STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968770	**02/07/2019**
NAME OF PROVIDER OR SUPPLIER **MAYDEL ALF 2 CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **14910 N OLA AVE** **TAMPA, FL 33613**	

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

0000 - Initial Comments

Assisted Living Facility

A Biennial licensure survey was conducted at the Maydel Assisted Living Facility (ALF) 2 Corp. on .

The Maydel ALF 2 Corp, Assisted Living Facility (License #12628), had deficiencies at the time of this visit.

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

Based on record review and interview, the facility failed to ensure completion of a medical examination by a health care provider within 60 days before admission to the facility or within 30 calendar days of the admission date after the resident's admission to the facility for 3 of 3 residents reviewed. The facility also failed to ensure signed and completed medical examination reports were submitted to the facility owner or administrator for 3 of 3 residents reviewed in order to determine appropriateness of facility admission and continued stay in the facility. The facility failed to ensure that required information that is not contained in the medical examination report conducted before the individual's admission to the facility was obtained within 30 days after admission for 3 of 3 residents reviewed.

Findings included:

Three of three Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823) reviewed were not completed within required time frames as follows: (photographic evidence obtained)

Record review conducted on revealed that Resident #1 was admitted to the Assisted Living Facility (ALF) on . Resident #1's file contained a Resident Health Assessment dated - Not completed within 60 calendar days before Resident #1's admission to the facility or within 30 calendar days after admission to the facility.

Record review conducted on revealed that Resident #2 was admitted to the ALF on . Resident #2's file contained a Resident Health Assessment dated . There was no evidence that an initial Resident Health Assessment had been completed as required. The Administrator stated on at 10:15am that she threw the initial assessment away when she obtained an updated assessment.

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Record review conducted on revealed that Resident #4 was admitted to the ALF on . Resident #4's file contained two Resident Health Assessments, one was undated -- Date of Examination not completed (blank) -- and one was dated . There was no evidence that an initial Resident Health Assessment had been completed as required.

Review of Resident Health Assessments on for Residents #1, #2, and #4 revealed incomplete, incorrect, and/or inconsistent information as follows: (photographic evidence obtained)

Resident #1's record revealed an Examiner's signature provided on the Resident Health Assessment, but Surveyor was unable to decipher the name from scribbled signature; a printed name was not provided in the space allotted on the form. The Administrator stated on at 10:00am that she was unable to read the examiner's name and did not know the name of the doctor. Resident #1's Health Assessment dated stated that Resident #1 required 24-hour nursing care. The examiner checked need for 24-hour nursing or care and wrote "nursing care" in comments. The Administrator stated that the facility does not provide licensed nurses. The Examiner checked that needs can be met in an Assisted Living Facility. Whether Resident #1 needs assistance with medication was not completed, nor was the section completed for whether Resident #1 needs assistance with self-administration, medication administration, or is able to self-administer without assistance. Examiner's determination of Elopement risk was not completed (blank). Services Offered or Arranged by the Facility based on needs identified -- Section 3 of Form 1823, which states on the form: "This section must be completed by the ALF Administrator or designee" -- was not completed (blank).

Resident #2's Health Assessment Form 1823 dated stated Resident #2 needs medication administration. The Administrator stated on at 10:15am that the facility does not have a nurse available to provide medication administration. The Administrator stated on at 10:40am that all residents get assistance with self-administration of medications.
Services Offered or Arranged by the Facility based on needs identified was not completed (blank).

Resident #4's record revealed an undated Form 1823 that stated Resident #4 requires 24-hour nursing care (not provided by the facility). Whether Resident #4's needs can be met in an ALF was not completed (blank). If resident needs assistance with medication was not completed, nor was section completed for whether resident needs assistance with self-administration, medication administration, or is able to self-administer without assistance. Date of Examination was not completed (blank). Services Offered or Arranged by the Facility based on identified needs was not completed (blank). Resident #4's record also revealed a second 1823, dated , which stated that Resident #4 is bedridden and requires 24-hour nursing care; examiner checked that needs can be met in an ALF. There was no indication of when Resident #4 became bedridden. The Administrator stated on at 11:20am that

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Resident #4 gets out of bed 2 hours a day and that the facility does not have nurses. Services Offered or Arranged by the Facility based on needs identified was not completed (blank). Resident #4's record revealed admission to Hospice on . There was no updated Assessment (Form 1823) in Resident #4's record when this change in condition occurred; the undated 1823 did not indicate hospice.

Class III

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

Based on record review and interview, the facility failed to ensure that two of two residents with changes in condition requiring additional services had -to- medical examinations by a health care provider and that the results of the examinations were recorded on a written health assessment (AHCA Form 1823).

Findings included:

Record review conducted on revealed that Resident #2 was admitted to the Assisted Living Facility (ALF) on and admitted to hospice on . Resident #2's record contained one Resident Health Assessment (AHCA Form 1823), dated . There was no updated Health Assessment in Resident #2's record when the change in condition requiring hospice services occurred.

On at 10:49am, the Administrator stated that the hospice nurse said she will send a new 1823 due to Resident #2's change of condition to hospice care.

Resident #4's record revealed an undated Resident Health Assessment (AHCA Form 1823) with facility name & address provided and no indication of Resident #4's need for hospice services. Resident #4's record also revealed an 1823 dated that stated regarding Nursing, Treatment, , Service Requirements: "Hospice to provide." Resident #4's record revealed admission to Hospice on . There was no updated Health Assessment (Form 1823) in Resident #4's record when the change in condition requiring hospice services occurred.

Class III

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

Based on observation, interview, and record review, the facility failed to provide medications for one of one sampled residents (Resident #4) with prescriptive authority to be given "as needed," in accordance with physician orders within the specific parameters that preclude independent judgment on the part of

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the unlicensed staff person assisting with self administration of medication.

Findings included:

Review of Resident #4 Medication Observation Record (MOR) and medications revealed Resident #4 was prescribed with physician orders to take 1 tablet by every 4 hours as needed for . The physician's orders were printed on both Resident #4's pack containing the medication and on Resident #4's Medication Observation Record (MOR) for the month of , 2019. Surveyor observed handwritten on the medication pack: "8am, 2pm, 7pm" and observed "8am, 2pm, & 8pm" handwritten on the MOR in spaces for initials of medication provider. (photographic evidence obtained)
The Administrator stated that staff put the times on the MOR in those spaces when they provide the medication. The MOR indicated that the PRN medication was provided every day at 8am, 2pm, and 8pm as a regularly prescribed medication, not as needed in accordance with physician orders. The Administrator stated that those are the times Resident #4 needs the , medication, so they provide the medication every day at those times.

On at 2:00pm, Surveyor observed Staff A provide Resident #4's (medication prescribed to be provided every 4 hours as needed) and wrote 2pm on Resident #4's Medication Observation Record (MOR). Resident #4 was not observed to request the medication.

Class III