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	AL11967189	**11/27/2018**
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SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

An unannounced biennial relicensure survey with extended congregate care and emergency power plan monitoring, and complaint (CCR #201813184) was conducted on -27, 2018 at Princeton Village of Palm Coast. Deficiencies were identified at the time of the visit.

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

Based on observation, record review and staff interview, the facility failed to properly assist with medication self administration for 3 of 3 sampled residents, Residents #2, #4, and #6.

The findings include:

On at 9:40 AM, Employee C, a Medication Technician, was observed assisting with medication self administration for Resident #2. She removed 5 pills from the medication cart and placed them in a medication cup and went to the room. She handed the resident the cup of medication and the resident took them. Employee C did not read the medication labels in front of the resident.

On at 9:42 AM, Employee C was observed assisting with medication self administration for Resident #4. Employee C removed 1 medication from the medication cart, placed it in a small medication cup and went to the room. She handed the resident the cup and the resident took it. Employee C did not read the medication label in front of the resident.

On at 9:46 AM, Employee C,was observed assisting with medication self administration for Resident #6. The medication cart was in the hallway. She removed 3 medications, , , and Carvediolol and placed them in a small medicine cup. She stated Resident #6 also had baby , ordered but it was not in the cart. Employee C went down to the room and handed Resident #6 her three medications and then told her " I do not have your , now but will bring it later". Employee C did not read the medication labels in front of the resident.

The Health Wellness Director on 11/26/2018 at 4:20 PM stated Employee C should read the medication labels in front of the residents.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

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Based on resident record review and staff interview, the facility failed to ensure licensed staff notified the physician of an abnormal level per physician order for 1 of 2 sampled residents, Resident #9.

The findings include:

Record review for Resident #9 revealed a physician order was dated , which included a for use. It mandated that for a reading over 401 to give 8 units of and to call the physician.

The Medication Record revealed that on at 12:00 PM, the licensed nurse recorded the resident's at 411 (a high reading).

Further record review did not reveal that the physician was notified of this high level.

The Health and Wellness Director on 11/27/2018 at 1:40 PM confirmed she could not find evidence that the nurse called the physician per order to relay the high level.

Class III

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

Based on observation, record review, and staff interview, the facility failed to properly maintain the Medication Record for 1 of 3 sampled residents, Resident #6.

The findings include:

Employee C was observed assisting with medication self administration for Resident #6 on at 9:46 AM. The medication cart was in the hallway. She removed 3 medications, , , and Carvediolol and placed them in a small medicine cup. She stated Resident #6 also had baby , ordered but it was not in the cart. Employee C went down to and handed Resident #6 her three medications and then told her " I do not have your , now but will bring it later".

The Medication Record (MR) for Resident #6 was reviewed on at 4:14 PM. There was staff initials on for the 8:00 AM dose of , 81 MG (as if it had been given) despite Employee C's previous comment that she still needed to give it, at 9:46 AM.

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Employee K, a Licensed Practical Nurse on at 4:15 PM stated that they did not stock 81 MG of the medication cart. He stated that no had been delivered today, so Employee C could not have given it to Resident #6.

The Health and Wellness Director on 11/26/2018 at 4:20 PM stated they should not have run out of the for Resident #6. She confirmed Employee C did not document the Medication Record correctly.

On at 7:25 AM, Employee C confirmed she did not give the to Resident # 6. She thought she had documented it correctly.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation, record review, and staff interview, the facility failed to properly store and dispose of that was not dated when opened for 2 of 2 sampled residents, Residents # 9 & #10.

The findings include:

Employee A, a Licensed Practical Nurse was observed administering to Resident #9 on /218 at 11:40 AM. He performed a check for Resident #9 and obtained a high reading of 386. Employee A removed two from the medication cart. Both were opened and in the same clear bag. One was and the other one was . There was only a name written in black marker on it, and the pharmacy label for the . The had an date opened label on it. The did have not have an open date on it. (photographic evidence obtained). Employee A dialed 6 units of and injected it into abdomen of Resident #9.

Employee A was questioned about the expiration date of once opened. He stated he wasn't sure but thought it was good for about 40 days. He confirmed one of the was not dated when opened so he shouldn't use it. He also stated both should not be in the same bag.

On at 11:50 AM, Employee A was observed administering for Resident #10. Employee A first did a test. It was 276. Employee A removed a clear bag of containing and . The label on the bag had the resident's name handwritten on it, with a label for . Neither had an open date on it. Employee A dialed 14 units on the and injected it into the resident's left arm.

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The Health and Wellness Director on 11/27/2018 at 12:30 PM stated that two different should not be stored in the same bag and that is only good for 28 days after opening. If there was not an open date on the , is should be thrown out and not used.

Class III

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

Based on observation and staff interview, the facility failed to properly label for 2 of 2 sampled residents, Residents # 9 & #10.

The findings include:

Employee A, a Licensed Practical Nurse was observed to remove medication from the medication cart for Resident #9 on /218 at 11:40 AM. Employee A removed a bag of from the medication cart with a handwritten name of Resident #9 on it. The were two different kinds, and . The Pharmacy label only identified the on it. Employee A was questioned about storing two different in the same bag with only 1 pharmacy label. Employee A stated he did not think they should be in the same bag if the label does not identify it.

On at 11:50 AM. Employee A removed a bag of for Resident #10. This bag contained two , and . The name of Resident #10 was handwritten on the bag and the pharmacy label only listed the .

The Health Wellness Director on 11/27/2018 at 12:30 PM stated that the two different should not be stored in the same bag and each should be separately labeled.

Class III

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

Based on observation, record review, and staff interview, the facility failed to provide therapeutic diets for 9 of 22 sampled residents, Residents # 3, #9, #10, and #17- #22).

The findings include:

On at 8:32 AM, an observation was made of the main dining room on at 8:32 AM. It was a large room and residents were being served breakfast. Staff members were observed

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going up to the residents asking them what they wanted, going to the kitchen and returning with a meal. Salt and pepper shakers were observed on each table.

One of the staff members assisting with breakfast, Employee B was interviewed on at 8:39 AM in main dining room. She stated they take orders from residents and serve them whatever they ask for. She does not alter the diets for or for anyone else.

On at 3:00 PM an interview was conducted with the Director of Dietary Services. He stated the only therapeutic diets he was aware of was mechanically altered. He did not know of any residents needing or low diets. He relies on nursing to give him the dietary slip for any therapeutic diets. He stated he served everyone in the building a regular breakfast and lunch today. He stated if someone was on a low diet, he would alter the potato that was served. He stated for dinner tonight, he would alter the pasta. For , the brownie would be eliminated. But he did not have to do that because no one was on a therapeutic diet. The Dietary Director was asked to check with Nursing to determine if anyone in the facility had a therapeutic diet.

On at 8:20 AM, the Dietary Director confirmed there were residents on therapeutic diets. He was asked for a list residents on therapeutic diets.

Resident #18 was observed in the main dining room eating his breakfast on at 8:45 AM . He was asked if he was on any special type of diet. He stated they tell him he was a but he doesn't think so. He orders anything he wants off the menu and they give it to him. He had a glass of milk, muffin, and oatmeal that he was eating. He was not instructed or offered any special diet.

On at 9:00 AM, an observation of the breakfast meal was observed in the Beacon Unit where two residents resided, Residents #9 & #10. They were sitting at two separate tables eating breakfast. Employee B was present and stated that she served both residents a regular diet. She stated she just asks the nurse (today it was Employee A, LPN) which residents were allowed to recieve juice. Employee A was interviewed on 11/27/2018 at 9:10 AM. He stated that this morning both Residents #9 and #10's were fine (156, 141) so they can eat a regular meal. He did not know if these residents should be on a diet.

On at 8:50 AM, the Dietary Director gave a list of therapeutic diets. It revealed 8 , 1 ordered a low diet, and 1 ordered a diet.

On at 9:00 AM, the Health and Wellness Director gave a copy of all the Health Assessments of residents with therapeutic diets (totalling 9), and it revealed the 3 sampled residents:

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Resident #3, who had a Health Assessment dated , in which a Low diet was ordered;
Resident #9, who had a Health Assessment dated , in which a Controlled, , soft diet was ordered; and
Resident #10, who had a Health Assessment dated 11/29/2017, in which a diet was ordered.

The 6 unsampled residents revealed:

Resident # 17 had a Health Assessment dated , in which a LCS (diet) was ordered.
Resident #18 had a Health Assessment dated , in which a Calorie Controlled diet was ordered.
Resident #19 had a Health Assessment dated , in which a no added salt diet was ordered.
Resident #20 had a Health Assessment dated , in which a no added salt diet was ordered.
Resident #21 had a Health Assessment dated , in which a low diet was ordered.
Resident #22 had a Health Assessment dated , in which a no added salt diet was ordered.

Employee A, a Licensed Practical Nurse was observed to administer to Resident #9 on /218 at 11:40 AM. He performed a check for Resident #9 and obtained a high reading of 386.

On at 11:50 AM. Employee A did a check for Resident #10. It was also high, at 276. Employee A stated the for this resident was always high.

Class III

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

Based on employee record review and staff interview, the facility failed to maintain complete an employment applications for 2 of 4 sampled employees, the Administrator and the Food Service Director.

The findings include:

1. On at 3 PM , the Food Service Designee (FSD) was interviewed. He stated he was not employee of this facility and his services were . He began working here in , . He stated he did not evidence Continuing Education Units. He would attempt to get them from his previous employer.

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On at 3:40 PM, the Health Wellness Director stated that they do not have an employee file for the FSD. The FSD still had not heard from previous employer and she could not produce any documentation of this education.

2. Review of the Administrator's employee file revealed there was no application. There was a resume on file but it had no references. It revealed references " available upon request". The Administrator was hired on . The Business Office Manager on 11/27/2018 at 12:30 PM confirmed there was no application on file for the Administrator.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on resident record review and staff interview, the facility failed to obtain a new resident contract or add an addendum for changes in services for 1 of 2 sampled residents, Resident #3.

The findings include:

Record review reveled Resident #3 initially moved into the Community (independent living) with his wife on . The resident then decided to move into the assisted living facility in . Resident #3's wife signed the resident agreement on and agreed to pay $3,039/month. In , Resident #3's the wife joined him in the assisted living facility and began paying $6717/month for services. However, the facility failed to obtain another residency agreement for Resident #3 and his wife in .

The Business Office Manager on 11/26/2018 confirmed she did not have a new residency agreement/ addendum for Resident #3 and his wife indicating services provided and current payment.

Class

Based on observation, Emergency Environmental Control Plan (EECP) review, and staff interview, the facility failed to have maintain access to fuel to run its alternative power source as indicated in the emergency power plan in order to keep air temperature at 81 degrees or below.

The findings include:

Review of the facility EECP revealed the facility had 3 portable generators (1 used propane, 1 used

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gasoline, and 1 used either propane or gasoline). This would run power to ensure a temperature of 81 degrees or less in the dining room and common areas to cool 2060 square . . for 40 residents for 96 hours. This alternate power source to be completed on .

The Administrator was interviewed on 11/26/2018 at 8:39 AM. He stated the EECP plan for the fixed generator has not been approved yet. They are still building it. He confirmed their alternate plan to have 3 portable generators that run on both propane and gasoline. They are not allowed to store gasoline on premises so rely on propane mainly. They have a 500 gallon propane tank underground that services the kitchen appliances on a daily basis. He stated that is what they would access in an emergency.

On at 8:30 AM, the 3 generators were observed running, two on gasoline and one on propane (currently connected to a 20 gallon portable propane tank). The Maintenance Director says he starts these generators weekly to ensure they are functioning. He was asked how he would refill the portable propane tank when it runs out of fuel. He stated he would have to leave the premises and get it filled elsewhere. He was asked why he could not get it from the 500 gallon underground tank. The Maintenance Director stated there was no access point/valve built into the piping to access the underground propane tank.

On . . . . at 8:40 AM, the Administrator walked outside to the running generators and propane piping. He stated he thought there was already a valve to access the 500 gallon tank.

Class III

E207 - ECC - Services - 58A-5.030(8) FAC

Based on observation, record review, and staff interview, the facility failed to provide Extended Congregate Care (ECC) services for 1 of 3 sampled residents, Resident # 1.

The findings include:

Record review for Resident #1 revealed a physician order dated . . . . for ECC services for . to be on in morning, and to remove at the hour of sleep. Review of the progress notes revealed day shift on . . . . did not put them on.

On . . . . at 1:30 PM, an observation was made Employee B was escorting Resident #1 out of the dining room. Resident #1 was not observed without her . The resident was unable to explain why they were not on. Employee B stated that Resident #1's . / . . were really . . . and maybe

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that was why the nurse did not put them on her today. Only the nurses put them on. The resident's were observed red and . On her right upper , there was a large adhesive bandage in place.

On at 1:37 PM, the Health and Wellness Director stated she spoke with Employee K (the Licensed Practical Nurse assigned to ECC services today) and he stated he was in the resident's room twice this morning and just forgot to do it. He just put them on her now.

Class III

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on employee record review and staff interview, the facility failed to ensure that Employee C sign an attestation form for 1 of 4 sampled employees, Employee C.

The findings include:

Employee record review for Employee C revealed she was hired on . She was currently employed as Medication Technician. Her employee file did have a copy of the Attestation form however it was not signed. This form is completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense.

The Business Office Manager confirmed this on 11/27/2018 at 11:28 AM.

Class