STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963719	**09/21/2018**
NAME OF PROVIDER OR SUPPLIER **WYNDHAM LAKES JACKSONVILLE**	STREET ADDRESS, CITY, STATE, ZIP CODE **10660 OLD ST. ROAD** **JACKSONVILLE, FL 32257**	

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

0000 - Initial Comments

On . . . . to . . . . . a biennial relicensure survey was conducted at Wyndham Lakes Jacksonville (license number 5572). Deficient practice was identified during the survey.

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 conduct and document 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 facility records found no evidence that all direct care staff had participated in elopement drills, as required, on a semi-annual basis.

Review of the facility's Employee Listing as of revealed there were 45 active employees at the time of survey.

An interview was conducted with the Administrator at 2:45 pm on . She stated she had conducted an elopement drill on Monday. She produced the drill dated ; however, only 5 staff were in attendance. The Administrator explained she had only worked in the facility since 2018, and was still prioritizing items that required fixing. She acknowledged the requirement for all staff participation in the elopement drills on a semi-annual basis.

Photographic Evidence Obtained

Class III

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

Based on a observation, resident record reviews, and staff interview, the facility failed to provide assistance with the self-administration of medications in accordance with procedures described in

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section 429.256, F.S. and rule 58A-5.0191, F.A.C. for 2 of 3 residents observed (Residents #4 and #5).

The findings include:

1. An observation was conducted on at 10:42 am in the common area between the 900 and 1100 residential hallways. Employee B, Medication Technician (MT) was at the medication cart with an open electronic medication observation record (MOR). She reviewed the MOR, then retrieved Resident #5's medication bubble packets from the drawer. Employee B dispensed the following into a small cup: , 81 milligrams (mg); Cranberry 250 mg; Hydrochlorothiozide (treats high , and fluid retention) 12.5 mg; Quietapine (, ,) 25 mg; and, 1000 micrograms. Using a pill crusher and small plastic baggie, she crushed the tablets, and emptied the capsules into the medicine cup. Employee B mixed the medications with applesauce and took the mixture and a cup of water to Resident #5's . After Resident #5 sat up in her bed, Employee B placed a spoonful of the medication and applesauce mixture into Resident #5's mouth. She repeated this with the second, and final, spoonful, spooning the mixture directly into the resident's mouth. Employee B did not read the medication labels in the presence of Resident #5, nor did she tell her what she was receiving.

A review of Resident #5's MOR revealed the Hydrochlorothiozide was scheduled to be taken at 8:00 am; 2 hours and 45 minutes prior to the actual time of administration.

Review of the AHCA form 1823, Resident Health Assessment, dated revealed Resident #5 had diagnoses of , and with behavioral disturbances. Resident #5 required supervision and assistance with activities of daily living, but was independent with eating. She required assistance with the self-administration of her medication.

2. An observation of assistance with medications was conducted in the memory care unit at 1:00 pm on . Employee B, Medication Technician, identified Resident #4, and dispensed the following pills into a small cup with some applesauce: , , ( ) 4 mg ½ tablet before meals; and, Mapap (treats pain) 325 mg (2 tablets). Employee B then poured 30 milliliters of Mintox suspension ( ) into a graduated medication cup. She handed the Mintox to Resident #4, who drank it independently. Employee B then fed the medication mixture to Resident #4, placing 2 spoonfuls directly into the resident's mouth. She did not read the labels to Resident #4, or tell her what she was receiving.

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A review of the AHCA form 1823 for Resident #4 completed on . . . . revealed diagnoses including . . . . . , ... , and . . . . . . She required assistance with all activities of daily living including eating, and with the self-administration of medication.

A personnel file review for Employee B revealed she was hired on 11/. . . . , and received training in assistance with self-administration of medications on . She was not a licensed nurse.

An interview was conducted with the Director of Nursing on . . . . at 620 pm. She acknowledged the medication administration time error for Resident #5, and confirmed her awareness of the requirement that only licensed staff administer medications.

Class III

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

Based on interview and record review the facility failed to provide a written statement from a health care provider documenting that two of four sampled employees (the Administrator and Employee C) did not have any signs or symptoms of communicable . . . . . .

The findings include:

Review of personnel file for the Administrator, hired . . . . . , revealed that there was no documentation stating that she was free of signs and symptoms of communicable . . . . .

Review of personnel file for Employee C, a CNA hired . , revealed that there was no documentation stating that she was free of signs and symptoms of communicable . . . . . .

An interview was conducted with the Administrator on . . . . at 4:55pm, during which she confirmed the missing documents for each of the staff members.

An interview was conducted with the Business Office Manager on at 5:40pm, during which she confirmed the missing documents for each of the staff members.

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Class III
Based on interview and record review the facility failed to provide a written statement from a health care provider documenting that two of four sampled employees (the Administrator and Employee C) did not have any signs or symptoms of communicable .

The findings include:

Review of personnel file for the Administrator, hired , revealed that there was no documentation stating that she was free of signs and symptoms of communicable .

Review of personnel file for Employee C, a CNA hired , revealed that there was no documentation stating that she was free of signs and symptoms of communicable .

An interview was conducted with the Administrator on at 4:55pm, during which she confirmed the missing documents for each of the staff members.

An interview was conducted with the Business Office Manager on at 5:40pm, during which she confirmed the missing documents for each of the staff members.

Class III

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

Based on staff interview and personnel record review the facility failed to ensure that three of four sampled employees whose records were reviewed (Employees A, B and C) received required in service trainings on resident elopement response policies and procedures within 30 days of employment .

The findings include:

A personnel file review for Employee A, revealed that she was hired on an LPN. Further review of the file revealed had no evidence of having received the required trainings in the facility's elopement procedures.

A personnel file review for Employee B, revealed she was hired on as a med tech. Further review of the file revealed that she had no evidence of having received the required trainings in the facility's elopement procedures.

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Personnel file review for Employee C, revealed that she was a CNA hired on . . . . . Further review of the file revealed no evidence she received the required trainings in the facility's elopement procedures.

An interview was conducted with the Administrator on at 4:55pm, during which she confirmed the missing documents for each of the staff members.

An interview was conducted with the Business Office Manager on . . . . at 5:40pm, during which she confirmed the missing documents for each of the staff members.

Class III
Based on staff interview and personnel record review the facility failed to ensure that three of four sampled employees whose records were reviewed (Employees A, B and C) received required in service trainings on resident elopement response policies and procedures within 30 days of employment .

The findings include:

A personnel file review for Employee A, revealed that she was hired on . . . . . an LPN. Further review of the file revealed had no evidence of having received the required trainings in the facility's elopement procedures.

A personnel file review for Employee B, revealed she was hired on . . . . as a med tech. Further review of the file revealed that she had no evidence of having received the required trainings in the facility's elopement procedures.

Personnel file review for Employee C, revealed that she was a CNA hired on . . . . . Further review of the file revealed no evidence she received the required trainings in the facility's elopement procedures.

An interview was conducted with the Administrator on at 4:55pm, during which she confirmed the missing documents for each of the staff members.

An interview was conducted with the Business Office Manager on . . . . at 5:40pm, during which she confirmed the missing documents for each of the staff members.

Class III

0087 - Training - Prov & Curriculum Appr - 58A-5.0194 FAC

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Based on observation, staff interview and review of facility and employee records, the facility failed to ensure that two of four sampled sampled staff whose records were reviewed (Employee B and C) received required trainings in 's Level I and II.

The findings include:

During a tour of the facility on at 9:58am the locked memory care unit was observed. There was a census of nine individuals residing in the unit at the time of survey.

Review of the facility's website (www.pacificaseniorliving.com) revealed services were provided for memory and care for individuals with 's and other related 's.

Review of personnel file for Employee B, a Med Tech hired on 11/ , revealed that there was no record of the 's Level I and II trainings.

Review of personnel file for Employee C, a CNA hired on , revealed that there was no record of the Level I and II trainings.

An interview was conducted with the Administrator on at 4:55pm during which she confirmed the missing documents for each of the staff members.

An interview was conducted with the Business Office Manager on at 5:40pm during which she confirmed the missing documents for each of the staff members.

Class III
Based on observation, staff interview and review of facility and employee records, the facility failed to ensure that two of four sampled sampled staff whose records were reviewed (Employee B and C) received required trainings in 's Level I and II.

The findings include:

During a tour of the facility on at 9:58am the locked memory care unit was observed. There was a census of nine individuals residing in the unit at the time of survey.

Review of the facility's website (www.pacificaseniorliving.com) revealed services were provided for memory and care for individuals with 's and other related 's.

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Review of personnel file for Employee B, a Med Tech hired on 11/, revealed that there was no record of the 's Level I and II trainings.

Review of personnel file for Employee C, a CNA hired on , revealed that there was no record of the Level I and II trainings.

An interview was conducted with the Administrator on at 4:55pm during which she confirmed the missing documents for each of the staff members.

An interview was conducted with the Business Office Manager on at 5:40pm during which she confirmed the missing documents for each of the staff members.

Class III

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

Based on interview and record review the facility failed to ensure that one of four sampled staff (Employee C) received at least one hour of training in the facility's policies and procedures regarding

The findings include:

A review of personnel records revealed that Employee C, a CNA hired on , did not have the required training in the facility's policies and procedures regarding .

An interview was conducted with the Administrator on at 4:55pm during which she confirmed the missing training for Employee C.

An interview was conducted with the Business Office Manager on at 5:40pm during which she confirmed the missing training for Employee C.

Class III

Based on interview and record review the facility failed to ensure that one of four sampled staff

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(Employee C) received at least one hour of training in the facility's policies and procedures regarding .

The findings include:

A review of personnel records revealed that Employee C, a CNA hired on , did not have the required training in the facility's policies and procedures regarding .

An interview was conducted with the Administrator on at 4:55pm during which she confirmed the missing training for Employee C.

An interview was conducted with the Business Office Manager on at 5:40pm during which she confirmed the missing training for Employee C.

Class III

0168 - Resident Refund Policy - 429.24(3)(a) FS

Based on a review of closed resident records, and interview with staff, the facility failed to provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident for 2 of 3 discharged residents whose records were reviewed.

The findings include:

1. A closed record review for Resident #11 revealed he was admitted to the facility on . He expired on and his discharge date was listed as .

He executed a Residence and Care Agreement on for a monthly amount of $2800.00. The agreement included information that if a refund was due, it would be paid within 45 days of . Records reflect a change in the level of care Resident #11 required in 2017, with an increase in his patient responsibility to $4980.00 a month. Resident #11 was issued a refund check in the amount of $3486.00; however, it was not issued until , over 3 month after his belongings were removed from his .

2. A closed record review for Resident #13 revealed she was admitted on and discharged on . She had a Residence and Care Agreement dated for a monthly rate of $3345.00. The agreement included information that if a refund was due, it would be issued within 45 days of discharge.

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There was no further information regarding a refund in the record. Resident #13 was due a refund amount of $1726.45 for 16 days in , 2018, based on the daily rate of $107.90.

In an interview with the Business Office Manager (BOM) at 4:55 pm on , she explained that after a resident turned in their apartment keys and a walk-through was completed, she sends the refund request to the corporate office for processing and signature. The BOM was not sure what happened with Resident #11's late refund. She explained she just started in , 2018. The facility lost the former BOM in the middle of , and until , there was no BOM. When she began her employment, she started processing the refunds that were due the best she could. Typically, the facility sent the information necessary to process and issue the refund to the corporate office (in California) within 7 days. Then, corporate sends the refund within 30 days.

A second interview was conducted with the BOM at 6:06 pm on . When asked about the status of the refund for Resident #13, she stated that if a refund was due, it should have been issued by now. She confirmed that the required 45-day timeframe had passed. The BOM stated she would have to look for that information. The information was not located by the end of the survey day on , and the Administrator was asked at 6:45 pm to contact corporate for an updated status of Resident #13's refund, and provide the information to the survey team the next day.

In an electronic mail (e-mail) correspondence from the Administrator on at 4:36 pm she provided an attached e-mail.. It was directed to the Business Office Manager (BOM), and dated at 7:00 pm. The email referenced Resident #13, and noted the status of the refund check as of was "Waiting for Signature". It stated "We have cut the check for your recent refund submission and are currently awaiting signature. We will notify you again when the check is sent out in the mail." Under the "Notes" section, it stated:

" CK (check) #4094 for $1390.97 payable to (Resident #13) was sent for signature.
verification docs completed and forwarded....
emailed BOM potential [dup] charges for .

The Administrator's comment in the e-mail confirmed the refund check for Resident #13 was still pending signature by the company's CEO. (Scanned evidence was obtained)

Class III