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	AL11968280	R 10/15/2018
NAME OF PROVIDER OR SUPPLIER **M H TENDER CARE III**	STREET ADDRESS, CITY, STATE, ZIP CODE **36 BRONSON LN** **PALM COAST, FL 32137**	

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

0000 - Initial Comments

A follow-up visit to a biennial survey was conducted at MH Tender Care III (License Number: 12210) on . MH Tender Care III had deficiencies at the time of the visit.

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on observation, a review of facility records, and interviews with residents and staff, the facility failed to provide an ongoing and diversified activities program, and schedule activities on at least 6 days, and not less than 12 hours, per week, for 5 of 5 residents residing in the facility (Residents #1, #2, #3, #5, and #6).

The findings include:

A tour of the facility was conducted on at 8:55 am. There were 5 residents confirmed to reside in the home; 2 residents were in their , another 2 were observed sitting in their wheelchairs on the screen porch, and 1 was in the living in a chair. There was no activities calendar observed to be posted at any location in the home.

Observations conducted during survey between 8:45 am and 11:30 am on revealed the only activity observed as offered to the residents was watching television. Resident #1 remained in the same chair in front of the television for most of the survey, and Residents #5 and #6 remained in their for the duration of the survey. At approximately 1030 am, Residents #2 and #3 were moved inside in front of the television, but neither appeared to watch.

Resident #6 was interviewed in her 10:35 am on . When asked about the activities offered in the home, she stated they had tried to have exercise, but there were not many activities. There were just "some little things we do. I would have to say there are not any." Resident #6 stated she did realize the facility was supposed to offer scheduled activities for up to 2 hours a day on 6 days per week.

An interview was conducted with Resident #5 in her 10:38 am on . When asked about

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an activities program in the home, she stated there was none.

An interview was conducted with Resident #1 at 10:42 am on . She was asked about the facility's organized activity program, or if she was every provided the opportunity to participate in daily activities such as games, musical activities, crafts, or bingo. She replied "No", and stated there were no activities in the facility.

An interview was conducted with Employee B, Caregiver, at 10:55 am on . When asked what activities she provided to the resident, she stated she had a bingo set, and that there was a ball somewhere. Employee B added that sometimes, she walked with Residents #2 and #3. She was not aware of any activities calendar or regularly scheduled activities. At 11:10 am, Employee B came to the desk where this surveyor was working, and showed a small box of dominoes. She announced "Sometimes we do Dominoes." She was not aware of the requirements for a scheduled activities program.

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

Based on observations, a review of resident records, and interview with staff, the facility failed to maintain an accurate daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications that recorded each time the medication was taken or any missed dosages, and that was updated each time the medication was offered for 3 of 5 residents whose MORs were reviewed (Residents #1, #2, and #5).

The findings include:

1. Review of Resident #1's MOR revealed she had an order for (a medication) 50 micrograms (mcg), take one tablet by mouth daily on an empty stomach 30 minutes

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before first meal. The medication was signed out as given every night at 8:00 pm.

Resident #1 also received (an , medication) 7.5 milligrams (mg), one tablet by mouth twice daily at 8:00 am and 8:00 pm for pain. The signature boxes indicating the medication was given as ordered was not signed out on 13 or 14, 2018, with no documented explanation why. Photographic evidence was obtained.

2. Resident #2's MOR revealed she received Quietapine (anti-,) 25 mg, one twice daily 8:00 am and 8:00 pm. There were no signatures indicating the 8:00 pm doses were given for the entire month of 2018. All fields were left blank. There was no documented explanation or order change noted. Photographic evidence was obtained.

3. Resident #5's MOR was reviewed and revealed an order for (cognition enhancer) 10 milligrams (mg) tablet, take 1 by mouth twice daily (at 8:00 am and 8:00 pm). The MOR corresponding signature box was not initialed for Resident #5's 8:00 pm dose of on , 9, 10, 11, 12, 13, or 14, 2018. There was no explanation on the back of the MOR why the medication was not signed as given, and no direction change or note the medication had been discontinued on the MOR. Photographic evidence was obtained.

Resident #5 had order for (treats high ,) 25 mg twice daily at 8:00 am and 8:00 pm, but the 8:00 pm doses had not been signed as given on 13 or 14, 2018. There was no documented explanation. Photographic evidence was obtained.

4. An interview was conducted with Employee B at 10:13 am on . She stated the resident's dinner was served at 5:00 pm each evening.

In a second interview with Employee B at 10:55 am, she was asked to reviewed the MOR and the resident's pharmacy-issued medication bubble packs with this surveyor. She confirmed Resident #1's was packaged and available in each of the 8:00 pm unit dose packets, but the the MOR was not being signed for this dose consistently. She also confirmed Resident #2's Quietapine and Resident #5's and has not been signed out on the MOR. Employee B read the instructions for Resident #1's to be given before a meal, stating she had not realized the

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error. She said the pharmacy would need to correct the MOR. Employee B acknowledged the importance of reading the MOR instructions and medication labels in their entirety prior to providing assistance with self- administration of medications.

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

Class III

0076 - ( ) - 58A-5.0186 FAC

Based on a review of resident records, and interview with staff, the facility failed to ensure staff was knowledgeable in ( ) and facility procedures, in order to honor the advanced directive for 2 of 5 residents who executed a (Residents #1 and #2).

The findings include:

An interview was conducted with Employee B, Caregiver, at 9:23 am on . When asked if she knew what a was, she said "You mean like if there is a fire?" When asked again if she knew what a was, she responded, "You mean like direct orders?" A third attempt to ask if she knew what it meant to not a resident, she was unable to answer. Employee B was then asked, in the event she found a resident unresponsive, which residents she would start ( ) on, and who she would not. Employee B stated she would start on any and all of the residents if they passed out, and call 911. When asked again to confirm that she would initiate for any of the 5 residents residing in the facility, she stated "Yes, I have to!"

Record review for Resident #1 revealed she had yellow a (DH Form 1896, Florida Form, , 2004) form dated . The form had been signed by resident and her physician.

Record review for Resident #2 found a form dated and signed by the resident and her

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physician.

The facility policy and procedure titled " and Advanced Directives" was reviewed, and stated: (Facility) WILL NOT administer chest compressions, insert an airway, administer resuscitative drugs, defibrillate or , provide , assistance, initiate resuscitative , or initiate monitoring to any resident who has a . (Facility) will administer chest compressions ( ) to residents who do not have a .

A second interview was conducted with Employee B at 10:55 am on . She was shown the yellow State of Florida for Residents #1 and #2. She said she did not know what those forms were, or what they meant. She never went into the resident's records. When the was explained to her, she said she never knew that. Employee B was asked if she received any training on from the Administrator, or anyone else. She stated no, she had not received any training. She also confirmed she was scheduled to be the only staff member in the building to assist the 5 residents.

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

Photographic Evidence Obtained

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on observations, a review of facility records, and interview with staff, the facility failed to maintain an up-to-date admission and discharge log listing the names of all residents and each resident's date of admission, and the facility or place from which the resident was admitted for 1 of 5 residents residing in the facility (Resident #2).

The findings include:

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During an interview with Employee B on . . . at 8:45 am, she stated there were 5 residents living in the facility. Tour of the facility at 8:55 am on . . . confirmed a census of 5, with Resident #1, #2, #3, #5 and #6 observed to be present in the home. Photographic evidence was obtained.

A review of the facility's admission and discharge log reflected Residents #1, #3, #5 and #6, but failed to list Resident #2 as being admitted. There was no name, admission date, or place she was admitted from. A record review for Resident #1 revealed she was admitted on . . . . .

An interview was conducted with Employee B at 10:55 am on . She reviewed the admission and discharge log, and confirmed Resident #2 was still not listed on the log as a current resident.

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

Class III

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

Based on a review of personnel files, and interview with staff, the facility failed to maintain personnel records for each staff member that contain, at a minimum, a copy of the employment application, documentation verifying freedom from signs or symptoms of communicable . . . . . , documentation of compliance with all training and continuing education required by Rule 58A-5.0191, F.A.C.; and documentation of compliance with level 2 background screening for 1 of 3 employees (the Administrator).

The findings include:

Upon entrance to the facility on at 8:45 am, Employee B was working alone and was asked to inform the Administrator of the survey activity.

Employee B was asked for the Administrator's personnel file at 10:30 am on . . . . . Employee B

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searched, but could not locate the file in the personnel file drawer or on the work desk. Employee B acknowledged the Administrator's file was required to be kept on site.

The Administrator did not arrive on site by 11:20 am on . . . . . to be able to provide additional information about her personnel file.

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

Class III