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	AL11968832	02/12/2019
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SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A biennial relicensure survey was conducted from through at The Inn at Aging Grace. The facility had deficiencies at the time of the survey.

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(I)

Based on staff interviews and record reviews, the facility failed to conduct elopement drills twice a year for direct care staff.

The findings include:

During an interview on at 11:30 am with Employee E, caregiver, she was asked how often she has participated in elopement drills. She stated "I have never been told anything about it or anything." She stated that Resident #8 eloped recently and they had to call the police.

During an interview on at 11:50am with Employee D, caregiver, she stated that she had not participated in any elopement drills since she's worked at the facility. She stated that there have been residents elope and they went to look for them and called the police recently for Resident #8. She stated she has had the training and feels like she knows what to do, but they are not conducting drills.

At 12:25 am on the administrator produced a form that indicated elopement drills were conducted monthly. When asked for the sign in sheets for the elopement drill trainings he stated he did not have any. When informed that his staff had reported not having been drilled, he shrugged his but did not answer.

The facility Elopement Drills Policy and Procedure read: Simulated drills will be conducted twice yearly at a minimum in order to assure all staff's familiarity with the drill (within 30 days of employment and a least one other time). These drills will be documented and kept in the facility records. Outcomes of the drill will include the effectiveness of the execution of the facility's policies and procedures and to the drills themselves.

Photographic Evidence Obtained

Class III

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

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Based on observation, staff interview, and facility record review, the facility failed to store , at a temperature of 36 degrees to 46 degrees Fahrenheit (F) when not in use, and failed to follow its policy and procedure for medication storage, for 4 of 5 sampled residents (Resident #1, #6, #9, and # 11).

The findings include:

A medication storage observation was conducted on at 1:50 pm with Employee D, medication technician. When she opened the top drawer of the medication cart a cardboard box was observed with six , lying in it.

Employee D opened another drawer of the medication cart to reveal a bag of , and another box of , sitting in the drawer. The bag and the box were appropriately labeled. She stated that those pens were not being used yet and she was using the loose pens in the top drawer. She stated they just keep the pens in the cart to store them when not in use . When she uses up the one in the top drawer she just takes another one out of the bag or box, depending on which Resident's pen is empty.

During an interview with the Director of Clinical Services on at 2:10 pm she stated that the , can be kept in the medication cart once removed from the bag or box labeled from the pharmacy. The rest of the , are to be kept in the refrigerator until they are used.

A medication storage observation was conducted on at 10:45 am. Employee D opened the cart and revealed the bag and box of , had been removed.

During an interview with the Director of Clinical Services on at 10:45 am she stated that her little medication refrigerator broke so she has to keep them in the refrigerator in the kitchen. Several boxes and bags of , were observed in an tray in the bottom of the refrigerator with food stored on top of them. She confirmed that she had just moved them to the refrigerator in the kitchen. She stated that the facility had just received a food delivery and that was why food was stored on top of the tray with the , in it.

Review of the manufacturers' instructions for storage found in each box or bag of , revealed they read: Store unused pens in the refrigerator at 36 degrees F to 46 degrees F.

Review of the facility Medication Storage Policy and Procedure revealed it read: It is the policy of this Community to establish and maintain a safe and effective medication delivery system ....The medication system will support the health and medical care needs of residents on a 24-hour basis. The Community

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will assure that safe medication assistance/administration and treatment systems are in place ...The Executive Director is responsible for ensuring adequate professional oversight of the medication and treatment systems. The medication room or storage space will contain a refrigerator for perishable medications, supportive of the medication delivery system. Refrigerator will be designated for medications only.

Photographic Evidence Obtained.

Class III

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

Based on observation, staff interview, clinical record review and facility policy and procedure review the facility failed to label , , in use, for four residents (#1, #6, #9 and # 11) out of five sampled residents prescribed . . via . . , . . injections.

The findings include:

A medication pass observation was conducted on . . . . . at 12:30 pm with Employee D, medication technician. When she opened top drawer of the medication cart a cardboard box was observed with six . . , . . lying in it. One pen was appropriately labeled with a pharmacy label. The remaining five had no pharmacy label with the resident's name, the dose, expiration date or fill date on them.

Employee D opened another drawer of the medication cart to reveal a bag of , and another box of . . , . . sitting in the drawer. The bag and the box were appropriately labeled. She stated that those pens were not being used yet and she was using the loose pens in the top drawer. She stated they just keep the pens not in use in the cart to store them. When she uses up the one in the top drawer she just takes another one out of the bag or box. When asked how she knows which pen is for which resident, she stated that she just knows which type of . . each resident gets and knows that pen because it is labeled with the brand name of the . . . She confirmed that there are several residents who get the same type of . . and the pens should be labeled individually by the pharmacy so when taken out of the bag or box (that is appropriately labeled) to be used daily, it can be identified correctly. She confirmed that she is not able to tell which pen belongs to which resident if two or more residents use the same brand of . She confirmed she is not the only staff member passing medications at this facility.

During an interview with the Director of Clinical Services on . . . . . at 2:10 pm she stated that the

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can be kept in the medication cart once removed from the bag or box labeled from the pharmacy. She looked at the five pens with no pharmacy label on them and confirmed she was unaware that the in the top drawer had no identifying label on them. She stated she had a small label that was to be applied to each pen when removed from the original bag or box that had the pharmacy label on it. She stated the medication technician that removes the pen should be applying the small label to the individual pen prior to use. She confirmed that if the wrong pen were used on the wrong person that and could be passed from one resident to another resident via the pen.

Review of the Medication Observation Record (MOR) dated through for Resident #1 revealed he received Kwik Injection 100/ML. Orders were to inject per before meals and at bed time, and 15 units before meals and at bedtime.

Review of the MOR for Resident #6 revealed he received Injection Flextouch. Orders were to inject 40 units twice a day 8AM and 8PM.

Review of the MOR for Resident #9 revealed he received Flextouch 100 units/ML. Orders were to inject 40 units daily. He also received Mix per .

Review of the MOR for Resident #11 revealed he received Flextouch 100 units/ML injection. Orders were to inject 30 units twice a day 8AM and 8PM.

Review of the facility Medication Labeling and Orders Policy revealed it read: The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled. If a customized patient medication package is prepared for resident and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and 2. The identification of each medicinal drug in the container.

Photographic Evidence Obtained

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 429.52( ),58A-5.019(1) FAC

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Based on interview and record review, the facility failed to notify the agency of the change of administrator within 10 days.

The findings include:

Review of the Florida Health Finder website on at 8:30am revealed that Employee F was listed as the current Administrator of the facility.

During an interview on at 9:04am with Employee D, a Caregiver, she was asked if Employee F was the Administrator. She stated that Employee F was no longer the Administrator and was now employed as a Caregiver.

During an interview on at 4:15pm with the Director of Clinical Services, she was asked when the Administrator resumed his position as Administrator. She stated, "Oh it's been a while. Over a year ago."

The Administrator confirmed during an interview on at 6:00pm, that he has always been the Administrator because no other staff could pass the test. He also stated that there has not been another Administrator at the facility.

Photographic Evidence Obtained

Class III

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

Based on interview and record review the facility failed to ensure that one of four staff members sampled (Employee E) submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable within 30 days after beginning employment. The facility also failed to document evidence of a negative ( ) examination on an annual basis for two of four employees sampled (the Administrator and Employee F).

The findings include:

Review of the employee record for Employee E revealed a hire date of . An Employee Health Statement was in the file but it did not contain evidence the employee was screened for communicable . The form contained written notification that "no physical examination [was] completed".

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Review of the employee record for the Administrator contained a exam dated . There was no evidence found to show a more recent exam.

During an interview on with the Director of Clinical Services, she confirmed the lack of documentation for Employee E's communicable status.

During an interview on at 4:34pm with the Administrator, he confirmed the test results were out dated.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observations and staff interview the facility failed to provide a safe and decent living environment free of accident hazards when broken tiles, accumulated debris on air vents and fan blades, black biological substance on bathtub grout and a rusted bath grab bar were found in the facility. This has potential to effect all residents of the facility.

The findings include:

During the biennial licensure survey on a tour of the facility was conducted. Broken tiles on the floor, black biological growth on the grout around the bathtub and a rusted grab bar were observed at 9:45 am in the resident bathroom near the main dining room and kitchen. Employee E was observed mopping the floor at 10:00 am with a rag mop and a bucket of mop water. She did not remove the black biological growth on the bathtub grout. Accumulated debris was observed on the ceiling air vent, the air conditioner intake vent and a box fan in a resident's room in the smaller residential building of the facility. Broken tiles were observed in the floor tiles of the main hallway and the ceiling was peeling around the air vent in the smaller residential building of the facility.

During an interview on at 9:21 am with the administrator he stated that the broken tiles in the bathroom next to the kitchen have been broken for about one month as far as he could remember. He was not aware of the rusted grab bar or the black grout. He was not aware of the debris on the air vents and the broken tile in the small building. He stated he has a maintenance worker that he has come in to make repairs when things break or get damaged. The caregivers are responsible for some of the housekeeping chores but not the cleaning of the air vents.

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Photographic evidence obtained.

Class III

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

Based on observation, interview, and record review, the facility failed to maintain records of physician orders for one of 11 residents sampled, Resident #3.

The findings include:

An observation of an concentrator in the room of Resident #3 was conducted on at 11:00am. The machine was in use at the time.

An second observation was made on at 5:20pm of Resident #3 utilizing the concentrator located in his room.

Record review revealed an order for 2L pro re nata (PRN) dated , which was discontinued.

During a telephone interview on at 2:21pm with the physician, he confirmed that he discontinued the . He stated that during his assessment of Resident #3 on "he didn't need the " and therefore the order was discontinued at that time.

During an interview with the Director of Clinical Services, she was asked who ordered the for Resident #3 to which she replied, "I don't know. I'm not sure." When asked for the orders for the she stated "I don't have anything."

Photographic Evidence Obtained.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(&) FS; 58A-5.0241 FAC

Based on staff interviews and record review, the facility failed to report an Adverse Incident to the Agency for Health Care Administration (AHCA) when one of eleven sampled residents (Resident#8) eloped from the facility.

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The findings include:

During an interview on at 11:30 am with Employee E, caregiver, she stated that Resident #8 eloped recently and they had to call the police. The police him because he would not come to the facility.

During an interview on at 11:50 am with Employee D, caregiver, she stated that there have been residents who eloped, the staff went out to look for them and called the police recently for Resident #8.

Review of the Facility Rules read that Residents must sign out/in when leaving and returning to the facility and approximate time of return.

During an interview with the Administrator on at 10:47 am, he stated that Resident #8 did come from the hospital with a on his arm and he was by the sheriff's office. He was not sure of the exact date.

During a telephone interview with Resident #8's Advanced Registered Nurse Practitioner (ARNP) on at 11:00 am, she stated he was on . She stated she was at the facility to see him that morning before he eloped and he was telling her had a job to go to and he was late. He had some thinking. She also confirmed he had a broken after the incident.

During an interview with Resident #8 on at 11:15 am, he confirmed that he had broken his . He held up his left and pointed to his palm.

Review of the ARNP's progress notes received on at 4:30 pm, revealed the ARNP documented that Resident #8 "met me at my vehicle this morning and when I asked him where he was going he told me that he was going to work." It was documented that he was oriented to person and place but thought content/perception were poor, insight/judgement- at times.

Review of Resident #8's Health Assessment form dated revealed he was diagnosed with damage. He required supervision with handling financial and personal affairs. His general wellbeing and whereabouts were to be monitored daily.

During an interview with the Administrator and the Director of Clinical Services on at 5:50 pm, the Administrator stated he did not understand why they should have reported Resident #8's elopement and subsequent to AHCA as an adverse incident. He did not understand why

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when Resident #8 left the property it was considered an elopement. The Director of Clinical Services stated she understood the mandatory requirement for ALF providers to report and investigate.

Review of the facility Elopement Drills policy and procedure revealed "Personal supervision is offered and residents' general whereabouts is known via our facility sign-in/out sheet. Steps were mandated for what to do "when a resident has not complied when leaving our facility by signing out and is then determined missing". Section f of this subsection read "A Day #1 Adverse Incident Report will be completed and submitted to AHCA by the Administrator."

Review of the facility Adverse Incident Reporting Policy showed the "Facility shall ensure that it follows AHCA incident reporting which includes initial incident and full adverse incident. The preliminary adverse incident report required must be submitted within one (1) business day after the incident. 2. Full Adverse Incident Report. For each adverse incident report under subsection (1) above the facility shall submit a full report within fifteen (15) days of the incident."

Review of the sign out/in logs provided by the facility revealed no evidence that Resident #8 signed out according to the facility's policy and procedure when he left on .

Photographic Evidence Obtained

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record review and interview, the facility failed to maintain complete and up to date contracts for 13 of 20 residents sampled who are receiving services in the facility (Residents #1, #5, #6, #7, #10, #11, #13, #14, #15, #16, #17, #18 and #19). Additionally the facility failed to ensure the resident contract stated that the resident or the resident's representative would receive a refund within 45 days of discharge, transfer or . . . . for 2 of 20 residents, Resident #2 and Resident #3.

The findings include:

1. Records were requested on . . . . and received on . . . . for review.

Review of resident records revealed contracts for Residents #1, #5, #6, #7, #10, # 11, #15, #16, #17, #18 and #19 contained contracts that listed an end date for room and boards services which occured in the past. There were no contracts on file executed after the end date of the contracts for these residents.

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The record review also revealed that the contracts for Residents #13 and #14 were missing the monthly rate for services provided.

During an interview on at 2:18pm with the Director of Clinical Services she was asked if the contracts that were provided to the surveyors onsite were all the contracts available for the current residents. She replied; "I believe so." She was asked if the contracts provided were the most recent for all of the current residents. She confirmed. She was then asked if there were any new contracts or if any changes or updates had been made to the contracts provided. She replied that "I don't make any changes, everything stays the same as far as their rate."

2. Review of the contract for Resident #2 dated revealed no statement that the resident would receive a refund within 45 days of discharge if a refund were due.

Review of the contract for Resident #3 dated revealed no statement that the resident would receive a refund within 45 days of discharge if a refund were due.

During an interview with Employee C, assistant manager, on at 1:25 pm. She reviewed the contracts of both Resident #2 and #3 and stated that she was unaware that the contract did not state that the facility must give the resident a refund within 45 days of discharge, transfer or . She stated that recently the facility changed the contract and she was sure the old one had the refund statement in it.

During an interview on at 5:50pm with the Administrator and Director of Clinical Services, the Administrator stated that Employee C had informed him that the contracts for Residents #2 and #3 do not state that a refund will be given to the resident or the resident's representative within 45 days of discharge, transfer or . He stated he was unaware that the new contracts did not contain this statement.

Photographic Evidence Obtained

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on facility document review, observation and staff interview the facility failed to resubmit its Emergency Environmental Control Plan (EECP) for approval following changes; failed to ensure policies and procedures were developed for staff to use in the event of power failure; failed to store fuel onsite;

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failed to ensure written notification of the plan was provided to residents; and failed to install monoxide detectors. This has the potential to affect all current residents in the event of power loss.

The findings include:

Review of the EECP approved plan submitted to AHCA revealed the facility's plan for power outage is to provide emergency power with a fixed generator that would cool 3700 square of space (the entire facility). A letter from the county's emergency management agency was dated approving the plan.

A tour of the outside grounds of the facility on revealed no fixed generator on site.

Review of the EECP plan provided by the administrator on revealed the facility's plan is to have a portable generator that runs on gasoline to provide emergency electricity to the facility during power outages. The generator would cool 1500 square , run a portable air conditioning unit, two table lamps, six four speed fans and an 18 cubic refrigerator.

During an interview with the administrator on at 4:30 pm, he stated that the EECP plan he provided on was not approved by AHCA or the local emergency management agency, and is not the same as the plan he sent in and was accepted. He confirmed there was no monoxide detector or fuel stored on site, and was unaware of these requirements. He stated he had not notified the residents or the residents' legal representatives in writing of the implementation of the EECP. He had not developed a policy and procedure for use of the EECP.

Photographic Evidence Obtained

Class III

Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on facility document review, observations and staff interviews the facility failed to maintain the licensed capacity of 24 residents when 25 residents were found to be residing in the facility.

The findings include:

During the biennial licensure survey on , Employee D, caregiver, was asked for a list of current residents at 9:05 am. She went to the Medication Record binder lying on top of the medication

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cart, opened it and produced a sheet of paper numbered from 1 through 26 with each resident's name on it. She was asked if all of these residents did indeed live at this facility. She stated yes, and there was one resident (#12) out at the hospital.

Review of the posted license in the entry way of the main building of the facility revealed the facility had a capacity of 24. Review of the admission/discharge log revealed twenty five residents currently residing in the facility. The last resident admitted was Resident #13 on .

A list of all residents with their room numbers was provided. The list had 25 residents on it.

From to , 25 of the residents were observed at various times. Resident #12 had belongings at the facility but was hospitalized during the observations.

Review of the Medication Observation Records for all residents revealed 26 residents received medication during the months of , and , . Contracts were reviewed for all 26 people listed.

During an interview with the Administrator on at 4:30 pm. He stated that all 26 of the people on the list provided, did live at the facility. Resident #12 was also residing there before his hospitalization. He confirmed that on /0219 there were 25 residents physically present at the facility. He confirmed the licensed capacity of the facility is 24.

Photographic evidence obtained.

Unclassified