STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967962	**04/11/2019**
NAME OF PROVIDER OR SUPPLIER **TRANSITION CARE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **1613 SW MERIDIAN AVE** **PORT SAINT LUCIE, FL 34953**	

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

0000 - Initial Comments

An unannounced Relicensure survey was conducted on at Transition Care Assisted Living Facility, License #11948. The facility had deficiencies at the time of the survey.

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

Based on observations, interviews and record review the assisted living facility (ALF) failed to ensure AHCA Forms 1823 (health assessments) were complete and accurate for 2 of 2 sampled Residents (1 and 2).

The findings included:

Review of resident medical records conducted on revealed the following concerns:

1. Resident 1's written health assessment dated documented the following:
a. The section for a list of all current medications had "See Attached" but nothing was attached to the form.
b. The section related to the level of assistance for, or if a licensed nurse was required, administration of medications had both "Needs Assistance with Self-Administration of Medications" and "Needs Medication Administration" (by a licensed nurse) checked off. Observations and interviews with the resident throughout the survey, and specifically when he received his medication, revealed he could not self-administer his medications; he needed assistance.
c. The section titled Services Offered or Arranged by the Facility for the Resident (the ALF's "care plan") was left blank. It was not signed by the resident or his representative, nor was it signed by the Administrator or her designee.

These concerns were discussed with and acknowledged by the Administrator on at 11:57 AM.

2. Resident 2's written health assessment dated documented the following:
a. The section for a list of all current medications had "See Attached" but nothing was attached to the form.
b. The section related to whether or not the resident needs help with taking medications, and the level of assistance required, was left blank.
c. The section titled Services Offered or Arranged by the Facility for the Resident (the ALF's "care plan") was left blank. It was not signed by the resident or his representative, nor was it signed by the

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Administrator or her designee.

These concerns were discussed with and acknowledged by the Administrator on at 11:10 AM.

Class III

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

Based on observations, interviews and record review, the assisted living facility (ALF) failed to maintain a sanitary living environment for 1 of 3 sampled Residents (2).

The findings included:

During review of the ALF's medication systems conducted on , the following concern was identified. At 8:41 AM, at the conclusion of Resident #2's medication pass, Staff A left a vial of solution on the table. Resident 2 placed the vial in his pants pocket. At 9:03 AM, this writer asked Resident #2 about his unit. At that time, he stated he needs to do his and removed the vial from his pocket. He was asked to identify certain parts of the unit. He identified the medication container which holds the medication liquid, and the mouthpiece he holds in his while receiving the treatment. Further observation of these parts revealed they were soiled and had light gray spots inside the parts. The outer side of the parts had a white substance around the rims where they connected to other parts (photographic evidence obtained). In an interview conducted at that time, the resident stated it needed cleaning, and he had cleaned it only once since he has been there. (He was admitted on , more than five mouths earlier.) The resident proceeded to pour the liquid medication into the container, turned on the unit, and inhaled the vapor produced by the unit. Note, concerns related to staff medication techniques are cited at Tag A0052 herein.

Review of Resident 2's medical records revealed a written HCP order dated calling for , , - 0.5 milligrams-3 milligrams (2.5 milligram base)/3 milliliters nebulization solution, inhale 3 milliliters three times a daily via nebulization route. The resident's , MOR revealed an entry calling for "Iprat Albutersol 0. (2.5) milligrams/3 milliliters inhaler 1 unit vial via every 6 hour - ".

This was discussed with and acknowledged by the Administrator on at 12:07 PM.

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Class III

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

Based on observations, interviews and record review, the assisted living facility (ALF) failed to ensure unlicensed staff who assist residents with self-administration of medications followed required standards of practice for 2 of 2 sampled Residents (1 and 2).

The findings included:

1. Review of the ALF's medication systems conducted on revealed the following concerns related to Resident #2:

a. Observation of Resident #2 receiving assistance with self-administration of medications was conducted with Staff A, a Caregiver and Medications Technician. At 8:41 AM, it was noted Staff A did not use the resident's written medication observation record (MOR) to determine what medications were to be received by the resident. She did not compare the medications selected to be given to the resident to the MOR for accuracy. Staff A did not observe the resident actually taking his medications; she was turned away from the resident at the time he took his medications.

b. On at 7:57 AM, a package of Diskus (medicated inhalation powder) was observed stored on the dining room table. The prescription label documented it belonged to Resident #2. A written Health Care Provider (HCP) order dated called for Diskus 100 micrograms-50 micrograms per dose, one puff by twice daily. Written instructions on the side of the box disclosed, "After each dose, rinse your with water and spit it out. Do not swallow the water." Review of his MOR revealed an entry calling for " diskus inhale 1 puff twice daily, rinse after each use" (photographic evidence obtained). Note, concerns resulting from observation of improper storage of the medication are cited at Tag A0055 herein.

Resident #2, present at the time of observation, was asked and stated the medication was his; staff leave it out for him to use; he puts it on the kitchen counter when he is done. At 8:07 AM, Staff A, the Caregiver and Medications Technician on duty at the time, was asked about it but did not provide a relevant answer. She did confirm the medication is stored in the locked medication cabinet when not in use.

c. At 8:41 AM, at the conclusion of Resident #2's medication pass, Staff A left a vial of solution on the table. Resident #2 placed the vial in his pants pocket. Review of his medical records revealed a

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written HCP order dated . . . . called for , . . . , . . - . . . . . 0.5 milligrams-3 milligrams (2.5 milligram base)/3 milliliters nebulization solution, inhale 3 milliliters three times a daily via nebulization route. The resident's , MOR revealed an entry calling for "Iprat Albutersol 0. (2.5) milligrams/3 milliliters inhaler 1 unit vial via . . . . . every 6 hour - . . . ".

At 9:03 AM, this writer asked Resident 2 about his . . . . . unit. At that time, he stated he needs to do his . He removed the vial from his pocket and placed it on the nightstand next to the . . . . . unit (photographic evidence obtained). The resident proceeded to pour the liquid medication into the container, turned on the unit, and inhaled the vapor produced by the unit. Note, concerns resulting from observation of the . . . . . unit are cited at Tag A 0030 herein.

2. Review of the ALF's medication systems conducted on . . . . . revealed the following concerns related to Resident #1:

a. Observation of Resident #1 receiving assistance with self-administration of medications was conducted with Staff A, a Caregiver and Medications Technician. At 8:51 AM, it was noted Staff A did not use the resident's written medication observation record (MOR) to determine what medications were to be received by the resident. Nor did she compare the medications selected to be given to the resident to the MOR for accuracy.

These concerns were discussed with and acknowledged by the Administrator on at 12:07 PM.

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

Based on observations, interviews and record review, the assisted living facility (ALF) failed to ensure medications were stored in a secured manner for residents who receive assistance with self-administration for 1 of 2 sampled Residents (2).

The findings included:

On at 7:57 AM, a package of Diskus (medicated inhalation powder) was observed stored on the dining room table (photographic evidence obtained). The prescription label documented it belonged to Resident #2. A written Health Care Provider (HCP) order dated called for Diskus 100 micrograms-50 micrograms per dose, one puff by . . . twice daily. Review of his , ... MOR revealed an entry calling for " . . diskus inhale 1 puff twice daily, rinse after each use".

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Resident #2, present at the time of observation, was asked and stated the medication was his; staff leave it out for him to use; he puts it on the kitchen counter when he is done. At 8:07 AM, Staff A, the Caregiver and Medications Technician on duty at the time, was asked about it but did not provide a relevant answer. She did confirm the medication is stored in the locked medication cabinet when not in use.

This was discussed with and acknowledged by the Administrator on at 12:07 PM.

Class III

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

Based on observations, interviews and record review, the assisted living facility (ALF) failed to ensure unlicensed staff who assist residents with self-administration of medications followed written Health Care Provider (HCP) orders for 1 of 2 sampled Residents (Resident#2).

The findings included:

Observation of Resident #2 receiving assistance with self-administration of medications was conducted with Staff A, a Caregiver and Medications Technician on at 8:41 AM. She was observed giving two tablets of (an medication) to Resident #2. Observation of the prescription label attached to the medication container called for " 2 [milligram] tablets, take 2 tablets by at bedtime" (photographic evidence obtained).

Review of Resident #2's medical records revealed:

1. A written HCP order dated that called for " 2 l[milligrams] 1 [by twice a day at hour of sleep]

2. A written HCP order dated that called for " 2 [milligrams] tablet, take 1 tablet twice a day by oral route".

3. His medication observation record (MOR) included an entry calling for " 2 [milligrams] tablet - take (1) one twice daily". It had two entries for staff initials (to indicate the medication was received) scheduled for 8:00 AM and 8:00 PM. All doses scheduled thus far in were initialed as received by the resident.

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This was brought to the attention of the Administrator at 10:33 AM. At 2:54 PM, she was asked and stated she did not have clarification of the intended order available for review.

Class III

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

Based on observation and interviews, the assisted living facility (ALF) failed to maintain required emergency food, water and supplies. This has the potential to affect all 3 current residents.

The findings included:

On at 10:05 AM, this writer asked ALF staff to show me the ALF's current supply of non-perishable foods, water and disposable supplies. A lower cabinet in the kitchen and a small amount of foods were identified. It was not adequate for 3 residents plus staff for 3 days. There was no emergency water available. There were no related disposable supplies such as paper or plastic plates and cups, plastic flatware, paper napkins, etc (photographic evidence obtained).

This was discussed and acknowledged by the Administrator at the time of observations.

Class III

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

Based on interview and record review, the assisted living facility (ALF) failed to maintain the required admissions and discharge log.

The findings included:

The facility currently has three residents; on at 10:45 AM, the ALF's admission and discharge log was reviewed. Two of the five entries were not completed. The residents had moved out of the facility but no date of discharge, reason for discharge, and place discharged to were left blank.

This was discussed with and acknowledged by the Administrator at the time of review.

Class

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0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on interviews and record review, the assisted living facility (ALF) failed to obtain the required approval of their comprehensive emergency management plan (CEMP) from the local authority.

The findings included:

On at 1:55 PM, the Administrator was asked to present the letter from the local county Emergency Division showing their CEMP had been approved during the past year. She was not able to do so. In a telephone interview conducted on at 2:01 PM, a representative of the county stated a second revision request letter was mailed to the ALF on 11/01/2018. She further stated only a couple of minor revisions were needed by had not yet been received from the ALF.

This was discussed with and acknowledged by the Administrator on at 2:31 PM.

Class III