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	AL11932678	**03/05/2019**
NAME OF PROVIDER OR SUPPLIER **SWEET WATER AT LARGO**	STREET ADDRESS, CITY, STATE, ZIP CODE **11290 WALSINGHAM ROAD** **LARGO, FL 33778**	

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0000 - Initial Comments

Assisted Living Facility

A Complaint Survey (CCR#: 2019000229 and 2019000961) was conducted at Sweet Water at Largo Assisted Living Facility on . Sweet Water at Largo Assisted Living Facility had deficient practice identified at the time of the survey.

(License#: 8175)

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

Based on observation, interview and record review, the Facility failed to provide required supervision and oversight of residents by failing to ensure at least one staff member was awake at night for a census of 43 residents, failed to maintain records which contained documentation of illnesses, , significant changes-in-condition, and treatments required for the residents and failed to notify residents' Health Care Providers and Responsible Parties (RP) as required with significant changes as required.

Findings Included:

During an observation of Staff A, conducted on at 05:05am, Staff A opened the front door of the facility for an unannounced survey. Staff A appeared half-awake as the staff's , were not open all the way; the staff was hugging self; and, the staff's hair was disheveled. Staff A appeared as if the staff had just woken up. Upon entry tour, observed to the right of the entry and down the hall, there was a sitting room with two couches and both couches had blankets on them with one person lying on one of the couches wrapped in a cream-colored blanket. When the person woke up, that person identified themselves as a staff person (Staff B).

A record review for Resident #1, conducted on , revealed that Resident #1 was admitted in to the Facility on . Resident #1's Health Assessment Form dated indicated that the resident was independent with eating and required assistance with ambulation, bathing, , grooming, toileting, transferring, and medications. Resident #1 had an Emergency Department (ED) visit report in the resident's record that stated that the resident visited the ED on at 11:55am for a , hematoma, injury, and mechanical Resident #1's Progress Notes also indicated that Resident #1 had a on . A review of facility reports did not have a corresponding report for the but did record a on which was not noted in the resident's record. There was no documentation regarding of any intervention/prevention measures

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implemented to prevent Resident #1's reoccurrence.

A record review for Resident #7, conducted on , revealed that Resident #7 was admitted in to the Facility on . Resident #7's Health Assessment Forms dated and stated that the resident had a to the resident's . Resident #7's Health Assessment Form stated that the resident was forgetful. Resident #7's Health Assessment Form stated that the resident was independent with eating but required assistance with ambulation, bathing, , grooming, toileting, transferring, and medications. Resident #7's diet was not noted and the resident had no orders for a diet type in the resident's record. Resident #7 required daily oversight for wellbeing, whereabouts, and reminders for important tasks. The Facility had no care or service plans in place to meet Resident #7's needs. There was no documentation in Resident #7's regarding the condition changes of the . An incident report reviewed that stated that Resident #7 on at 12:00pm with no documented notifications to the resident's health care provider or responsible party. There was no documentation regarding Resident #7's or intervention/prevention measures implemented to prevent reoccurrence.

A record review for Resident #16, conducted on , revealed that Resident #16 was admitted in to the Facility on . Resident #16's Health Assessment Forms dated that the resident required precautions and supervision with bathing, , grooming, toileting, and transferring; and assistance with ambulation and medications. The Health Assessment Form had no diet noted and there were no orders in the resident's record for the type of diet Resident #16 required. Resident #16 required daily oversight for wellbeing, whereabouts, and reminders for important tasks. A review of incident reports revealed that Resident #16 had a on at 10:30am in which the resident sustained a injury specifically a "raised area above the resident's right on her forehead with , scrape, and ". There was no evidence that Resident #16's Health Care Provider was notified and there was no documentation as to whethermedical treatment was sought for Resident #16's injury. Another facility incident report dated at 09:50am indicated Resident #16 was "observed on the floor". There was no date or time that the Health Care Provider or Responsible Party was notified. There was no documentation regarding of any intervention/prevention measures implemented to prevent Resident #16's reoccurrence.

A record review for Resident #17, conducted on , revealed that Resident #17 was admitted in to the Facility on . Resident #17 was admitted to Hospice services on an unknown date. There was no Hospice admission form in Resident #17's record. There was no Interdisciplinary Care Plan for the provision of service that Hospice provided and those that the Facility provided to the resident. Resident #17's Health Assessment Form dated stated that the resident was independent with all Activities of Daily Living and required assistance with medications. Resident #17's Health Assessment

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Form stated that the resident was at times "weak". Resident #17 required daily oversight for wellbeing, whereabouts, and reminders for important tasks. A review of incident reports revealed that Resident #17 had a at 05:30am (no date noted) where the resident slipped and lost balance and on bottom. There were no documented notifications to Resident #17's Health Care Provider or Responsible Party. There were no steps noted to prevent reoccurrence. There was no documentation in Resident #17's of the decline in the resident's condition that ultimately led to the resident's admission to Hospice services.

A record review for former Resident #26, conducted on , revealed that Resident #26 was admitted in to the Facility on and discharged from the Facility due to " ". Resident #26's Health Assessment Form dated stated that the resident required supervision with eating and assistance with ambulation, bathing, , grooming, toileting, transferring, and medications. Resident #26's Health Assessment Form stated that the resident had history of from , had , . . Resident #26 required daily oversight for wellbeing, whereabouts, and reminders for important tasks. There was no documentation in Resident #26's of the decline in the resident's condition that ultimately led to the resident's .

A record review for former Resident #27, conducted on , revealed that Resident #27 was admitted in to the Facility on and discharged from the Facility due to " ". Resident #27 was admitted to Hospice services on an unknown dated. There was no Hospice admission form in Resident #27's record. There was no Interdisciplinary Care Plan for the provision of service that Hospice provide and those that the Facility provided to the resident. Resident #27's Health Assessment Form dated stated that the resident required supervision with eating and assistance with ambulation, bathing, , grooming, toileting, transferring, and medications. . Resident #27 required daily oversight for wellbeing, whereabouts, and reminders for important tasks. The Facility had no care or service plans in place to meet Resident #27's needs. There was no documentation in Resident #27's of the decline in the resident's condition that ultimately led to the resident's .

During an interview with the Facility Manager, conducted on at 05:38am, the Facility Manager stated that "it was unacceptable" for staff to sleep on duty at the Facility. At 10:55am, the Facility Manager acknowledged and confirmed that Residents #1, #7, #16, #17, #22, #26, and #27's records did not contain documentation of all changes-in-condition, , interventions/prevention measure to prevent reoccurrences, and all notification to residents' health care providers or responsible parties. The Facility Manager stated that the Facility does not currently have a policy and procedures. The Facility Manager stated that the Facility does not currently have a program in place for residents at risk for or need precautions. The Facility Manager stated that Resident #27 was admitted from the Hospice House and requested to go due to "a lot of , " and that the resident expired at the Hospice House. The Facility Manager confirmed that Resident #27's record had no documentation

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regarding "a lot of ".

Class III

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

Based on observation, record review, and interview, the Facility failed to treat residents with respect and failed to provide a safe living environment by providing requested assistance with medication.

Findings included:

During an observation of the medication pass with Staff C for Resident #23, conducted on at 07:25am, Resident #23 asked Staff C to break the Extended Release 30MEQ pill in half Staff C stated, "No, you have to swallow it". Resident #23 swallowed all the pills except for the and began attempting to break the pill in half. Staff C pointed at the pill and stated, "You have to swallow that". Resident #23 stated, "I can't". Resident #23 worked at breaking the pill a little while longer. When the pill broke in half, Resident #23 stated, "Now I can swallow it" and swallowed the med. The pill was scored and able to be broken in half by Staff C.

During an interview with Resident #21's Responsible Party (RP), conducted on at 09:15am, Resident #21's RP stated that on the RP observed Staff F yelling at Resident #16 to reach for the resident's walker. When Resident #16 did not reach for the walker, Staff F "threw the walker at [Resident #16] and walked away". Resident #21's RP stated that, "a few Saturdays ago (no date given) [Staff E] was in the dining room ...yelling at one of the residents (no name provided) because they did not want to eat [and Staff E] started to force feed the resident".

During an interview with the Facility Manager (FM), conducted on at 07:15am, the FM stated that on that "two staff [Staff E and F) were taken off the schedule."
At 10:55am, the FM stated that Staff C did not inform the FM that Resident #23 had difficulty swallowing the prescribed medication and agreed that there were other easier to swallow forms of available from the Pharmacy. The FM stated that it "was unacceptable" for Staff C not to assist Resident #23 and break the in half or to notify the Facility Manager or other staff of the need for a different form of the medication. The Facility Manager stated that, " is scored and can be broken in half".

During an interview with the Owner, conducted on at 07:41am, the Owner stated that the Owner was called in to the Facility on related to the "cook was rude and would not make a

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sandwich for [Resident #21's] RP and that two employees [Staff E and F] had been mistreating the residents" and that [Staff E and F] were sent home per investigation".

Class III

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

Based on observation and interview, the Facility failed to compare the medication (med) labels to Medication Observation Records (MORs); failed to read medication labels out loud to residents; failed to remove medications from their original container (bubble packages) in front of residents and failed to follow safe control standards.

Findings Included:

During an observation of the medication (med) pass with Staff A, conducted on at 06:25am, Staff A obtained the 7.5mg for Resident #18. Staff A popped the pill out the med pack into a soufflé cup, at the medication (med) cart, which was parked by the medication desk down the hall from Resident 18's room. Staff A brought the soufflé cup and water into Resident #18's room. Resident #18 was asleep when Staff A entered and called the resident's name six times before the resident woke up. Staff A handed the med to Resident #18 and stated, "I have your 06:00am med". Resident #18's 7.5mg was not a scheduled med for the resident and was an "as needed" med for the resident so the resident would have to request the med. There was no evidence that Resident #18 requested the "as needed" Staff A did not compare Resident #18's med label to the MORs and Staff A did not read the med label to the Resident. Staff A did not wash or sanitize their before or after med pass.

During an observation of the med pass with Staff C, conducted on at 07:19am, Resident #4 requested a med from Staff C. Staff C walked out of the dining room and down the hall to another med cart leaving MORs in the dining room. Staff C obtained 325mg and popped out two pills out of the med card in to a soufflé med cup and returned to the dining room where Resident #4 was waiting. Staff C handed the soufflé cup and water to Resident #4 and stated, "here's your med". Staff C did not compare Resident #4's med label with the resident's MORs. Staff C did not read the med label out loud to Resident #4. Staff C did not wash or sanitize before or after assisting Resident #4 with meds. At 07:25am, Staff C popped pills out of med cards in to a soufflé cup for Resident #23. The pills included Resident #23's prescribed meds 40mg, 1000mcg, 150mg, Extended Release 20MEQ, 25mg, 5mg, and 100mg. Staff C picked up the soufflé cup and water and walked out of the dining room and down the hall

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to Resident #23's room. Staff C woke Resident #23 up and stated, "I got your medicine okay". After Resident #23 swallowed the meds, Staff C assisted Resident #23 in to a standing position and with a walker. Staff C then returned to the dining room, placed trash in the trash receptacle, and continued with the med pass and preparation for the next resident. Staff C never washed or sanitized during or after the med observation. Staff C did not compare Resident #23's med label with the resident's MORs. Staff C did not read the med labels out loud to Resident #23.

During an interview with the Facility Manager, conducted on , the Facility Manager agreed that while assisting residents with meds that med labels should be read to the residents and the pill should be popped out of the med card/bubble package in front of the residents. The Facility Manager stated that Medication Technicians should wash their before and after assisting residents with meds and sanitizing their in between residents.

Class III

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

Based on observation, interview, and record review, the facility failed to maintain accurate Medication Observation Records (MORs) for residents; failed to immediately update resident MORs when medications were offered to residents; and failed to have a system in place for accurate documentation of assistance with self-administration of medications (meds).

Findings Included:

A review of the Facility's medication documentation process, conducted on , revealed that the Facility had two systems in place for the documentation of assisting residents with medications (paper MORs and electronic MORs).

A review of the paper MORs records for Residents #2, #8, #9, #13, #14, #15, and #20, conducted on , revealed that Residents #2, #8, #9, #13, #14, #15, and #20's paper MORs had medication not documented as given and had medications documented as given in advance of assisting the residents with self-administration of medication, which included:
- Resident #2's MORs had the prescribed medications , 10mg and , DR 20mg already documented as given on for at 06:00am.
- Resident #8's MORs had all 08:00am medications due on already signed as given at 05:40am.
- Resident #9's MORs had the prescribed medications , 10mg and Extended

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Release not documented as given on and at 08:00am. All of Resident #9's medications due on 08:00am were already signed as given at 05:40am.
- Resident #13's MORs had the prescribed medications 40mg and 3.125mg not documented as given on and at 09:00am. All of Resident #13's medications due on at 08:00am were already signed as given at 05:40am.
- Resident #14's MORs had the prescribed medication 3.125mg not documented as given on , , and at 08:00pm.
- Resident #15's MORs did not include the resident's prescribed as a prescribed medication.
- Resident #20's MORs had all of the resident's medications due on at 08:00am already signed as given at 05:40am.

During an interview with the Facility Manager, conducted on at 05:45am, the Facility Manager acknowledged and confirmed that Residents #2, #9, #13, and #14's paper MORs had medications not documented as given for the aforementioned medications, dates, and times. The Facility Manager acknowledged and confirmed that Residents #8, #9, #13, and #20's paper MORs had medications already signed as given and the medication were not due. The Facility Manager acknowledged and confirmed that Resident #15's paper MORs did not include the residents prescribed . The Facility Manager stated that the Facility was currently "in transition from paper MORs to electronic MORs [and] the paper MORs were for Medication Technicians that had not had the training [for the electronic MORs and] they should be using the electronic MORs system."

A review of the electronic MORs records Residents #2, #8, #9, #11, #14, and #20, conducted on , revealed that Residents #2, #8, #9, #11, #14, and #20's electronic MORs had medication not documented as given and missing required data, which included:
- Resident #2's MORs did not include the resident's diagnoses, the Pharmacy, the Primary Care Physician (PCP), and the PCPs phone number.
- Resident #8's MORs had the prescribed medication not documented as given on at 11:00pm.
- Resident #9's MORs had the prescribed medication not documented as given on at 11:00pm.
- Resident #11's MORs had the prescribed medication 88mcg not documented as given on and at 06:00am
- Resident #14's MORs had the following prescribed medications not documented as given:
  - o , 81mg not documented as given on at 06:00am
  - o 3.125mg not documented as given on
  - o 1mg not documented as given on at 10:00am

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o 750mg not documented as given on at 10:00am
o 5mg not documented as given on at 06:00am
o 1000mcg not documented as given on at 06:00am
- Resident #17's MORs did not include the resident's diagnoses, the Pharmacy, the Primary Care Physician (PCP), and the PCPs phone number. Resident #17's MORs had the prescribed medication Methadone 10mg not documented as given on at 08:00am
- Resident #20's MORs did not have a dose level for the Resident #20's prescribed medications and , Extended Release.

During an interview with the Facility Manager, conducted on at 10:55am, the Facility Manager acknowledged and confirmed that Residents #8, #9, #11, and #14's electronic MORs had medications that were not documented on their electronic MORs. The Facility Manger acknowledged and confirmed that Residents #2 and #17's electronic MORs had missing required data, which included the residents' diagnoses, Physician, Physician telephone number, and Pharmacy. The Facility Manager acknowledged and confirmed that Resident #20's prescribed and , did not have a dosage of these medications.

Class III

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

Based on observation, record review, and interview, it was determined that the Facility failed to ensure that only a licensed or registered Pharmacist transferred medication from one storage container to another storage container for one (#15) of one medication reviewed; failed to ensure residents' medications were filled, or refilled, in a timely manner for three (#15, #17 and #21) of three records reviewed; and, failed to ensure that residents who required assistance with self-administration of medications received their medications as ordered by their Health Care Provider.

Finding Included:

During an observation of Staff A, conducted on at 05:15am, Staff A walked up to the medication (med) cart with a garbage bag half full of trash and opened the top right drawer of the med cart. Staff A took out a stack of soufflé med cups and threw them in the garbage bag. Staff A dropped one small white pill on the floor and hurriedly walked away. Staff A stated that the staff had already passed the 06:00am meds and only had one to two residents left. When Staff A returned to the med cart, when asked, Staff A stated that it was not pre-popped meds that the staff threw away but "it was my trash" from the med pass. Staff A did not respond when asked why trash was placed inside the med

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drawer instead of the trash receptacle. The small white pill that appeared consistent with the medication in size, shape, and color.

During an observation of Resident #15, conducted on at 05:50am, Resident #15 wheeled up to the med desk and stated, "I need my 06:00am " and repeated this statement three times. When Staff A approached, Resident #15 stated to the staff, "I didn't get my ".

At 06:25am, Staff A obtained the 7.5mg for Resident #18 and brought the pill to the sleeping resident. Staff A called the resident's name six times before the resident woke up. Staff A handed the med to Resident #18 and stated, "I have your 06:00am med". Staff A then left the building at approximately 07:05am after counting with the on-coming shift without passing the "one to two resident left" for the 06:00am med pass.

During an interview with Resident #21's family member, conducted on at 09:15am, the family member stated that Resident #21 "has been out of [the resident's] since Saturday".

A med cart audit, conducted on , revealed medications were not given to residents as ordered. Resident
#9's prescribed medication , 10mg and Extended Release 10MEQ med cards were for the month of , sent on . Resident #9's medications were cycle filled medication and distributed by the first of each month. Both medication cards had six pills missing from each card. Each card stated to "punch out today's date" and each pill had a number 1 through 28 as there were only 28 days in (See Photographic Evidence2). There were no med cards for and the date of survey was the fifth day of the month. An attempt to count Resident #15's pills, conducted on , revealed that the resident's pill bottle contained two different pills (one orange and one white) and it was not possible to ensure an accurate count do to the mixing of two different pills (See Photographic Evidence1). The Administrator was present during the pill audit and verified that the med bottle contained two different types of pills.

A record review for Resident #15's electronic Medication Observation Records (MORs) conducted on , revealed that Staff A signed Resident #15's as given to the resident. Resident #15's paper MORs did not have the med noted on the MORs to give the resident. Resident #15's MORs indicated that the prescribed med 50mg and SF 5000 Plus Cream was not given to the resident through due to "awaiting delivery". There was no evidence found in Resident #15's record of attempts to obtain the resident's prescribed or SF 5000 Plus Cream or evidence that the resident's Health Care Provider was notified that the resident was out of the medication and was not given these

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meds.

A review of Resident #17's MORs, conducted on , revealed that Resident #17's prescribed medications 500mg, , Spirolactone 25mg, 2mg, , 30mg, and 5mg were documented as not given due to "awaiting Pharmacy" and "waiting for delivery" and "awaiting Hospice delivery". There was no evidence found in Resident #17's record of attempts to obtain the resident's prescribed , , , Spirolactone, , , , and or evidence that the resident's Health Care Provider was notified that the resident was out and was not given these meds.

A review of Resident #18's MORs, conducted on , revealed that Resident #18's was not a scheduled med at 06:00am but was an as needed med for . Resident #18 did not receive the scheduled 06:00am med .

A review of Resident #21's MORs, conducted on , revealed that Resident #21 was not given to the resident due to "awaiting Pharmacy to deliver". There was no evidence found in Resident #21's record of attempts to obtain the resident's prescribed or evidence that thre resident's Primary Care Physician was notified that the resident was out and was not given this med.

During an interview with Staff C, conducted on at 09:53am, Staff C confirmed that the medication for Resident #21 was not available and the prescription was "called in to [the resident's] doctor yesterday" ( ).

During an interview with the Administrator, conducted on at 05:38am, the Administrator made no response and only shook her when Surveyor described the events that took place with Staff A for the 06:00am med pass and throwing out the soufflé cups with meds in them. At 05:50am, the Administrator told Resident #15 that the resident's Physician would be called regarding missing the resident's 06:00am . At 11:45am, the Administrator stated that the resident's doctor "won't get with me when residents won't take meds".

Class III

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

Based on record review and interview, the facility failed to ensure the 2 hour Preservice Orientation was completed prior to interacting with residents for 2 (Staff A and Staff D) of 6 employee records reviewed.

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Findings Included:

Employee record review conducted on . . . . . revealed Staff A with a date of hire of . . . . . did not have proof of the required 2 hour preservice orientation in employee record.

Employee record review conducted on . . . . . revealed Staff D with a date of hire of . . . . . did not have proof of the required 2 hour preservice orientation in employee record.

An interview with Manager was conducted on . . . . . beginning at 11:56am. The Manager confirmed Staff A and Staff D did not have the required training.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on observation, record review and interview, the facility failed to ensure staff had documentation of training on assisting residents with self-administration of medication for 1 (Staff A) of 6 employee records reviewed for staff who assisted with medication.

Findings included:

During medication observation conducted on . . . . . at 6:25am, Staff A was observed assisting with self-administration of medication with Resident #18.

Record review conducted on revealed there was no initial training for assistance with self-administraition of medications for Staff A.

During an interview with the Manager at 11:56am, the Manager reviewed the file and confirmed Staff A did not have the initial assistance with self-administration of medications training in their employee record.

Class III

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

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Based on record review and interview, the Facility failed to maintain an up-to-date admission and discharge log with all of the required data (See Photographic Evidence3).

Findings Included:

A record review for Resident #7, conducted on , revealed that Resident #7's Health Assessment Forms dated stated that the resident had a , to the . Resident #7 was admitted in to the Facility on . An updated Health Assessment Form dated stated that the resident had a , to the .

A review of the admission and discharge log (A&DL), conducted on , revealed that the Facility did not maintain the A&DL with all of the required data. The A&DL stated "home" for the place of admission or discharge instead of an address as required. The A&DL did not include Resident #6's date of admission or the place that Resident #6 was admitted from. The A&DL did not include the required information that Resident #7 had a , . The A&DL did not include Resident #24's date of discharge. The A&DL stated that Resident #27 was discharged due to .

During an interview with the Administrator, conducted on at 10:55am, the Administrator acknowledged and confirmed that the A&DL did not include all of the required data regarding dates, places, and reasons for admissions and discharges. The Administrator acknowledged and confirmed that the A&DL did not include that required data that Resident #7 was admitted in to the Facility with a , . The Administrator stated that Resident #27 discharged from the Facility to return to the Hospice house per Resident #27's request and was not discharged due to .

Class III

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

Based on record review and interview, the Facility failed to keep required documents in resident records and retained for two years following discharge for two Hospice Residents (#17 and #27) of two sampled Hospice residents.

Findings Included:

A record review for Resident #7, conducted on , revealed that Resident #7's Health Assessment Form dated did not specify the resident's diet as required. There were no diet orders in

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932678	03/05/2019
NAME OF PROVIDER OR SUPPLIER **SWEET WATER AT LARGO**	STREET ADDRESS, CITY, STATE, ZIP CODE **11290 WALSINGHAM ROAD** **LARGO, FL 33778**	

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

Resident #7's record.

A record review for Resident #16, conducted on , revealed that Resident #16's Health Assessment Form dated did not specify the resident's diet as required. There were no diet orders in Resident #16's record.

A record review for Resident #17, conducted on , revealed that the Facility did not keep the required documents that Resident #17 was a Hospice resident. Resident #17 was admitted in to the Facility on . There was no Hospice Admission Form or an Interdisciplinary Care Plan, which specified serviced that Hospice provided and those services that the Facility provided in Resident #17's record.

A closed record review for Resident #27, conducted on , revealed that the Facility did not keep required documents that Resident #27 was a Hospice resident for two years post discharge of the resident. Resident #27 was admitted in to the Facility on and discharged from the Facility due to on . There was no Hospice Admission Form or an Interdisciplinary Care Plan, which specified services that Hospice provided and those services that the Facility provided in Resident #27's closed record.

During an interview with the Facility Manager and the Hospice Nurse, conducted on at 12:05pm, the Administrator confirmed that Resident #17 and #27's records did not contain the required Hospice admissions document or their Interdisciplinary Care Plans. At 12:05pm, the Facility Manager acknowledged and that Resident #7 and #16's Health Assessment Forms did not include the residents' required diets.
Class III

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on employee record review and interview, the facility failed to maintain documentation of the eligibility results of a Level II Background screening for 1 (Staff A) of 6 employee records reviewed.

Findings Included:

Employee record review conducted on revealed there was no results of Staff A's Level II Background screening.

Interview with the facility Manager was conducted on beginning at 11:56am. The Manager

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SUMMARY STATEMENT OF DEFICIENCIES
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confirmed there was no evidence of the Level II Background screening in the employee file for Staff A.

Unclassified

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

Based on employee record review and interview, the facility failed to maintain an up-to-date Background Screening (BGS) Roster by failing to include two (Staff B and Staff D) current employees on the roster.

Findings Included:

Record review conducted on of the facility roster revealed Staff B with a date of hire of and Staff D with a date of hire of were not on the BGS Roster.

An interview with Manager was conducted on beginning at 11:56am. The Manager confirmed Staff B and Staff D were not on the BGS Roster.

Unclassified

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on record review and interview, the facility failed to maintain the compliance attestation for 1 (Staff D) of 6 employee records reviewed.

Findings Included:

Employee record review conducted on revealed Staff D with a date of hire of had no compliance attestation in the employee record.

An interview with the Manager was conducted on beginning at 11:56am. The Manager confirmed Staff D did not have a signed compliance attestation in the employee record.

Unclassified