STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967884	**09/17/2018**
NAME OF PROVIDER OR SUPPLIER **ORCHIDS HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **2960 MEADOWS OAKS DR S** **CLEARWATER, FL 33761**	

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

0000 - Initial Comments

Assisted Living Facility

On [redacted] 17. 2018, an abbreviated biennial re-licensure survey with limited mental health (LMH) was conducted at Orchids Home. Deficient practice was identified during the survey.

(License #11901)

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

Based on observation and interview, the facility failed to follow procedures for assistance with self-administration of medications as required under Section 429.256 Florida Statutes, for one (Resident #1) of one resident observed during a medication review.

Findings included:

A medication review was conducted at 5:05 PM on [redacted]. Staff A was observed taking Resident #1's medication out of the medication cart and popping the pill in to a cup while the resident was not present. Staff A then gave the cup containing the medication to the Administrator.

The Administrator went to the area in the facility where Resident #1 was located, identified Resident #1 by name, and described the medication in the cup to the resident. While handing the cup to the resident, the pill [redacted] to the floor. The Administrator bent down, picked up the pill, and quickly handed it to Resident #1 who immediately swallowed the pill while drinking a beverage.

The Administrator was interviewed at 5:10 PM on [redacted] and asked why they did not dispose of Resident #1's medication when it [redacted] on the floor. The Administrator stated that they were told by a nurse that they could not throw pills away. The Administrator was then asked to provide a copy of the facility's [redacted] control policy and procedures when assisting residents with self-administration of medications. The Administrator went to their office and was unable to provide a copy of the facility's policy and procedures for [redacted] control.

Class III

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

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Based on observation, interview, and record review, the facility failed to ensure that medication observation records (MORs) were immediately updated each time medication was offered for one (Resident #1) of one resident observed during a medication review.

Findings included:

A medication review was conducted at 5:05 PM on . Staff A popped Resident #1's pill (- 1 MG) in to a cup and handed it to the Administrator, who then watched the resident take the pill a few minutes later.

A review of the MORs at 5:29 PM on showed that the provided to Resident #1 was not initialed as given (photographic evidence obtained).

The Administrator was interviewed at 5:30 PM on and showed that the MORs were not initialed for Resident #1's . The Administrator reviewed the MORs and acknowledged that they did not initial it as required.

Class III

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

Based on observation, record review, and interview, the facility failed to maintain a posted menu dated and planned one week in advance and failed to maintain a six-month file of regular menus served.

Findings included:

A dining and food service review was conducted on . The Administrator was asked to show their posted menu dated for the current week and their six-month file of regular dated menus.

The Administrator was interviewed at 5:15 PM on and they acknowledged that there was no menu dated for the week or a six-month file of dated menus.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation, interview and record review, the facility failed to implement their emergency environmental control plan (EECP) or obtain an extension for its implementation.

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Findings included:

During survey on , a request was made to review the facility's EECP. No EECP or policies and procedures related to the EECP were provided during the survey.

Review of Floridahealthfinder.gov revealed that no consumer friendly summary related to the facility's EECP was posted on the facility's page on Floridahealthfinder.gov.

The Administrator was interviewed at 10:25 AM on concerning implementation of their EECP. The Administrator stated that they have not yet , their EECP or requested an extension from the Assisted Living Unit at AHCA. They stated that they did not have a plan to maintain or test the alternate power source that would be used in an emergency and have not yet hired anyone to assist in testing and maintenance of this generator.

The Administrator was asked if they developed written policies and procedures to ensure the facility can effectively and immediately operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. They stated that they did not have these written policies and procedures.

The Administrator was also asked if they had a monoxide detector at the facility and they stated that they did not. Observation throughout the facility on the date of survey from 10:00 AM-5:00 PM revealed no monoxide detector.

Class III

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

Based on observation, record review, and interview, the facility failed to maintain the employment status of staff members within the employee roster listed in the AHCA background screening clearinghouse (Employee Roster), within 10 business days of initial employment, for one (Staff A) of two employees sampled.

Findings included:

A review of employee records conducted on showed that Staff A was hired on . Staff A was observed providing assistance to residents with self-administration of medication and had access to residents' .

A review of the Employee Roster on showed that Staff A was not entered.

The Administrator was interviewed at 5:35 PM on concerning the lack of entry in to the Employee Roster for Staff A. The Administrator was shown the Employee Roster on a laptop computer. The Administrator stated that they thought they had entered Staff A in to the Employee Roster and acknowledged that it wasn't there.

Unclassified