STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966928	10/25/2018
NAME OF PROVIDER OR SUPPLIER **NORWOOD ASSISTED LIVING, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **325 NORWOOD ST** **MERRITT ISLAND, FL 32953**	

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

0000 - Initial Comments

A complaint investigation #2018015402 was conducted on , , and . Norwood Assisted Living, license #11011, had deficiencies at the time of the investigation.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review and interview, the facility failed to ensure the appropriateness of continued residency for 2 of 5 sampled residents who 1) had a that was not healing (#1), and 2) did not have a licensed nurse for a resident who required medication administration and was unable to assist with feeding or medications (#4).

Findings:

Record review for resident #1 revealed he was admitted into the facility on . The resident health assessment (AHCA form 1823) dated noted the resident did not have any , 3 or 4 pressure sores. The form also documented the resident had a right ankle dressing, but did not indicate what the dressing was for.

On at 10:00 AM, staff A and B, unlicensed caregivers, stated they did not know anything about the for resident #1, but that home health came to take care of it.

On at AM, the home health nurse visiting the resident stated she was there to provide care. She said she thought it was a and was healing. She stated she left a note for the visit on and would have her office fax all of the care notes to the facility for this resident.

Review of the facility's records did not find any documentation of the or the care plan. No notes from the home health agency were on file in the resident's record. Facility staff were unable to find any notes from the visit.

Review of the care documentation from the home health agency, received and provided to the surveyor on , revealed the earliest note for the care by this agency was and documented the as a to the right lateral malleolus. The measurement on was 1.2 x 1.8 x 0.6cm.
Further review of the record revealed the following measurements:
No measurement were provided for , 2018

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the measured 1 x 1 x 0.1-
the measured 0.6 x 0.5 x 0.1 -
the measured 0.3 x 0.3 x 0.1-
The was improving, but still classified as a on .

The facility retained the resident with a which exceeded residency criteria for an Assisted Living Facility.

On at 2:30 PM, the administrator confirmed he had reviewed the documentation prior to sending it to the surveyor. He confirmed resident #1 had a and no longer met the criteria for residency in an assisted living facility.

2. Observation of resident #4 revealed she was in a hospital bed, with the head of the bed raised. She did not respond when greeted, but stared straight ahead. Continued observations at lunchtime revealed staff B seated at the bedside for resident #4, feeding her a modified meal. Resident #4 was not participating, her hands were at her sides. She opened her mouth for each spoonful of food.

On at 12:30 PM, when asked if the resident was able to feed herself or hold a spoon, staff B said no. When asked how resident #4 is able to take her medicines, staff B replied, "We crush them, put them in applesauce and feed them to her."

Review of the personnel record for staff B, caregiver hired , revealed she was not a licensed nurse. A certificate for a 6 hour class in assisting with self-administration of medications in an assisted living setting was dated . No further updates were found in her record.

Review of the record for resident #4 revealed she was admitted on . She began receiving hospice care on . Her most recent health assessment (form 1823) was dated and documented the resident as bed-bound and receiving hospice care. She required total assistance with all activities of daily living (ADLs). The form documented she required assistance with self-administration of medications.

Review of the Medication Observation Record (MOR) for resident #4 for the current month (2018) revealed all medications were signed as given by unlicensed staff.

On at 2:30 PM, the administrator confirmed staff B was not a nurse, and that no nurses were on staff at the facility. He confirmed that resident #4 was no longer able to feed herself, including holding a spoon for medications. The administrator confirmed resident #4 exceeded the residency requirements

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for an assisted living facility without nurses on staff around the clock.

Class III

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

Based on observation, interview and record review, the facility failed to maintain a general awareness of a resident's whereabouts and were unavailable to hear residents, which allowed a resident with documented . . . . . to leave the facility without supervision (#2).

Findings:

Observations during a tour of the facility on . . . . at 9:45AM revealed resident #2 was dressed and asleep in a recliner in the living . She was not observed to be wearing any Identification (ID) on her wrists or on a lanyard.

On . . . . at 10:50 AM, the daughter of resident #2 approached the surveyor and said, "My mom is why you are here." She proceeded to state that one day about a week ago, the alarm on the front door was not working and her mother walked out the front door alone. She was found by a neighbor and taken to the hospital by the paramedics. She stated the facility looked for her as soon as they realized she was gone. She stated her mother had never attempted to leave the facility in the past year and a half since she moved in.

On at 12:50 PM, staff A stated, "I was in the back storage staff B doing weekly food inventory. There are 2 freezers there and we were going through supplies. It was before lunch, around 11am. We were going back and forth, checking freezers. Resident #2 was in her bed laying down. When we came back to the kitchen, she was in her recliner in the living . . . When we came out again, we noticed she was not in her chair. We looked throughout the facility and outside. Staff B called 911 while I went out in my car to look for her. I went down the street and circled around several blocks, but did not find her. The neighbor down the street saw her and called 911. The police came here. The paramedics met the neighbor and took resident #2 to the hospital. It was about 10 minutes from when we notified 911 to when she was found. Resident #2 never attempted to leave the facility before that day. She never showed any exit seeking behaviors."

On . . 18 at 1:05PM, staff B said, "We were doing food inventory in the back storage area. Emptying old containers, checking dates. We do it once a week. Resident #2 was in bed when we started. The first time we came out she was in the recliner in the living . . . We went back to do more. Then next time

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she wasn't anywhere. We checked everywhere in the house, the perimeter outside, up and down the street- we did not see her. Staff A got in her car and I called her on my cell phone. Using the house phone, I called the administrator and 911. This happened sometime between 10am and lunch. The police came before lunch. One officer arrived before Staff A came back. He asked for resident #2's photo and her birthdate- I gave them to him. He said she had been found and was on her way to the hospital. A female officer also arrived. Staff A was outside talking to her. I stayed inside with the residents. When resident #2 first came to the facility in 2017, she was . She arrived here right from the airport and wasn't sure where she was, but she never tried to leave before." According to staff B, they try to keep her . On at 11:35 AM, she stated on the day resident #2 eloped, "she was resisting being changed. Usually she doesn't mind. Other than that, she seemed normal."

Review of the record for resident #2 revealed she was admitted to the facility on . Her admission health assessment (form 1823) was dated and documented diagnoses including and , . She was noted to be forgetful and at times. She required assistance with self-administration of medications and was independent with most activities of daily living (ADLs), except supervision for bathing and . She was reassessed on when she entered into hospice care. Her diagnosis on was documented as . She was noted to be a risk, and required assistance with all ADL's, except supervision only with eating. She was not noted to be an elopement risk on either health assessment. A new health assessment was provided on , following her elopement. Her diagnoses included and mood . She required total care with all ADLs except assistance with transferring and ambulation. On she was noted to be an elopement risk. Her record documented a history of frequent , ( ).

During an interview with the administrator on at 1:20 PM, he confirmed the resident did elope on . The administrator stated resident #2 had not been evaluated to be an elopement risk. He stated they had a door alarm because of previous residents who were exiting seeking and at risk for elopement, but they have not lived in the facility since resident #2 arrived. He restated resident #2 had never exhibited exit seeking behaviors and had never attempted to leave the facility since her arrival in , 2017. When asked what measures were in place to prevent it from happening again, he stated the staff was re-educated on the elopement policy, a 4 point plan was developed to prevent future occurrences, the front door alarm was repaired, they added motion sensors at the front door and in each resident's , and created shift observation records to document resident #2's whereabouts. The administrator confirmed resident #2 did not have any ID on her person on and still did not on . He said they were trying to get something through the sheriff's office that she can wear, but did not have it yet.

Class III

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0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(l)

Based on observation, interview and record review, the facility failed to (#2) make a daily effort to determine that residents at risk for elopement have identification on their persons that includes their name and the facility's name, address, and telephone number as required by 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(l)

Findings:

Observations during a tour of the facility on at 9:45AM revealed resident #2 was dressed and asleep in a recliner in the living . She was not observed to be wearing any ID on her wrists or on a lanyard.

On at 10:50 AM, the daughter of resident #2 approached the surveyor and said, "My mom is why you are here." She proceeded to state that one day about a week ago, the alarm on the front door was not working and her mother walked out the front door alone. She was found by a neighbor and taken to the hospital by the paramedics. She stated the facility looked for her as soon as they realized she was gone. She stated her mother had never attempted to leave the facility in the past year and a half since she moved in.

Review of the record for resident #2 revealed she was admitted to the facility on . Her admission health assessment (form 1823) dated and a subsequent assessment dated did not note her to be an elopement risk. A new health assessment was provided on , following her elopement on . Her diagnoses included and mood . She required total care with all ADLs except assistance with transferring and ambulation. On she was noted to be an elopement risk. Her record documented a history of frequent ( ).

During an interview with the administrator on at 1:20 PM, he confirmed the resident did elope on . The administrator stated resident #2 had not been evaluated to be an elopement risk prior to the day she eloped. He stated they had a door alarm because of previous residents who were exiting seeking and at risk for elopement, but they have not lived in the facility since resident #2 arrived. He restated resident #2 had never exhibited exit seeking behaviors and had never attempted to leave the facility since her arrival in , 2017. When asked what measures were in place to prevent it from happening again, he stated the staff was re-educated on the elopement policy, a 4 point plan was developed to prevent future occurrences, the front door alarm was repaired, they added motion sensors at the front door and in each resident's , and created shift observation records to document resident #2's whereabouts. The administrator confirmed resident #2 did not have any ID on her person

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on and still did not on . He said they were trying to get something through the sheriff's office that she can wear, but did not have it yet.

Class III

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

Based on medication observation record (MOR) review and interview, the facility failed to ensure the MOR was properly labeled with the correct dates for 5 of 5 sampled records (#1, 2, 3, 4 & 5).

Findings:

Review of the MOR for resident #4, found the current MOR did not have any month of year documented on the pages. Further review for all 5 residents found none of the pages on the MOR that was supposed to be for 2018, contained documentation indicating 2018. The month and year portion of each page of the MORs were blank.

On at 2:00PM, the administrator confirmed the findings.

Class III

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

Based on observation, record review and interview the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience by allowing unlicensed staff (B) to administer medications for a resident with , ability (#4).

Findings:

Observation of resident #4 revealed she was in a hospital bed, with the head of the bed raised. She did not respond when greeted, but stared straight ahead. Continued observations at lunchtime revealed staff B seated at the bedside for resident #4, feeding her a modified meal. Resident #4 was not participating, her hands were at her sides. She opened her mouth for each spoonful of food.

On at 12:30 PM, when asked if the resident was able to feed herself or hold a spoon, staff B said no. When asked how resident #4 is able to take her medicines, staff B replied, "We crush them, put them in applesauce and feed them to her."

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Review of the personnel record for staff B, caregiver hired , revealed she was not a licensed nurse. A certificate for a 6 hour class in assisting with self-administration of medications in an assisted living setting was dated . No further updates were found in her record.

Review of the record for resident #4 revealed she began receiving hospice care on . Her most recent health assessment (form 1823) was dated and documented the resident was bed-bound and receiving hospice care. She required total assistance with all activities of daily living (ADLs). The form documented she required assistance with self-administration of medications.

Review of the Medication Observation Record (MOR) for resident #4 for the current month (2018) revealed all medications were signed as given by unlicensed staff.

On at 2:30 PM, the administrator confirmed staff B was not a nurse, and that no nurses were on staff at the facility. He confirmed that resident #4 was no longer able to feed herself, including holding a spoon for medications.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on personnel record reviews and interview, the facility failed to ensure that 1 of 3 sampled staff (B) received the required annual training updates regarding assistance with self-administration of medications.

Finding:

Review of the personnel record for staff B, caregiver hired , and who provided assistance with self-administration of medications, revealed a 6 hour initial training certificate dated . Continued review of the record did not reveal any certificates for the annual 2 hour training update for 2017 or 2018.

On at 2:00 PM, the administrator confirmed the findings.

Class III