STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965867	R 09/06/2018
NAME OF PROVIDER OR SUPPLIER **CUNNINGHAM ELDERLY, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2909 COURTLAND BLVD** **DELTONA, FL 32738**	

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

0000 - Initial Comments

An unannounced second follow up survey to the biennial licensure survey on , , was conducted at Cunningham Elderly, Llc (License #10202) on , , .

Cunningham Elderly, Llc had deficiencies found at the time of the visit. The facility was recited for A0053 and A0079.

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

Based on resident record review and staff interview, the facility failed to ensure accuracy of AHCA Form 1823 Resident Assessment for Assisted Living Facilities for Admission Health Assessments for 2 of 2 sampled residents. (Resident #1 and Resident #5)

The findings include:

Record review for Resident #1 revealed an AHCA 1823 Resident Assessment signed by a physician based on a date of examination. Further review of page 4 of the AHCA 1823 revealed "Question B. Does the individual need help with taking his or her medications?" was answered "yes." The type of assistance checked was, "Needs Medication Administration." The diagnoses on page 1 of the AHCA 1823 were , , , and , , and the resident's status was forgetful.

Record review for Resident #5 revealed an AHCA 1823 Resident Assessment signed by a physician based on a date of examination. Further review of page 4 of the AHCA 1823 revealed "Question B. Does the individual need help with taking his or her medications?" was answered "yes." The type of assistance checked was, "Needs Medication Administration."

The Administrator was notified on at 12:05 PM, that the AHCA Form 1823 Resident Assessment for Assisted Living Facilities for Admission Health Assessments for Resident #1 and Resident #5 needed medication administration. The Administrator confirmed that neither resident needed licensed staff to give their medication.

Record Review of the Medication Observation Records for both Resident #1 and #5 revealed that unlicensed staff were assisting both residents with their medication.

(Photographic evidence obtained)

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Class III

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

Based on record review and staff interview, the facility failed to maintain accurate medication observation records for 1 of 2 sampled residents. (Resident #5)

The findings include:

On [redacted] at 9:33 AM, a Home Health Nurse was observed coming in to the facility to see Resident #5 to check the resident's [redacted]. During an interview with the home health nurse on [redacted] at 9:50 AM. The Home Health Nurse stated there was a new order on [redacted] for Resident #5's [redacted] to be at 5 milligrams (MG) every morning. The order was reviewed in the Home Health Nurse's computer that effective [redacted] to change the [redacted] to 5 MG for B/P greater than [redacted]. She looked in her computer and stated Resident #5 had been seen by a home health nurse for three weeks to get her [redacted] under control. The first week three times, then 2 times for two weeks and next week will be one time. The Home Health Nurse stated the facility did not the 5 MG until [redacted] as she and the Administrator had to call the pharmacy and the doctor.

Record review of the medication observation record (MOR) for Resident #5 found the [redacted] 5 MG was annotated as given at 9:000 AM on [redacted] through [redacted]. Record review of the prescription bottle containing the medication found it was dated as received on [redacted].

An interview with the Administrator on [redacted] at 12:05 PM confirmed the findings. She agreed that the medication was not received until [redacted] and the MOR was documented as if the medication were given before they were received.

Class III

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

Based on observation and interview, the facility failed to keep medication stored in a safe manner to ensure the safety of the 6 residents that reside at the facility.

The findings include:

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On entry to the facility on at 8:30 AM, Resident #1 was observed sitting on a recliner with a clear plastic shoebox size container full of prescription pill bottles. There were three bottles on the side table and Resident #1 was continuing to look at bottles and place them on the table with the other bottles. She then took about pills and put them in a small cup. She said she had about 11 pills. She stated she sometimes takes her own pills. She walked away from the pills and went in the kitchen and put the clear plastic container in the cabinet. She went in the living room and sat down and took the pills. An observation in the kitchen immediately after the resident left found a cabinet with an open lock. There was a key sitting on the counter below. The lock was easily removed and the cabinet open. The cabinet was found to be full of medication belonging to all of the residents at the facility. (Photographic evidence obtained) While in the kitchen Resident # 3 walked by and said hello. Employee C was in the bathroom with another resident during this observation.

During an interview with Resident #1 on at 9:08 AM, she was asked how she got her pills today. She said there is a key in the drawer to the cabinet so she went and got her pills because of a problem she has today. She then pointed to her and let out a little .

Record review for Resident #1 revealed an AHCA 1823 Resident Assessment signed by a physician based on a date of examination. Further review of page 4 of the AHCA 1823 revealed "Question B. Does the individual need help with taking his or her medications?" was answered "yes." The type of assistance checked was, "Needs Medication Administration." The diagnoses on page 1 of the AHCA 1823 were , , and and the resident's status was forgetful.

During an interview with the Administrator and the Administrator's daughter on at 12:05 PM both stated that they will need to do something with the key so Resident #1 cannot get access to the medication. Both stated they felt the resident was not safe to take her own medication.

Class III

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

Based on record review and staff interview, the facility failed to maintain the minimum required staff hours of 212 hours a week for the 6 residents that reside at the facility.

The findings include:

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During a telephone interview with the Administrator on at 8:45 AM, the Administrator was asked for her employee schedules. She stated they were on the refrigerator. They were found behind the menus.

Record review of the employee schedules while the Administrator was on the phone found the most recent schedule was labeled -25. Record review of the schedule found the facility had only one employee working at any given time. The Administrator (Employee A) was on the schedule Sunday, Monday, Tuesday, Wednesday and Saturday from 8:00 AM to 4:00 PM. Employee B was on the schedule on Monday, Tuesday, Wednesday, Thursday and Friday from 4:00 PM to 8:00 AM. Employee C. This gave the total number of hours on the schedule as at 168 with the required number of hours for the 6 residents observed in the facility being 212. The Administrator was informed over the phone that having one staff member at all times did not meet the required hours for 6 residents. (Photographic evidence obtained)

The Administrator arrived on at 11:15 AM. She was asked if she had any other schedules and she stated she still needed to complete the schedule for . During an exit conference with the Administrator on at 12:05 PM she still did not have enough hours of employee coverage on her schedule. It was explained that the hours each week on the schedule needed to add up to 212 if she continued to have 6 residents. She confirmed the hours added up to 168 and stated she would adjust the schedule and work more hours.

Class III

0180 - Emergency Management - 58A-5.026(1) FAC

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

Based on record review and staff interview, the facility failed to update the agency background screening clearinghouse for 1 of 1 sampled employees currently working at the facility (Employee C).

The findings include:

Record review of the background screening system on at 10:26 AM found Employee C was not listed as working at the facility. (Photographic Evidence Obtained)

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During an interview with Employee C on [redacted] at 10:30 AM she stated she started work at the facility on [redacted].

During an interview with the Administrator and her daughter on [redacted] at 12:05 PM the findings were confirmed. The administrator's daughter stated she was trying to get Employee C into the background screening system and was having trouble.

Unclassified