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	AL11965169	02/05/2019
NAME OF PROVIDER OR SUPPLIER **ATRIA PORT ST LUCIE**	STREET ADDRESS, CITY, STATE, ZIP CODE **9825 S. U.S. HIGHWAY 1** **PORT SAINT LUCIE, FL 34953**	

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0000 - Initial Comments

An unannounced Relicensure survey was conducted on - at Atria Port St Lucie, License #9628. The facility had deficiencies identified at the time of the survey.

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

Based on interview and record review, it was determined the facility failed to ensure each resident's current health assessment (1823 form) was complete and accurately reflected the resident's status, for 1 of 2 sampled resident records reviewed (Resident #14).

The findings included:

1) During interview and review of Resident #14's current health assessment (dated) with the (Resident Services Director), on at 10:30 AM, she acknowledged the following sections were blank:

a. Physical or Sensory Limitations
b. Nursing/Treatment/ Services Required
c. Health Care Provider's telephone number
d. Health Care Provider's address

2) During a review of Resident #2's health record, including the resident's Health Assessment (AHCA Form 1823) dated , it was noted that Resident #2's current Health Assessment did not reflect the following:

1) Resident #2 was receiving Hospice services;
2) Resident was ordered and receiving a modified mechanical soft diet;
3) Resident was on precautions;
4) Resident #2 was not Total Assist for many of her ADLs.
5) Section 3: "Services Offered or Arranged by the Facility for the Resident" had not completed by the facility.

During interview with the Administrator and Resident Services Director on at 2 PM, they acknowledged the need to update the resident's Health Assessment (AHCA Form 1823) to accurately reflect the current health status of Resident #2.

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Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation, interview, and record review, it was determined the facility failed to ensure the following;
a) failed to post in full view in a common area that is accessible to all residents in Assisted Living and Memory Care Unit the required telephone numbers for staff, residents and resident's family. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.

b) failed to provide each resident with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d) and for facilities with a licensed capacity of 17 or more residents in which residents do not all have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside for 1 of 1 residents observed receiving a call that was not private (Resident #2).

c) failed to perform health care services in accordance with established and recognized standards within the community, specifically related to failure to wash/sanitize during medication observations conducted on .

The findings included:

1) During initial observational tour of Assisted Living and Memory Care Unit conducted with Staff F, one beginning at 7:50 AM, she was asked where the required telephone numbers were posted. She pointed out the Ombudsman poster that was located next to the mailboxes in Assisted Living. She stated she was not aware of the requirement to post any other telephone numbers. Staff F was then asked if all residents of this facility had their own telephones. She replied that they did not. She was asked the location of telephones on both floors of Assisted Living and in the Memory Care Unit where residents had unrestricted access to make a private telephone call. Staff F replied the receptionist's phone and there is a land line phone in the kitchen in Memory Care. She asked the Community Business Director to join us, on at 8:10 AM, and if she was aware of the location of the mandatory telephone numbers. She too pointed out the Ombudsman poster next to the mail boxes. The Community Business Director asked the Maintenance Director to join this observation and conversation. The Maintenance Director arrived on at 8:20 AM. He was asked if he was aware of the location of the mandatory posting of telephone numbers in Assisted Living and in Memory

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Care. He replied we have the Ombudsman poster in Assisted Living by the mailboxes. He was asked how the facility provides unrestricted access for residents to have a private telephone conversation in Assisted Living and in Memory Care. He replied there is a land line at the reception desk and all a resident has to do is ask to use the phone and that there is a land line telephone in the kitchen and in the medication room in Memory Care. Staff F confirmed the medication room in Memory Care is locked and residents do not have independent access to this land line telephone. She was asked if a resident would be left alone in the medication room to receive or make a private telephone call. She confirmed that staff have to be present because medications are kept in this room.

During observation conducted in the Memory Care dining room, on . . . . . beginning at approximately 11:30 AM, Resident #2 was brought to the kitchen counter so she could receive a telephone call. She stood at this counter and utilized the land line, from the kitchen, while approximately 7 other residents were eating or being served their lunch meal. Review of Resident #2's Resident Orientation Move-In Checklist noted an explanation and review of Resident Rights was conducted on .

2) Review of the facility's policy entitled Handwashing, indicated employees must wash their before and after having direct physical contact with residents and after removing gloves. This policy also notes handwashing in an extremely important factor in preventing the transmission of .

During medication observation conducted in Memory Care with Staff F, on beginning at approximately 11:53 AM, she was observed to provide Resident #9 with . . . . . 1gm and , -Levo ER 50-200. Staff F was not observed to wash or sanitize prior to or after the provision of these medications.

During medication observation conducted in Memory Care with Staff F, on . . . . . beginning at approximately 12:00 PM, she was observed to provide Resident #10 (in his room) with Diclopenac Sod 1% gel apply 4gm to (. . . . .) "affected area." Staff F was not observed to wash or sanitize prior to or after the application of this gel (gloves were worn). Staff F returned to the medication room and made a telephone call.

The medication room in Memory Care does not contain handwashing facilities. It only has a sanitizer dispenser mounted on the wall. However, this was not utilized during this medication observation by Staff F.

During interview conducted with the ED (Executive Director) on . . . . . beginning at approximately 1:45 PM, she acknowledged she was aware the medication room in Memory Care does not have any

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handwashing facilities.

Class III

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

Based on observation, record review and staff interview, the facility failed to ensure unlicensed staff who provided assistance with self-administration of medication followed regulatory requirements and facility control policy and procedures during the distribution of medications to 3 of 3 residents (Residents #13, #15, and #16).

The findings included:

1) On beginning at 8:04 AM, Staff B was observed providing the following assistance with self administered medications to Resident #13:
a) Staff B did not wash her prior to assisting this resident;
b) Staff B removed medication packets from the locked medication cart;
c) Staff B compared the Medication Observation Record (MOR) with the medication label
d) Staff B initialed the medications on the MOR prior to giving the medications to the resident.
e) While standing with her towards the resident while at the medication cart, Staff B removed the medication from the labeled package and placed the pills into a small med cup;
f) Staff B took the medication cup over to the resident and handed it to the resident;
g) Staff B did not notify this resident of any of the medications being provided.
h) Staff B observed the resident swallow the medications;
i) Staff B, then, donned disposable gloves without washing or sanitizing her , and removed a patch from its package;
j) Staff B initialed the patch and the notified resident she was going to place his "patch".
k) Staff B placed the patch on the right side of Resident's .
l) Staff B removed her gloves but did not wash or sanitize prior to assisting the next resident.

2) Staff B was observed providing the following assistance with self administered medications to Resident #15:
a) Staff B did not wash her prior to assisting this resident;
b) Staff B removed medication packets from the locked medication cart;
c) Staff B compared the Medication Observation Record (MOR) with the medication label
d) Staff B initialed the medications on the MOR prior to giving the medications to the resident.
e) While standing with her towards the resident while at the medication cart, Staff B removed the

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medication from the labeled package and placed the pills into a small med cup;
f) Staff B took the medication cup over to the resident and handed it to the resident;
g) Staff B did not notify this resident of any of the medications being provided.
h) Staff B observed the resident swallow the medications;
i) Staff B did wash her after assisting this resident.

3) Staff B was observed providing the following assistance with self administered medications to Resident #13:
a) Staff B did not wash her prior to assisting this resident;
b) Staff B removed medication packets from the locked medication cart;
c) Staff B compared the Medication Observation Record (MOR) with the medication label.
d) Staff B initialed the medications on the MOR prior to giving the medications to the resident.
e) While standing with her towards the resident while at the medication cart, Staff B removed the medication from the labeled package and placed the pills into a small med cup;
f) Staff B took the medication cup over to the resident and handed it to the resident;
g) Staff B did not notify this resident of any of the medications being provided.
h) Staff B observed the resident swallow the medications;
i) Staff B did not wash/sanitize her after assisting this resident.

Per state regulation, Staff assisting with the self-administration of medication must:
(a) Take the medication, in its previously dispensed, properly labeled container, and bring it to the resident.
(b) In the presence of the resident, read the label, open the container, remove a prescribed amount of medication from the container, and close the container.
State Regulation also specifies all trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.

The facility's policy regarding Assistance with Self-Administered Medication documents:
"Compare prescription label to the MOR no less than three times"
"Wash - Soap and water or sanitizer between each assistance."

On at 2 PM, the Administrator and Resident Services Director acknowledged Staff B did not follow the proper procedure when providing assistance with self-administered medications.

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

Based on observation, interview, and record review, it was determined the facility failed to ensure that each resident's MOR (Medication Observation Record) was immediately updated each time a medication is offered or administered for 6 out of 7 residents observed for medications (Resident #9, Resident #10, Resident #11, Resident #13, Resident #15, and Resident #16).

The findings included:

1) Review of the facility's policy related to Standard Times of Medication Administration indicated medications are to be noted on the MAR/MOR (Medication Administration Record/Medication Observation Record) and initialed after ingestion is observed.

During observation of Staff F providing medications to Resident #9 and Resident #10 on [redacted], and of Resident #11 on [redacted], she was observed to initial the MAR/MOR prior to providing these residents with their medications. During interview conducted with Staff F, on [redacted] beginning at approximately 8:20 AM, she could not provide an explanation as to why she initials the MAR/MOR prior to the resident's consumption of their medications.
2) Staff B was observed providing the following assistance with self administered medications to Residents #13, #15 and #16:

a) Staff B removed medication packet for the Resident from the locked medication cart;
c) Staff B compared the Medication Observation Record (MOR) with the medication labels.
d) Staff B initialed the medications on the MOR prior to giving the medications to the resident.
e) Staff B removed the medications from its package and placed them a small plastic medication cup;
f) Staff B handed the medications to the Resident and observed the Resident take the medications.

Class III

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

Based on interview and record review, it was determined the facility failed to ensure each resident's medication orders were promptly and accurately documented in the resident's medication observation record, for 1 of 3 residents observed related to medications (Resident #10).

The findings included:

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During medication observation conducted with Staff F for Resident #10, on [redacted] beginning at approximately 12:00 PM, Staff F applied Diclopenac Sod 1% gel to both [redacted]. Upon review of the medication label, Medication Observation Record; and order, they all indicated to apply Diclopenac Sod 1% gel apply 4gm to "affected area" LE (lower extremity) 4 times daily. Staff F was asked how she knew the location of the "affected area" on the lower extremity. She shrugged her [redacted] and stated she just knew. She acknowledged the "affected area" should be more specifically identified.

Class III

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

Based on employee record review and staff interview, the facility failed to ensure 1 of 4 sampled staff obtained a statement from a health care provider documenting the individual does not have any signs or symptoms of communicable [redacted] (Staff C).

The findings included:

On [redacted], during a review of Staff C's personnel file (hire date [redacted]), no documentation could be found showing evidence of a statement from a health care provider verifying that Staff C does not have any signs or symptoms of any communicable [redacted] ( ).

A request for documentation of health statement was made to the Community Business Director on [redacted] at approximately 1:00 PM. No further documentation was provided at the time of the survey.

On [redacted] at 2:00 PM, the Administrator acknowledged the Health Statement was missing from Staff C's personnel file.

Class III

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

Based on interview and record review, it was determined the facility failed to ensure that staff who provide direct care to residents, other than nurses, CNAs or home health aides had documentation of receiving 3 hours of inservice training within 30 days of employment that covers the following subjects: Resident behavior and needs and Providing Assistance with Activities of Daily Living for 1 of 2 sampled direct care staff that were not CNAs, etc. (Staff B).

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The findings included:

During interview and personnel record review conducted with the CBD (Community Business Director), on beginning at approximately 11:15 AM, she was provided the opportunity to locate 3 hours of inservice training on Resident behavior and needs and Providing Assistance with Activities of Daily Living for the following direct care staff member:

1) Staff B: date of hire noted as

The CBD was not able to locate this required training documentation for the above noted staff. She stated when the new company purchased this building that the former company took the employee files.

Class III

0092 - Food Service - General Responsibilities - 58A-5.020(1) FAC

Based on observations, record review and staff interview, the Food Designee failed to ensure food is served in a safe and sanitary manner for Residents in the Memory Care Unit;

The findings included:

On during observation of the lunch meal in the Memory Care Unit, care staff assisting with the passing of meals were noted to bring 2 plates of food to each resident, each plate containing the entree choices for that day. The plates were held close to the residents so the resident was able to see each food item clearly. After the resident indicated which entree they wished to have, the plate not chosen was taken to the kitchen and another sample plate with the 2nd entree choice was picked up and brought out to a different resident. These sample entrees were often displayed before several residents, uncovered, allowing for potential contamination from resident to resident.

On during lunch observation in the Memory Care Unit, the care staff assisting with meals were not seen performing appropriate handwashing or using sanitizers between resident contact. One staff member assisting a resident to the bathroom, was seen exiting the bathroom with wet , as paper towel dispenser in the public restroom located in the Memory Care Unit off from the Dining Room was not dispensing the paper towels. The Care Staff did not re-wash and dry her upon leaving the bathroom.

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Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, interview, and record review, it was determined the facility failed to provide food at safe temperatures, specifically related to opened and unrefrigerated pudding product that is made with milk, during medication observation conducted on .

The findings included:

During medication observation and interview conducted with Staff F, on at approximately 11:53 AM, this staff member placed Resident #9's 1gm and -Levo ER 50-200 in a couple of spoonfuls of vanilla pudding that was obtained from an opened and unrefrigerated (also not kept cool by any means) single serving package. Staff F was asked if this single serving package of vanilla pudding had been refrigerated after opening and when it was opened. Staff F acknowledged this same package was opened this morning during the provision of medications to Resident #9 (as this is her own pudding). She also acknowledged it is not and has not been refrigerated. She then proceeded to conduct a search on the Internet for this brand of single serve puddings. The search revealed once the package is opened it is to be refrigerated (as it contains milk). (Picture of search obtained).

Class III

0094 - Food Service - Food Hygiene - 58A-5.020(3) FAC

Based on interview and record review it was determined the facility failed to maintain copies of inspection reports issued by the county health department for the last 2 years pursuant to Rue 64E-12.004 or Chapter 64E-11, F.A.C., as applicable on file in the facility for 2017 & 2018.

The findings included:

During interview with the ED (Executive Director), conducted on beginning at approximately 1:00 PM, she acknowledged the last Department of Health Sanitation Inspection was in 2017, therefore an annual inspection was not conducted in 2018. She did not produce the inspection from 2017 for review. The ED initially stated corporate was to track when inspections were due. Then she stated the Department of Health Inspection for 2018 was paid for but not conducted due to extenuating circumstances of the inspector.

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Class

0160 - Records - Facility - 58A-5.024(1) FAC

Based on interview and record review, it was determined the facility failed to maintain documentation of annual Fire Inspections (per 429.41 FS) and annual Department of Health Sanitation inspections (per 64E-11.013) that were readily available in electronic or paper format.

The findings included:

During interview with the ED (Executive Director), conducted on . . . . . beginning at approximately 1:00 PM, she acknowledged this facility had not received its annual Fire Inspections for 2018 (last inspection was dated . . . . .). She also acknowledged the last Department of Health Sanitation Inspection was in 2017, therefore an annual inspection was not conducted in 2018. She did not produce the inspection from 2017 for review. The ED initially stated corporate was to track when inspections were due. Then she stated the Department of Health Inspection for 2018 was paid for but not conducted due to extenuating circumstances of the inspector.

Class

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on interview and record review, it was determined the facility failed to maintain a copy of the employment application with references furnished for 2 of 3 staff sampled records (Staff A and Staff B).

The findings included:

During interview and personnel record review conducted with the CBD (Community Business Director), on . . . . . beginning at approximately 11:15 AM, she was asked for employment applications with references for the following staff:

1) Staff A: date of hire noted as
2) Staff B: date of hire noted as . . . . . .

The CBD was not able to locate employment applications with references furnished for the above noted staff. She stated when the new company purchased this building that the former company took the employee files.

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Class

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

Based on interview and record review it was determined the facility failed to obtain a copy of documentation of the , , of a health care proxy; guardian; health care surrogate; or the existence of a power of attorney for 1 of 1 sampled residents whose family member signed the admission paperwork (Resident #14).

The findings included:

During review of Resident #14's Residency Agreement/Contract (dated and signed by resident's son) and interview with the ED (Executive Director), on beginning at approximately 10:00 AM, the ED was asked for a copy of the documentation of , , of health care proxy/surrogate/power of attorney/guardian. She could not locate this documentation. She stated the son is in the process of getting that documentation. The ED did not provide an explanation as to why Resident #14 did not sign her own Residency Agreement/Contract. Review of Resident #14's record indicated she has been assessed to administer her own medications.

Class III