STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968805	**12/19/2018**
NAME OF PROVIDER OR SUPPLIER **AMERICAN HOUSE BONITA SPRINGS**	STREET ADDRESS, CITY, STATE, ZIP CODE **11400 LONGFELLOW LN** **BONITA SPRINGS, FL 34135**	

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

0000 - Initial Comments

An unannounced relicensure survey with Limited Nursing Services was conducted through at American House Bonita Springs, an assisted living facility (license #12672) in Bonita Springs, Florida.

The following is description of the deficiencies.

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

Based on observation and staff interview the facility failed to properly assist with assistance with self-administration of medication for 3 (Resident #11, #12, and #13) of 4 residents observed for medication pass.

The findings included:

On at 12:12 p.m., while doing dining observation in the facility's 2nd floor dining room, Medication Technician Staff A was observed entering the dining room after coming out of a stairwell. Staff A proceed thru the dining room with multiple paper pill cups in her . She proceed to place a pill cup on the table beside Resident
#11, #12, and #13. Each resident was at a different table around the dining room. Staff A did not stop to explain the pills she was giving or read the prescription label. The med tech did not remain by the resident to observe if the resident took the medication or not.

On at 12:15 p.m., Staff A said she knew that she was not supposed to give medication to the residents in that way. She said she was not to give medication in the dining room and she knew that she was supposed to read the medication she was giving to each resident so they were aware of what they were taking. She confirmed that she had her med tech training.

On at 12:20 p.m., the director of nursing said that Staff A did have her med tech training and she was wrong to bring multiple residents their pills in the dining room. She acknowledged that it was dangerous for Staff A to bring multiple pill cups in her and this is not how med techs are trained in the facility.

On at 12:30 p.m., Lead Medication Technician Staff G said that Staff A did not give the medication in the way the med techs have been taught. She said it was wrong.

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Record review of assistance with self-administered medications includes reminders, opening med packaging, reading labels to residents and observing the resident taking ordered dose and documentation of same.

Class III

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

Based on resident record review and staff interview the facility failed to order medications in a timely manner for 6 (Resident #10, #15, #16, #17, #18, and #19) of 6 residents in memory care reviewed for proper documentation of the medication observation record (MOR).

The findings included:

During an interview on at 1:30 p.m., the director of nursing said the med techs are supposed to order medications when they get down to one week. If the medication needs a script, it gives nurses a chance to get the script from the physician.

Resident #10 did not receive (a) on and . He also did not receive (used to prevent) on evening dose, morning dose, evening dose and morning and evening dose. The reason written on the MOR was not available.

Resident #15 did not receive (supplement) on evening dose, morning dose, morning and evening dose, morning and evening dose, morning and evening dose and morning dose. The reason written on the MOR was not available.

Resident #16 did not receive (used to prevent) on morning and afternoon dose. The reason on the MOR is awaiting delivery from the pharmacy. Resident #16 did not receive , (used to treat ,) on at bedtime, at bedtime, at bedtime and at bedtime. The reason on the MOR was not available.

Resident #17 did not receiver her (used to treat and rhythm problems) on in the morning and in the morning. The reason written on the MOR was awaiting delivery from the pharmacy.

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Resident #18 did not receive her (used to treat high) on at bedtime, at bedtime, at bedtime, at bedtime and at bedtime. The reason written on the MOR was not available.

Resident #19 did not receive her (supplement) on , 4, 6,7,8,9, 11 and 13 all due for 9:00 a.m. The reason written on the MOR is not available, awaiting delivery from the pharmacy. Interview with the director of nursing said Resident #19's sister brings in her medication and we were having difficulty getting it.

Review of Medication -Procedures Section: Medication Management Number: G-1 on page 2 Medication Reorders states: Family/responsible party brings medication: Community will notify family/responsible party in a timely fashion when the medications need to be reordered to allow them time to bring them in. In the evening if a medication is not available for a resident and the community has made all attempts to notify the power of attorney (POA) of the need for the medication, the community will order the medication from the community's preferred pharmacy. If medication continues to be "unavailable" from the POA, the community reserves the right to continue to use the community's preferred pharmacy until the medication is provided. The family and resident will be informed of this upon move in to the community and they will be responsible for the charges incurred.

During an interview on at 1:00 p.m., the Director of Nursing said I used to pull the reports every morning, but the lead med techs went to a training and were taught how to do it. I guess I will go to doing it myself.

Class III

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

Based on employee record review and staff interview the facility failed to have communicable statements for 4 (Staff D, H, J, and K) of 6 employee records reviewed.

The findings included:

Staff D has a hire date of . The communicable statement for Staff D was dated .
Staff H has a hire date of . There was no communicable statement for Staff H on file.
Staff J has a hire date of . The communicable statement for Staff J was dated .
Staff K has a hire date of 11/17/16. The communicable statement for Staff K was dated 11/7/17.

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During an interview on at 1:17 p.m., the director of nursing said the former human resource manager kept track of all the training, communicable statements and training and she would send up a list of who was due. I would let my staff know who was due. She has been gone and it hasn't been followed up on.

Class III

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

Based on employee record review and staff interview, the facility failed to have pre-service orientation for 2 (Staff C and E) of 6 employee files reviewed for pre-service orientation

The findings included:

Staff C had a hire date of 11/13/18 and Staff E had a hire date of . Both staff members did not have pre-service orientation that addresses the facility license type and services offered.

During an interview on at 11:30 a.m., the administrator said he will need to fix how the pre-service orientation is presented to the new employees.

Class

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on employee record review and staff interview the facility failed to have appropriate training documentation for 1 (Staff C) of 6 employee records reviewed.

The findings included:

Employee record review on at 10:00 a.m., showed staff C had a hire date of 11/13/18. Staff C had a certificate for 6 Hour Medication Technician Certification. There was no agenda as to what was taught or where it was taught.

During an interview on at 10:00 a.m., the director of nursing said she brought it from her other facility.

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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on employee record review and staff interview the facility failed to have a Level II background screening on 1 (Staff B) of 6 employee records reviewed for background screening.

The findings included:

Staff B has a hire date of . The background screening website shows an eligibility date of . During an interview on at 2:00 p.m., the Business Office Manager said this staff member is a snowbird and works a couple of months and then goes up north.

During an interview on at 11:00 a.m., the Administrator said it looks like one wasn't done. She was not rescreened when she came .

Unclassified