STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965464	R 09/04/2018
NAME OF PROVIDER OR SUPPLIER **M H TENDER CARE I**	STREET ADDRESS, CITY, STATE, ZIP CODE **9 WAINWOOD PLACE** **PALM COAST, FL 32164**	

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

0000 - Initial Comments

A unannounced revisit to the relicensure survey was conducted at MH Tender Care I from . . . . to . . . . . MH Tender Care I (License #9901) had deficient practice identified during the survey.

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

Based on observation, a review of resident records, and interview with staff, the facility failed to obtain complete information on the AHCA form 1823 (Resident Health Assessment), and failed to ensure the assessment was documented on the most current AHCA form 1823, dated 2017, for 2 of 2 residents whose records were reviewed (Resident #4 and #8).

The findings include:

1. An observation of Resident #4's 10:20 am on revealed all of her medications were stored on her over-bed table at her bedside. During an interview with Resident #4 at this time, she confirmed she takes her medications herself.

A record review for Resident #4 found an AHCA form 1823, Resident Heath Assessment, that was completed and signed by the examiner on . The assessment indicated Resident #4 required assistance with the self-administration of her medications. Photographic evidence was obtained.

2. Record review for Resident #8 found an AHCA form 1823 that was completed and signed by the practitioner on . The assessment was documented on the previous version of the form, dated . . . . . 2010. The section asking if the resident required assistance with self-administration of medications, and if so, what assistance he required, was left blank.

An interview was conducted with Employee A, Caregiver, at 10:50 am on . . . . . She reviewed the 1823s and confirmed they were on the 2010 forms instead of the updated 2018 document. She acknowledged Resident #4's health assessment stated the resident required assistance with the self-administration of medications, but that this resident keeps her medications in her self-administers. She also confirmed the blank self-medication assessment for Resident #8. Employee

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A confirmed the assessment needed to be updated and corrected.

This was previously cited during the biennial licensure survey conducted by a representative of this office on .

Class III

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

Based on a review of facility records, and interview with staff, the facility failed to include all direct care staff in resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S. on a semi-annual basis.

The findings include:

A review of the facility schedule found there were 3 employees actively working in the facility at the time of survey; Employees A, B and C. Employee A confirmed in an interview at 10:30 am on that those were the 3 staff currently working in the home.

A facility record review was conducted for elopement drills. The facility conducted an elopement drill on , which was signed by Employee A, Caregiver, and Employee C, owner. Employee B was not included in the elopement drill, as required. There were no personnel records onsite to review, but a review of the AHCA Background Screening Unit's Clearinghouse on showed Employee B was hired .

Review of the elopement drills and interview with Employee A at 10:50 am on confirmed Employee B had not participated in the drill.

This was previously cited by a representative of this agency during the biennial licensure survey conducted on .

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Class III

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

Based on observations and interviews, the facility failed to provide appropriate assistance with the self-administration of medication by failing to read the label in the presence of 1 resident (Resident #5) reviewed for medication administration, out of a total sample of 6 residents.

The findings include:

On at 8:52 AM, Employee A, a Med tech/Caregiver was observed assisting Resident #5 with self-administration of medications. She placed three pills on a spoon; 1 tablet of ( ) and 2 tablets of (medication). Employee A then handed the spoon to the resident, and told him to take the medication. She assisted him to place the spoon in his hand, then he took the medication off of the spoon. Employee A then placed 4 pills on the spoon; 1 (medication), 1 (pain medication), 1 (Iron supplement), and 1 , (, medicine). She told him again to pick up the spoon and take the medications. She then assisted him again to pick up the spoon before he took the pills. Employee A did not read the labels or tell Resident #5 what medications he was taking.

On at 8:57 AM an interview was conducted with Employee A about assisting Resident #5 with medications. She confirmed that she should have told him what the medications were, and what they were for.

This was previously cited by a representative of this agency during the biennial licensure survey conducted on .

Class III

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

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Based on a review of resident records, and interview with staff, the facility failed to maintain an accurate daily medication observation record (MOR) for 3 of 5 residents whose MORs were reviewed (Residents #4, #1 and #5), out of a total of 6 residents in the facility.

The findings include:

1. A review of the Medication Observation Record (MOR) for Resident #4 revealed she was to take (a medication that inhibits the production of stomach) 20 milligrams (mg) daily at 8:00 am. The corresponding signature boxes, intended to be noted after receiving this medication, were left blank from to . There was no note on the back of the MOR indicating why the medication was not signed as taken. Photographic evidence was obtained.

A record review for Resident #4 found an AHCA 1823, Resident Heath Assessment, that was completed and signed by the examiner on . The assessment indicated Resident #4 required assistance with the self-administration of her medications.

An interview was conducted with Employee A, Caregiver, at 9:47 am on . She stated the had been discontinued. She acknowledged the MOR needed to be corrected to reflect the discontinued medication.

2. A review of the MOR for Resident #1 revealed she was to receive , (used to treat high , and , among other conditions) 10 mg daily at 8:00 pm. The corresponding signature boxes on and were left blank, with no explanation on the back of the MOR as to why Resident #1 did not receive her medication. Photographic evidence was obtained.

3. Review of the MOR for Resident #5 found he was to receive (for) 500 mg 2 tablets twice a day, at 8:00 am and 8:00 pm. The signature boxes for this medication were not signed on or for the 8:00 pm dose. His , (for 20 mg twice daily) was not signed as given on at 8:00 pm. The instructions for Resident #5's /Acetamenaphin 5-325 mg twice daily were hand-written in on the bottom of the form, where there were no printed signature boxes. The staff initials were written free form due to having no boxes, but they were not aligned with the dates of

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the month; therefore, it not clear which days the medication was given. Photographic evidence was obtained.

4. An interview was conducted with Employee A at 10:50 am on . She reviewed the MORs for Residents #1 and #5, and confirmed the missing signatures and explanations.

Class III

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

Based on observations and interview the facility failed to ensure that all medications, including , were kept in a locked cabinet at all times, and that keys were not accessible to residents. The facility failed to ensure 1 of 1 discharged residents (Resident #9's) medications were disposed of within 30 days of discharge.

The findings include:

On at 9:07 AM an observation was conducted of Resident #5's medications (including) being placed in small black file cabinet, next to kitchen counter in dining . Employee A left the file cabinet drawer slightly open and walked away from cabinet, leaving it unattended. Photographic evidence was obtained.
On at 9:11 AM Interview was conducted with Employee A, Med Tech/Caregiver in regards to the medication cabinet being unlocked in the dining . She stated that they are supposed to keep it locked. She then stated that it was open now, because she was passing out medications.

Observations on throughout the survey from 8:30 am to 11:30 am revealed Employee A, Caregiver, left a set of house keys in the key-operated deadbolt lock in the interior of the front door.

At 11:30 am on , Employee A was asked to unlock the medication storage drawer for inspection. She went to the front door, and retrieved the keys that were hanging in the deadbolt lock. She returned to the medication storage cabinet, and unlocked the drawer with the medication key that was hanging on the ring.

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During inspection of the medication storage drawer at 11:30 am on , a pack of medications for a discharged resident, Resident #9 was observed. The medications included, but were not limited to: Metoclopramide (treats), (a cognition enhancer), , , (an anti- medication), (,), (treats high), , (reduces stomach), , (anti-depressant), ( ), (treats , retention), (treats high , and failure), and (a).

Review of the admission/discharge log revealed Resident #9 was discharged on ; 31 days ago.

A second interview with Employee A at 11:30 am on confirmed Resident #9 was discharged, and that his medications remained in the medication cabinet at the time of survey. Employee A also acknowledged that by leaving the medication key on the ring and in the door, it was accessible to the residents. She acknowledged the medication key should be kept on a separate key ring, inaccessible to the residents.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observations, staff and resident interviews, and facility and resident record reviews, the Administrator failed to exercise operational direction over the facility as required by Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter by failing to (1) ensure the accuracy of Resident Health Assessments (ACHA form 1823s) for 2 of 2 sampled residents reviewed (Residents #4 and #8); (2) ensure the participation of all staff in the facility's elopement drill(s); (3) provide assistance with the self-administration of medications to Resident #5; (4) maintain 1 of 3 employees personnel file in the facility (Employee B).

The findings include:

1. An observation of Resident #4's 10:20 am on revealed all of her medications were stored on her over-bed table at her bedside. During an interview with Resident #4 at this time, she confirmed she takes her medications herself.

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A record review for Resident #4 found an AHCA form 1823, Resident Heath Assessment, that was completed and signed by the examiner on . The assessment indicated Resident #4 required assistance with the self-administration of her medications.

Record review for Resident #8 found an AHCA form 1823 that was completed and signed by the practitioner on . The assessment was documented on the old form dated 2010. The section asking if the resident required assistance with self-administration of medications, and if so, what assistance he required was left blank.

An interview was conducted with Employee A, Caregiver, at 10:50 am on . She reviewed the 1823s and confirmed they were on the old 2010 forms instead of the updated 2017 document. She acknowledged Resident #4's health assessment stated the resident required assistance with the self-administration of medications, but that this resident keeps her medications in her self-administers. She also confirmed the blank self-medication assessment for Resident #8. Employee A confirmed the assessment needed to be updated and corrected.

2. A review of the facility schedule found there were 3 employees actively working in the facility at the time of survey; Employees A, B and C. Employee A confirmed in an interview at 10:30 am on that those were the 3 staff currently working in the home.

A facility record review was conducted for elopement drills. The facility conducted an elopement drill on , which was signed by Employee A, Caregiver, and Employee C, owner. Employee B was not included in the elopement drill, as required. The Background Screening Roster on the facility's Clearinghouse website was reviewed on and it was discovered her hire date was .

Review of the form and interview with Employee A at 10:50 am on confirmed Employee B had not participated in the drill.

3. On at 8:52 AM,an observation was conducted of Resident #5 getting assistance with medications from Employee A, Med Tech/Caregiver. She placed three pills on a spoon; 1 tablet of , ( ) and 2 tablets of (medication). Employee A then handed the

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spoon to the resident, and told him to take the medication. She assisted him to place the spoon in his hand, then he took the medication off of the spoon. Employee A then placed 4 pills on the spoon; 1 (medication), 1 , (pain medication), 1 (Iron supplement), and 1 , (medicine). She told him again to pick up the spoon and take the medications. She then assisted him again to pick up the spoon before he took the pills. Employee A did not read the labels or tell Resident #5 what medications that he was taking.

On at 8:57 AM an interview was conducted with Employee A about telling Resident #5 what medications she was providing. She confirmed that she should have told him what the medications were, and what they were for.

4. A review of the facility schedule found there were 3 employees actively working in the facility at the time of survey; Employees A, B and C.

Review of the employee files found there was no employee record on hand for Employee B.

An interview was conducted with Employee A, Caregiver, at 10:00 am. She confirmed Employee B was still working in the facility. In a second interview at 10:50 am, Employee A stated she did not know Employee B's file had to stay on site. She said it had been taken to a sister facility , where Employee B also worked. She acknowledged the requirements to maintain personnel files on site.

The above findings were previously cited by a representative of this agency at the relicensure survey conducted on .

Class III

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

Based on a review of employee records, and interview with staff, the Administrator failed to maintain personnel records for 1 of 3 staff members (Employee B) which contain, at a minimum, documentation of background screening and documentation of compliance with all training requirements.

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The findings include:

A review of the facility schedule found there were 3 employees actively working in the facility at the time of survey; Employees A, B and C. Employee A confirmed in an interview at 10:30 am on that those were the 3 staff currently working in the home.

Review of the employee files found there was no employee record on hand for Employee B.

An interview was conducted with Employee A, Caregiver, at 10:00 am. She confirmed Employee B was still working in the facility. In a second interview at 10:50 am, Employee A stated she did not know Employee B's file had to stay on site. She said it had been taken to a sister facility , where Employee B also worked. She acknowledged the requirements to maintain personnel files on site.

This was previously cited by a representative of this agency at the relicensure survey conducted on .

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observations, facility record review, and staff interview, the facility failed to prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan to address emergency environmental control in the event of the loss of primary electrical power, and that included the required information, having the potential to affect all residents of the facility.

The findings include:

An observation of the facility garage at 11:15 am on revealed a portable Generac RS5500

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generator, still in the box. At the foot of the garage, 5 gallons of gasoline was stored in a red plastic gasoline can. Employee A, Caregiver, stated at this time that the facility was still waiting for someone to come and "hook it up." The facility was toured at this time, and found there was no monoxide detector, and no portable or window air conditioner in the home.

Review of the facility's Comprehensive Emergency Management Plan (CEMP) found there was no emergency environmental control plan outlining the facility's response and preparedness to maintain acceptable air temperature in the event of a power outage. There was no plan for the acquisition of additional fuel in an emergency. There were no written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. There was no evidence an extension to implementing the enviornmental control plan was approved at the time of the survey.

The manufacturer's specifications for the generator were reviewed (https://www.electricgeneratorsdirect.com/Generac-6672-Portable-Generator/p17680.html) and revealed the unit included a 6.7-Gallon Extended Run Fuel Tank w/ a Built-In Fuel Gauge. The tank allows for up to 11 hours of run time at 1/2 load. Mathematical for the 5 gallons of gasoline that were stored on site, the unit would have operated for approximately 8.2 hours. This did not meet the requirement of storing 48 hours of fuel onsite.

An interview was conducted with Employee A, a caregiver, at 11:18 am on . She stated she did not know anything about an emergency power plan, policies and procedures, or a monoxide detector.

Class III