STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968340	R 08/27/2018
NAME OF PROVIDER OR SUPPLIER **NURSING CARE BY ANGELS, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8085 S BABCOCK ST** **PALM BAY, FL 32909**	

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

0000 - Initial Comments

A revisit to the Biennial licensure survey was conducted on , 2018. Nursing Care by Angels, License #12241, had deficiencies at the time of the visit.

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

REMAINED UNCORRECTED

Based on record reviews and interview, the facility failed to ensure an 1823 health assessment form was complete for 1 of 5 sampled residents (#4).

Findings:

Resident #4's record revealed a facility admission date of . A recent 1823 health assessment form, dated , was incomplete. The section on the form used to document the resident's diet was not completed. The information was not documented elsewhere on the form nor was it documented in the resident's record.

On at 12:05 p.m., the facility owner confirmed the findings and said she did not notice the information was missing from the form.

Class III

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

REMAINED UNCORRECTED

Based on record reviews and interview, the facility failed to follow a physician's order for 1 of 3 sampled residents who required assistance with self-administered medications (#2).

Findings:

Resident #2's record contained an 1823 health assessment form, dated , that indicated he required assistance with self-administered medications. A medication list, dated and attached to the 1823, contained an entry for , 5 milligrams (mg.) 1 tablet by mouth every 6 hours for .

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NURSING CARE BY ANGELS, LLC	**8085 S BABCOCK ST PALM BAY, FL 32909**

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

Resident #2's [illegible] 2018 Medication Observation Record (MOR) contained an entry for , 5 mg. 1 tablet by mouth every 6 hours for . However, the medication was scheduled to be given daily at 8 a.m., 2 p.m. and 8 p.m., which was not every 6 hours. The medication was signed as given at each of those times from through .

Resident #2's record did not contain an order from a health care provider to change the frequency of the , . Review of the medication package revealed the instructions on the prescription label were to take the medication every 6 hours.

On at 12:15 p.m., the facility owner confirmed the findings, said there was no order to change the frequency of the medication, said the resident wanted the medication only at those times, and said the health care provider was not notified of the resident's request to change the frequency.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observations, record reviews and interviews, the facility failed to honor resident rights and physically restrained 2 of 2 sampled residents (#4 & 6).

Findings:

Observations made on at 9:39 a.m. revealed both residents #4 and #6 were sitting in wheelchairs. Each resident had a blanket around their waists and tied in a knot on the back of their wheelchairs. When questioned as to whether she could freely remove the blanket, resident #4 said something that was incoherent and began trying to remove her pants. Resident #6 was asked the same question but she did not make eye contact and did not verbally respond.

On at 9:45 a.m., caregiver G said resident #4 was restrained to her wheelchair because she tries to get up, has poor balance, and she would , and resident #6 was restrained because she was not wearing underwear so the blanket was being used to cover her, and if it was untied, the resident would remove the blanket and expose herself.

On at 9:50 a.m., the facility owner arrived and when she was shown the restrained residents, she said they should not have been restrained to their wheelchairs and untied both blankets.

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

Resident #4's record contained an 1823 health assessment form, dated , that indicated her diagnoses included 's and . She had gait and balance , , was impulsive, had poor insight and required precautions. She was independent with ambulation and transferring.

Resident #6's record contained an 1823 health assessment form, dated , that indicated her diagnoses included with behavioral disturbances. She had , , irritability, , forgetfulness and required precautions. She required assistance with all of her Activities of Daily Living (ADLs). Review of her hospice careplan did not reveal any documentation regarding .

Class II

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

Based on observations, record reviews and interview, the facility failed to ensure the unlicensed staff who assisted a resident #6 with self-administration of medications followed the correct procedure (G).

Findings:

Observations made on at 9:45 a.m. revealed resident #6 sitting in a wheelchair at a table. Unlicensed caregiver G held a cup of pills in her hand, approached the resident at the table and told the resident it was time to take her medicine. The cup held 9 pills.

Caregiver G did not take the medications in their previously dispensed and properly labeled packages from where they were stored, bring them to the resident and in the presence of the resident, read the medication labels aloud, as required.

On at 10:10 a.m., caregiver G confirmed the findings.

Resident #6's record contained an 1823 health assessment form, dated , that indicated she required assistance with self-administered medications.

Class III

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

REMAINED UNCORRECTED

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SUMMARY STATEMENT OF DEFICIENCIES
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Based on personnel record reviews, review of the facility's background clearinghouse employee roster and interview, the facility failed to update its employee roster for 1 of 2 sampled staff within 10 business days of a change (F).

Findings:

Observations made on . . . . . at 9:30 a.m. revealed staff F was present in the facility and identified herself as a resident caregiver.

Caregiver F's personnel record revealed a hire date of .

Review of the facility's online employee roster on at 10:36 a.m. revealed caregiver F was not listed, as required.

On . . . . . at 11 a.m. the facility owner confirmed the findings.

Unclassified