pudding in the house. When asked why a vegetable was not served, she stated they do not really like them. When asked about writing the changes on a substitution log, she said she did not know where it was. "It used to be here on the side of the refrigerator, but the manager may have taken it down."

When asked to see the last 6 months of substitutions, the house manager was unable to provide a log for review.

On at 2:15 PM, the house manager found the substitution log on the floor between the kitchen counter and the refrigerator. She stated she was unaware they were out of banana pudding. The house manager also stated she was unaware of the required meal interval.

Class III

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

Based on observation and interview, the facility failed to provide a safe and clean living environment pursuant to Section 429.28(1) (a), F.S.

Findings:

Tour of the facility on at 8:30 AM revealed a 2-story home with tile flooring in the kitchen and living beige carpeting in the and on the stairway.

The carpeting on the stairs was dirty and did not appear to have been vacuumed in a long time. The carpeting in the second floor resident #2 revealed stains where the portable air conditioner had leaked. The resident stated she had asked for it to be cleaned, but it has not happened yet. The carpeting in the first floor resident #5 revealed dark stains throughout the .

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The stairway handrails were dirty.

The return air vent in the kitchen was covered in a black substance.

The microwave over the stovetop was covered in a greasy film and dust on all surfaces, including on the bottom edge over the cook top.

On [redacted] at 2:00 PM, the house manager stated they clean the carpets often. She said they no longer use the microwave over the stove and she had not noticed how dirty it was.

Class III

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

Based on observation, Admission and Discharge Log review and interview, the facility failed to ensure an accurate and up-to-date log was maintained for 2 of 7 sampled residents.

Findings:
During the re-licensure survey of the facility on [redacted], there were 5 residents residing in the facility. All 5 were observed. The facility had a capacity of 6 residents.

Review of the facility's admission and discharge log revealed 7 people listed as current residents. Two residents, who are no longer living in the facility, did not have a discharge date or location listed in the log.

In an interview with the house manager on [redacted] at 2:00 PM, she stated that was overlooked and those 2 residents did move out. She confirmed the log had not been updated to show their discharge dates.

Class III

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

Based on observation, personnel record review, interview, the facility failed to ensure staff records were accessible and available for review for 4 of 4 sampled staff (A, B, C & D).

Findings:

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Attempt to review the records for staff A found the file folder on the computer empty. Staff A had a couple paper copies of documents she kept for herself, which were reviewed.

Attempt to review the records for staff B, C, & D were unsuccessful. Staff A and the house manager (staff B) were unable to access the correct folders that contained these records.

On at 2:00 PM, the house manager confirmed she was unable to access the requested records.

Unclassified

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

Based on resident record review and interview, the facility failed to maintain documented weights for 1 of 2 sampled residents at least semi-annually (#4).

Findings:
Review of the record for resident #4, a hospice resident, revealed she was admitted on . The initial Health Assessment (1823), dated documented a weight of 75 lbs. A weight of 70 lbs. was documented in . There were no further weights available for review.

There was a weight loss of 6.7% in 3 months (2017- 2018). There were no notes or documentation found in the record that the resident's health care provider, hospice care team or family were notified.

On at 2:15 PM, the house manager stated that the hospice nurse did a measurement on the resident, but she said she knows they still have to weigh her.

Class III

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on observation, personnel record review, Agency Clearinghouse Website Review and Interview, the facility failed to maintain the eligibility results of employee screening in the employee's personnel file for 1 of 3 sampled staff (A).

Findings:

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Observation in the facility on at 8:00 AM found staff A working with the residents. She was on the facility staff schedule to work continuous 24-hour shifts from at 9AM until , 9AM.

Attempted review of the staff records for staff A found they were not accessible. The facility uses a computer to store all records. The folder for staff A was empty.

Review of the Agency's Background Screening website staff A had a level II eligibility date of . Review of the Agency Clearinghouse roster revealed staff A was listed on the roster with a start date of .

On at 12:45 PM, staff A stated she used to work at the facility but left for about 5 months. She just came back at the end of .

In an interview with the house manager on at 2:00 PM, she confirmed the records were not available for staff A.

Unclassified

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

Based on Agency Clearinghouse Website Review and Interview, the facility failed to register and maintain the employment status of employees within the Agency's Background Screening Clearinghouse for 3 of 6 sampled staff employees, and failed to ensure the proper position titles were represented in the roster for 3 of 6 sampled staff.

Findings:
Review of the Agency's Background Screening website current facility staff revealed 3 employees were listed on the roster that were not listed on the staff schedule.

Further review of the roster revealed the person listed with the position title of administrator was not the actual administrator, but was a registered nurse employed by the facility. The person who was the administrator on record was listed as an owner/operator. Another individual was also listed as an owner/operator who, according to Agency records, is not an actual owner of the facility.

In an interview with the house manager on at 2:00 PM, she confirmed all 3 employees no longer are employed by the facility. Concerning the incorrect position titles for the other 3 staff, she said she did not maintain the clearinghouse, but said another person had that duty.

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Unclassified

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

Based on observation, personnel record review, Agency Clearinghouse website review and interview, the facility failed to ensure a level 2 background screen had been obtained and eligibility confirmed prior to allowing a volunteer to assist in the care of residents (E).

Findings:

Observation in the facility on at 8:00 AM found staff A and staff E working with the residents. Both caregivers had non-sterile gloves on when I arrived and were assisting residents with morning dressing and toileting. Staff E was observed with staff A assisting resident #4 with turning in bed, toileting/changing, and getting her into a wheelchair. She was also observed with staff A assisting resident #5 with toileting and care (bag emptying).

Observation of the staff schedule for did not contain staff E for any days in . When asked, staff E stated she "did not work here yet. I am just observing today. Today is the first day I have been here."

When asked for the records for staff E, none was available. When staff E was asked if she had to provide a background screening prior to being assigned to help with residents today, she said she had not.

Review of the Agency Background Screening Website revealed staff E had an eligible status as of , but had ended her last position requiring a screening on .

On at 2:00 PM, the house manager confirmed she had not obtained any records confirming training for staff E, and had not checked her background screen yet. She stated she was unaware that was required before she worked in the facility. The house manager also stated she did not know a prospective employee would require a new screening after a lapse in employment for more than 90 days.

Unclassified