STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966454	R 07/03/2019
NAME OF PROVIDER OR SUPPLIER **WILLIAMS LOVING CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **4213 CHANTELLE ROAD** **ORLANDO, FL 32808**	

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

0000 - Initial Comments

A revisit to a biennial survey including Limited Nursing Service (LNS) was conducted at Williams Loving Care Assisted Living Facility on . Deficiencies were identified at the time of survey.

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

DEFICIENCY REMAINED UNCORRECTED

Based on observations, record review and interview, the facility failed to have evidence of an accurate resident health assessment form, 1823 for 1 of 3 sampled residents (3).

Findings:

Record review for resident #3 revealed an updated resident health assessment form, 1823 that was dated . The health care provider documented that the resident required total care with ambulation, bathing, , grooming and transferring which exceeded the criteria for residency in an Assisted Living Facility.

Observations on at 9:30 AM revealed resident #3 was and was able to walk and transfer without assistance.

On at 10 AM, the administrator said the resident did not require total assistance with ambulation, bathing, , grooming and transferring. She only required assistance because she was . She said the resident health assessment form was not correct.

Class III

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

DEFICIENCY REMAINED UNCORRECTED

Based on medication observation record (MOR) review, record reviews and interviews, the facility did not provide the care and services to meet the needs of 1 of 3 sampled (#3) and held medication for , without notifying the health care provider.

Finding:

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Record review for resident#3 revealed an updated resident health assessment form, 1823 that was dated , the health care provider noted the resident required assistance with the self-administration of her medications. The health care provider documented that the resident was to have 1 package with 8 ounces of water once a day.

Review of the MOR for and revealed they noted Polyethylene , dissolve 1 capful (17 gm) in 8 oz of water or juice and drink once a day for , (alternate with), there was a circle in the space for staff initials on at 8 AM and was left blank on at 8 A. There were also circles in the space at 8 AM from and on , , , , , , , , , , , , -there was no documentation on the that indicated what the circles meant.

On at 9:45 AM-Staff A, a caregiver said circle meant the medication was not given because the resident had .

Record review for resident #3 revealed there was no documentation to confirm that the health care provider was contacted regarding the resident having , there was also no order found to hold the medication.

On at 9:45 AM, Staff A said the facility staff did not contact the health care provider informing him of the resident having and did not obtain an order from the health care provider before holding the medication.

Class III

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

DEFICIENY REMAINED UNCORRECTED

Based on medication observation record (MOR) review and interview, the facility failed to maintain an accurate MORs for 1 of 3 sampled residents (#3).

Findings:

Record review for resident#3 revealed an updated resident health assessment form, 1823 that was dated , the health care provider noted the resident required assistance with the self-administration of her medications. The health care provider documented that the resident was to

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have 1 package with 8 ounces of water once a day and 1 mg one twice daily.

Review of the MOR for and revealed they noted Polyethylene dissolve 1 capful (17 gm) in 8 oz of water or juice and drink once a day for (alternate with), there was a circle in the space for staff initials on at 8 AM and was left blank on at 8 AM. There were also circles in the space at 8 AM from and on , there was no documentation on the of the MORs that indicated what the circles meant.

On at 9:45 AM-Staff a, a caregiver said the circles meant the medication was not given because resident #3 had .

Observation on at 9:15 AM with staff D, a caregiver during the medication pass revealed a package of 1 mg one twice daily that was filled on and only had 1 pill missing, the medication was not listed on the MOR as required.

Staff D said at the time she did not know if she should give the medication to resident #3 because it was not on the MOR, staff A. a caregiver said at the time the medication had ran out and the pharmacy had just delivered it last night ( ) and it was not listed on the MOR and had to be handwritten on the MOR. Staff A said she gave the medication to resident #3 last night and did not include it on the MOR.

Staff A was observed adding the medication to the MOR and then signed the MOR as given on at 8 PM.
Further observations on at 9:30 AM, revealed staff D's initial was now on the MOR as giving the medication on at 8 AM. Staff D was asked at the time if she had given resident#3 the medication, she stated she had not, although the MOR was signed as given.

Staff A said at the time that she signed the MOR using staff D's initials because she thought staff D had given resident #3 her medication. There was also now a circle in the space at 8 AM on and and at 8 PM on , for the .

Staff A said the circles in the spaces meant the resident had ran out of the medications and she did not take them. She said she had called the pharmacy on to check on the medication and did not write it on the of the MOR.

Further observations on at 10 AM, revealed staff D, gave resident #3 the , she wrote her initials over the initial that was in the space where staff A had signed for her.

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Class III

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

Based on observations, medication observation record (MOR), record reviews and interview, the facility failed to make every reasonable effort to ensure a prescription was filled in a timely manner for 1 of 3 sampled residents (#3) who received assistance with medications.

Findings:

Record review for resident#3 revealed an updated resident health assessment form, 1823 that was dated , the health care provider noted the resident required assistance with the self-administration of her medications.
Observation on at 9:15 AM with staff d, a caregiver during the medication pass revealed a package of 1 milligrams (mg) one twice daily that was filled on and only had 1 pill missing, the medication was not listed on the MOR.

Staff D said at the time she did not know if she should give the medication to resident#3 because it was not on the MOR, staff A. a caregiver said at the time the medication had ran out and the pharmacy had just delivered it last night ( ) and it was not listed on the MOR and had to be handwritten on the MOR. Staff A said she given the medication to resident #3 last night and did not include it on the MOR.

Staff A was observed adding the medication to the MOR and she also signed the MOR as giving the medication on at 8 PM. Further observations on at 9:30 AM, revealed staff D's initial was now on the MOR as giving the medication on at 8 AM. Staff D was asked at the time if she had given resident#3 the medication, she stated she had not.

Staff A said at the time that she signed the MOR using staff D's initials because she thought staff D had given resident #3 her medication. There was also now a circle in the space at 8 AM on and and at 8 PM on , for the .

Staff A said the circles in the spaces meant the resident had ran out of the medications and she did not take them. She said she had called the pharmacy on to check on the medication and did not write it down.
There was no documentation that the facility had made a reasonable effort to contact the pharmacy prior to the resident running out of her medication.

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Class III

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

Based on review of the agency for health care administration's background screening website, personnel record reviews and interview, the facility failed to have evidence that 1 of 4 sampled staff (D) received the required in-service training.

Findings:

Review of the agency for health care administration's background screening website, revealed the facility's roster noted staff D was hired on .

Personnel record review for staff A, revealed an application that was dated , further personnel record review revealed there was no documentation to confirm that she had received at least 2 hours of pre-service orientation prior to interacting with residents that covered resident rights and the facility's license type and services offered by the facility. That included the signature of the staff and the administrator.

There was no documentation to confirm that she had received in-service training that covered the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation, facility's resident elopement response policies and procedures and the facility's policy on recognizing and reporting resident , neglect, and .

On at 11:30 AM, the administrator said staff D had all of the training and she did not print the certificates.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on review of the agency for health care administration's background screening website, personnel record review and interview the facility failed to have evidence that 1 of 4 sampled staff (d) had at least one hour of training in the facility's policies and procedures regarding ('s) that included information in Rule 58A-5.0186, F.A.C. within 30 days after employment.

Findings:

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Review of the agency for health care administration's background screening website, revealed the facility's roster noted staff d was hired on . . . . . .

Personnel record review for staff A, revealed an application that was dated . . . . , further personnel record review revealed there was no documentation to confirm that she had received a one-hour training in the facility's . . . . policies and procedures that included information in Rule 58A-5.0186, F.A.C. within 30 days after employment.
On . . . . . at 11:30 AM, the administrator said staff d had the . . . . training and she did not print the certificate.

Class III