| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11911288** | **01/03/2019** |
| NAME OF PROVIDER OR SUPPLIER<br>**BEGGS POINTE ALF** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**4711 BEGGS ROAD**<br>**ORLANDO, FL 32810** | |

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

**0000 - Initial Comments**

A Complaint investigation #2018015288 was conducted on . . . . . Beggs Pointe ALF, license #5825, had deficiencies at the time of the visit.

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

Based on observations, record reviews, and interview, the facility failed to ensure a health assessment (form 1823) was accurate and complete for 1 of 4 sampled residents (#2).

Findings:

Observations during a tour of the facility on . . . . at 8:45 AM revealed resident #2 was in a hospital bed with the raised and half rails raised. A hospice nurse was visiting her that morning. At lunchtime, she was observed to be fed a pureed meal by a caregiver.

Review of the record for resident #2 revealed an 1823 which was not dated. The initial health assessment for the resident was dated . Her diagnoses included 's . She was receiving hospice care. Further review of the undated assessment revealed she required a regular diet, total assistance with all Activities of Daily Living (ADLs), and assistance with self-administration of medications. Observation notes in the record documented, "she is bed bound, . . . . . in arms and . Needs to be fed. Gets crushed meds and puree diet."

On at 12:30 PM, the administrator said the resident had recently been to the hospital and the current 1823 came from that visit. She stated she had not noticed it was not dated, and confirmed it was not accurate.

Class III

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

Based on observations, record reviews, and interview, the facility failed to ensure the appropriateness of continued residency for 1 of 4 sampled residents (#3).

Findings:

Observations during a tour of the facility on at 8:45 AM revealed resident #3 was dressed and

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napping on the sofa in the living room. At lunchtime she was observed to eat her lunch independently.

Review of the record for resident #3 revealed an 1823 which was dated . Further review of the assessment revealed she required total assistance with all bathing, , grooming and toileting and supervision with eating and ambulation. The form indicated she required medication administration. It further indicated she required 24 hour nursing or , supervision.

On at 12:30 PM, the administrator confirmed the form contained inaccuracies.

Class III

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

Based on record review and interview, the facility failed to ensure the continued safety of residents, did not maintain a general awareness of the resident's whereabouts, and did not prevent an altercation between 2 residents (#2 & #4) that resulted in hospitalization of one resident (#2) and incarceration of the other resident (#4).

Findings:

Review of the admission discharge log on found resident #4 was admitted to the facility on and discharged on to jail.

Review of the closed record for resident #4 found her health assessment, dated , documented diagnoses that included , and . She was not an elopement risk. She was independent with Activities of Daily Living (ADLs), except supervision for eating. She was documented to be appropriate for living in an Assisted Living Facility. She required assistance with self-administration of medications.

Observation notes for resident #4 documented an incident at 2:05AM on by the caregiver ( staff E) on duty that stated she saw resident #4 in the room of resident #2. Resident #2 had been sleeping. Staff E documented she "heard a screaming voice and found resident #4 hitting resident #2 on the with a grabber stick." Resident #4 voluntarily surrendered the stick to Staff E. Staff E called 911. and the police arrived. "Police enforcement came, handcuffed resident #4 and took her to jail." Resident #4's case manager and daughter were contacted. Resident #4 was discharged on . Her daughter removed her belongings on .

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

Review of the record for resident #2 revealed an 1823 which was not dated. The initial health assessment for the resident was dated . Her diagnoses included 's . She was receiving hospice care. Further review of the undated assessment revealed she required a regular diet, total assistance with all Activities of Daily Living (ADLs), and assistance with self-administration of medications. Observation notes in the record documented, "she is bed bound, in arms and . Needs to be fed. Gets crushed meds and puree diet."

Continued review of the observation notes for resident #2 found an entry on at 2:10 AM documenting that resident #2 had been in her room while sleeping. Staff E reported she "saw some on the resident's right arm, right and on her . 911 was called and paramedics came right away. The resident was awake, alert and moaning while being attended to by the paramedics." The resident was taken to the hospital for stitches. Hospice and the resident's guardian were notified. The resident returned to the facility on .

Review of the adverse reports for the facility found a day 1 and day 15 reported for a resident to resident altercation on . The incident is described as reported above. Within 1 minute, Staff E entered the room, broke up the and removed resident #4 from the room and secured the grabber tool and called 911. The administrator was contacted at 2:15AM. Analysis of the incident documented there was no lock on the door to resident #2's room, so resident #4 was able to enter. Corrective action documented a keyed door handle was installed, resident #4 was from the facility and staff have been instructed to monitor residents more closely who are awake and walking around during the night.

On at 11:00 AM the administrator stated resident #4 was a new resident and seemed , and pleasant up until that night. She stated Staff E was seated in the kitchen and heard resident #4 get up and walk in the hallway. She assumed she was coming for a glass of water. When she did not see her right away she stood up to go find her and heard screaming at that moment. Resident #2's room is adjacent to the kitchen and resident #4 was found holding a grabber stick and hitting resident #2 in bed. The administrator said resident #4 was saying something about her daughter and resident #2. She said 911 was called immediately and came very quickly. The police took resident #4 to jail while the paramedics treated resident #2 and took her to the hospital. She stated she was called by Staff E as soon as things settled down. The administrator made phone calls to hospice, guardians and case managers as appropriate. The administrator confirmed the incident occurred as reported in the notes.

Class III

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

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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 1 residents with , ability (#2).

Findings:

Tour of the facility at 8:45 AM was provided by Staff B, caregiver. She identified residents #2, 7 & 8 as bedridden and on hospice services.

On at 9:30 AM, the hospice nurse stated resident #2 was unable to feed herself or place medication in her . . . . When asked who was providing the medications, she stated the caregivers do it if the administrator is not available.

Observation on of resident #2 revealed she was in a hospital bed, with the of the bed raised. She smiled and said hello when greeted. Continued observations at lunchtime revealed staff C seated at the bedside for resident #2, feeding her a pureed meal. Resident #2 opened her for each spoonful of food but was unable to hold a utensil or feed herself. Her . . . . were at her sides.

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 #2 is able to take her medicines, staff B replied, "We crush them, put them in applesauce and feed them to her. The administrator usually does it, but if she's not here in the morning, we do it."

Review of the personnel record for staff B, caregiver hired , revealed she was not a licensed nurse. A certificate for a 4 hour class in assisting with self-administration of medications in an assisted living setting was dated . A 2 hr. medication update certificate was dated .

Review of the record for resident #2 revealed she was admitted on . The most recent health assessment (form 1823) was not dated and documented she 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 #2 for the current month ( . . . . , ) revealed all medications were signed as given by unlicensed staff.

On at 12:30 PM, the administrator confirmed staff B was not a nurse, and that no nurses other

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than herself were on staff at the facility. She confirmed that resident #2 was no longer able to feed herself, including holding a spoon for medications.

Class III