STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969069	**09/04/2018**
NAME OF PROVIDER OR SUPPLIER **NATIONAL CHURCH RESIDENCES OF BRADENTON**	STREET ADDRESS, CITY, STATE, ZIP CODE **3229 19TH ST W** **BRADENTON, FL 34205**	

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

0000 - Initial Comments

ASSISTED LIVING FACILITY

On , , 2018 a biennial re-licensure survey with Limited Nursing Services (LNS) was conducted at National Church Residences of Bradenton Assisted Living Facility. Deficient practice was identified during the surveys.

(License# 12926)

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

Based on records review and interviews, the facility failed to obtain a hospice evaluation as ordered by a health care provider and failed to maintain a written record of any significant changes that resulted in the provision of additional services for 1 of 2 residents reviewed (#11).

Findings included:

A review of resident #11's record on revealed that the resident had been living at the facility since . The record contained only 1 resident health assessment (AHCA form 1823) or (1823), which was dated . The 1823, prepared by a health care provider, stated that the resident was required to undergo a hospice evaluation. The resident's record was reviewed and there were no indications that the resident had ever undergone a hospice evaluation or that the facility had ever discussed having the resident undergo a hospice evaluation with the resident's family, doctor or hospice provider. Photographic evidence obtained.

Resident #11's 1823 dated also indicated that the resident had no pressure sores. In an interview with the Director of Nursing at 10:00am, it was learned that the resident was undergoing treatment for pressure sores. The record revealed a home health agency had provided care to the resident, as there were notes describing treatment for 2 pressure sores dating from . Pressure sores acquired in an assisted living facility (ALF) are considered a significant change resulting in the provision of additional services and would have required a new 1823 assessment by a health care provider. Photographic evidence obtained.

Resident #11's 1823 dated also indicated that the resident had orders for a regular diet. The resident's record contained orders from a health care provider, dated , for speech , and a

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swallow study and a change to the resident's diet to one of pureed foods and thickened liquids. A change in the resident's condition with regard to the ability to swallow food would have required a new 1823 assessment by a health care provider, the facility also failed to maintain a written record of the change in the resident's condition.

In an interview with the Administrator at 2:15pm on [redacted], the Administrator stated that the facility should have ensured the resident had a hospice evaluation, as required, and should have documented the resident's significant changes in condition with regard to the ability to swallow and pressure sores.

Class III

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

Based on observation, interview and record review, the facility failed to make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication are filled in a timely manner and failed to ensure that medications were labeled correctly for 1 of 3 residents observed (#12).

Findings included:

During a medication observation at 12:00pm on [redacted], Staff C, a medication technician (Med Tech) was preparing to assist Resident #12 with medications. The medication observation record (MOR) indicated that Resident #12 was due for 2 medications: Norco 10-325milligrams (mg), 1 tablet to be given every 6 hours (or 4 times per day). When Staff A looked at the label on the medication, the label stated Norco 10-325mg, 1 tablet to be given 3 times per day. Staff A, a nurse, was nearby and stated that Resident #12 recently had been in the hospital and came back with some new orders. The new orders were then reviewed and they revealed that, on [redacted], the resident's order for Norco had been changed to 4 times per day. 4 days had lapsed before the facility noticed that the new order did not match the label on the medication.

As Staff C continued preparing Resident #12's medications, it was noted that the resident was to receive a 10 milliliter (ml) dose of Sucralfate Oral Suspension. Staff C looked on the medication cart, but stated the Sucralfate was not on the cart. Staff A, a nurse, was nearby and stated that the Sucralfate was another new order that Resident #12 had received while at the hospital and that the facility was still waiting for the pharmacy to deliver it. The resident returned from the hospital on [redacted], therefore it had been 4 days since receiving the new order and it was not filled.

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In an interview with the Administrator at 2:30pm on , the Administrator stated that the facility should have made more of an effort to procure Resident #12's new medications in a timely manner.

Class III

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

Based on records review and interview, the facility failed to maintain resident records to include residents' weights recorded semi-annually and a copy of each resident's contract with the facility that includes evidence that residents were informed of the Bill of Rights for residents of assisted living facilities (ALFs) for 2 of 2 residents (#6 and #11).

Findings included:

During a records review of Resident #6's record on , it was revealed that the resident had been living in the facility since . There was no evidence in the record that the facility had provided a copy of the Bill of Rights for residents of ALFs in the record.

During a records review of Resident #11's record on , it was revealed that the resident had been living in the facility since , over 1 year. There was no evidence in the record that the facility had provided a copy of the Bill of Rights for residents of ALFs in the record. The only recorded weights for Resident #11 had were from and . The facility could not demonstrate that they had recorded the resident's weight semi-annually, as required.

In an interview with the Administrator at 2:15pm, the Administrator stated that the facility would be recording the residents' weights at least semi-annually and making sure that they provide a copy of the Bill of Rights to each resident in the future.

Class III

N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on record review and interview, the facility failed to employ or contract with a nurse to be available to provide services as needed by residents requiring limited nursing services (LNS) and maintain documentation of the nurse's qualifications in the facility's personnel files.

Findings included:

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During a monitoring survey for limited nursing services on , the facility said they were not certain that they held a specialy license to provide LNS services to residents. A record review conducted on revealed that the facility did hold an assisted living facility (ALF) license which included a specialty license for LNS services. The record review also revealed that the facility did not employ or contract with any nurse who would be available to provide services for residents requiring LNS services.

In an interview with the Administrator at 2:30pm, the Administrator stated that they would soon be employing or contracting with a nurse to provide LNS services to any residents in the facility needing those services.

Class III