STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968475	**09/27/2018**
NAME OF PROVIDER OR SUPPLIER **TUSCANY HOUSE**	STREET ADDRESS, CITY, STATE, ZIP CODE **5806 INDIGO CROSSING DR** **ROCKLEDGE, FL 32955**	

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

0000 - Initial Comments

The re-licensure survey with Limited Nursing Service (LNS) was conducted on , , 2018. Tuscany House, license #12357, had deficiencies at the time of the survey.

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

Based on record reviews and interview, the facility failed to ensure an 1823 health assessment form was complete for 2 of 2 sampled residents (#1 and #3).

Findings:

1. Resident #1's record revealed a facility admission date of . Page 5 of his most recent 1823 health assessment form, dated , and was not completed.

2. Resident #3's record revealed a facility admission date of . Page 5 of her most recent 1823 health assessment form, dated , and was not completed.

On at 2:48 p.m. the administrator confirmed the findings.

Class III

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

Based on observations, record reviews and interview, the facility failed to ensure the unlicensed caregiver (A) who assisted a resident (#1) with self-administered medications followed the correct procedure.

Findings:

Observations made during a medication pass for resident #1 on at 1:22 p.m. revealed unlicensed caregiver A washed her hands, unlocked a filing cabinet, removed a single and unlabeled plastic ampule, then she locked the cabinet. She approached resident #1, who was lying in his bed, and told him she was going to place the solution into his machine and place the mask on his face. She put the solution in the reservoir, placed the mask on the resident's face, turned on the machine, told him she would be back then she left the . She washed her hands in the kitchen, returned to the resident's , placed a chair next to his bed then sat down. At the

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conclusion of the treatment she turned off the machine and removed the mask from his face. She signed the Medication Observation Record.

Caregiver A did not take the medication, in its previously dispensed, properly labeled container, from where it was stored and bring it to the resident. She did not in the presence of the resident, read the medication label aloud, as was required.

On . . . . . at 2 p.m. caregiver A confirmed the findings.

Resident #1's most recent health assessment form, dated . . . . , indicated that he required assistance with self-administration medications.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observations, review of medication containers, record review and interview the facility failed to ensure a medication container was properly labeled for a resident (#1) who received assistance with self-administration of medications.

Findings:

Observations made during a medication pass for resident #1 on . . . . . at 1:22 p.m. revealed unlicensed caregiver A washed her hands, unlocked a filing cabinet, removed a single and unlabeled plastic ampule, then she locked the cabinet. She approached resident #1, who was lying in his bed, and told him she was going to place the solution into his and place the mask on his face. She put the solution in the . . . . . reservoir, placed the mask on the resident's face, turned on the . . machine, told him she would be back then she left the . . . She washed her hands in the kitchen, returned to the resident's . . , placed a chair next to his bed then sat down. At the conclusion of the treatment she turned off the machine and removed the mask from his face. She signed the Medication Observation Record.

Following the completion of the medication pass, caregiver A retrieved a box of . . . . solution that contained a prescription label. The label contained resident #1's name and the directions for use were to empty 1 ampule into the . . . . . machine and inhale by mouth every 4 hours for . . . . . .

Resident #1's . . . . . 2018 Medication Observation Record (MOR) listed the . . . . and the

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directions for use were to use 1 vial via . . . . four times a day.

Resident #1's record contained a health care provider's order, dated . . , that indicated he was to receive the . . . . solution daily at 9 a.m., 1 p.m., 5 p.m. and 9 p.m. and every 4 hours as needed.

The box of . . . . . solution did not contain an alert label that directed staff to examine the revised directions for use in the MOR, as was required.

On at 2:15 p.m. the administrator confirmed the findings.

Resident #1's most recent health assessment form, dated , indicated that he required assistance with self-administration of medications.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on review of the facility's staffing schedules and interviews, the facility failed to maintain a written work schedule that accurately reflected its 24-hour staffing pattern for a given time period.

Findings:

On . . . . at 10:25 a.m. caregiver A said she primarily worked at a sister facility however, she worked at this facility a total of four times. The most recent time was on . . . . and twice in . 2018.

The facility's staffing schedule for . . . indicated caregiver A was schedule to work from 7 p.m. until 7 a.m. however, her hours were crossed out and those same hours were written in next to the administrator's name.

Review of the facility's staffing time sheets revealed caregiver A worked on . . from 7 p.m. until 7 a.m.

On . . . . . at 10:50 a.m. the administrator confirmed caregiver A worked on . . . . and said the staffing schedule was not updated. In addition, she said caregiver A also worked at the facility on . . . . . .

Class .

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

Based on observations, record reviews and interviews, the facility failed to ensure that 2 of 4 sampled staff (A and B) received the required in-service training.

Findings:

Observations made on at 9 a.m. revealed caregiver A was present in the facility and providing resident care. Her personnel record revealed a hire date of .

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

Both caregiver A's and caregiver B's personnel record did not contain documentation to indicate they received at least 2 hours of preservice orientation prior to interacting with residents that covered resident rights and the facility's license type and services offered by the facility, as required.

In addition, caregiver A's personnel record did not contain documentation to indicate she received training on the facility's prevention policies and procedures.

On at 11:24 a.m. the administrator confirmed the findings and was unable to provide additional documentation. In addition, she said the facility did not have a policy on preventing .

Class III

0082 - Training - / - 58A-5.0191(4) FAC

Based on personnel record reviews and interview, the facility failed to ensure 1 of 3 sampled staff (B) completed a one-time education course on ( ) and ( ) within 30 days of employment.

Findings:

Caregiver B's personnel record revealed a hire date of . The record did not contain documentation to indicate she completed a one-time education course on and within 30 days of employment, as required.

On at 11:30 a.m. the administrator confirmed the findings and was unable to provide additional

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documentation.

Class III

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

Based on review of the facility's online background clearinghouse employee roster, review of the Agency's background screening website, personnel record reviews and interview, the facility failed to update the employment status for 2 of 4 sampled staff (A and B) within 10 business days of a change.

Findings:

On . . . . . at 10:25 a.m. caregiver A said she primarily worked at a sister facility however, she worked at this facility a total of four times. The most recent time was on and twice in 2018.

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

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

Review of the facility's online background clearinghouse employee roster on at 10:45 a.m. revealed caregivers A and B were not listed, as required.

On . . . . . at 10:50 a.m. the administrator said caregiver A worked at the facility on . . . . , which required that she be listed on the facility's background roster.

Review of the Agency's background screening website on at 10:55 a.m. revealed caregiver A had an eligible screening on . . . and caregiver B had an eligible screening on . . . .

On . . . . . at 11:04 a.m. the administrator confirmed neither caregiver was listed on the roster.

Unclassified