STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968049	03/10/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Grace Manor Suites, Llc	4620 Socrum Loop Rd Lakeland, FL 33809	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0150 - 58a-5.023(1) Fac - Physical Plant - New Facilities S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2013013185, was conducted on .

Grace Manor Suites, LLC, assisted living facility, had deficiencies at the time of the visit.

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

Based on interviews and Medication Observation Record (MORS) reviews the facility failed to make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner for 8 of 13 samples residents.

Findings include:

On at approximately 12:30 P. M. an observation was made of of Staff F completing a "medication pass". Staff F was asked if all residents had received their medications today and she stated that 3 residents names appeared on the "Med Pass Exception Report" as not receiving their medications this morning. The "Med Pass Exception Report" was given to the surveyor to review.

Resident #7 did not receive 2.5 mg at 7:00 a.m. because the facility did not have the medication.
Resident #1 did not receive his Powder 30 gm at 6:00 A.M. because the facility did not have the medication.
Resident #13 did not receive her 325 mg at 6:00 A.M. because the facility did not have the medication.

Interview with the administrator revealed that based on this report, she was aware of these medications not being available and is in the process of calling the pharmacy to have them refilled.

During a tour of the facility at 11:30 A.M. on , Resident #6 stopped the surveyor to ask what is happening with her medication to treat the she has. The resident was observed to have a red over most of her body. She stated that the doctor told her this morning that it was from that she had taken and she has heard nothing since then. She expected someone to bring her something. The surveyor asked Staff F about the resident's and what was being done about it. She stated that an order was written by the doctor for . At 4:30 P.M. the surveyor asked their administrator if Resident #6 had received her and she checked for the order from the doctor and could not find it. At 4:52 P.M. the order was found and faxed to the

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pharmacy. The administrator stated that it would be delivered tonight.

During an interview with Resident #2 at 11:00 A.M. on she stated that she has been here for about 1 month and that she did not get any of her medications for an entire weekend (3 days). She said that it was her understanding that the facility did not reorder her medications.. When she was admitted to the facility, she brought her medications with her from the hospital, so there was no problem.

The 2013, 2014, 2014 and 2014 MORS were reviewed for Resident #'s 1,2,3,4,5,6 and 7 and the following medications were not given as ordered:

A review of Resident #2's and 2014 MORS was conducted. The resident did not receive the following medications:

2014 at 9 PM

10 mg every night at bedtime
Oyster Shell 500 mg one by mouth 3 times a day
NA 125 mg every night at bedtime
Tears/AKWA/15ml 1 drop in each eye
0.83mg/ml solution inhale 1 vial via 3 times a day
BR 0.02% solution 1 vial by 2 times a day

The reason listed by the facility for the resident not receiving her medications was "do not have medication"

2014 and

0.83mg/ml solution inhale 1 vial via 3 times a day
BR 0.02% solution 1 vial by 2 times a day

The reason listed by the facility for the resident not receiving her medications was "do not have medication"

2014

0.83mg/ml solution inhale 1 vial via 3 times a day
BR 0.02% solution 1 vial by 2 times a day

The reason listed by the facility for the resident not receiving her medications was "physically unable to take"

2014

0.83mg/ml solution inhale 1 vial via 3 times a day
BR 0.02% solution 1 vial by 2 times a day

The reason listed by the facility for the resident not receiving her medications was "Do not have machine"

Ptoair HFA 90 mcg inhale 2 puffs by mouth 4 times a day

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The reason listed by the facility for the resident not receiving her medications was "do not have medication"

, 2014

Sens FF Lotion7.5zion apply to entire body every night at bedtime
Oyster Shell 500mg 3 times a day (not received at 9pm)

The reason listed by the facility for the resident not receiving her medications was "do not have medication"

, 2014

Oyster Shell 500mg 3 times a day
60mg once daily
15mg once daily
81m once daily

The reason listed by the facility for the resident not receiving her medications was "do not have medication"

The facility and physician stated that the pharmacy was at fault because they were supposed to have refilled the meds.

Resident #4 did not receive the following medications:

2013 at 9:00 P.M.

500 mg 1 at 8am and 1 at 9pm until completion with food

The reason listed by the facility for the resident not receiving her medications was "do not have medication"

, 2014

81 mg once daily at 8am w/breakfast
325 mg every morning with breakfast at 8am

The reason listed by the facility for the resident not receiving her medications was "do not have medication"

Resident #5 did not receive the following medications:

, 2013 at 8pm.

300mg one pill twice a day

2013 at 5pm

500 one by mouth twice a day with meals
Tears/AKWA/15ml 1 drop in each eye 4 times a day (2pm and 6pm not given)

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, 2013

. .| Tears/AKWA/15ml 1 drop in each eye 4 times a day (all doses missed)

. . 2014 at 6pm

. . :Diskus 50mcg GLX 1 puff by mouth 2 times a day

The reason listed by the facility for all of Resident #5's medications not being given was "do not have medication".

The administrator was interviewed related to all of these missed dosages of meds and she stated that there has been a problem with the system they had in place at the facility. There was no follow up to the daily exception reports. The med techs must now call the Resident Care Coordinator immediately if a medication is not available. She in turn must follow up with the pharmacy. In addition an email must be sent to the Administrator and Wellness Director. Any medication bottle that has less than 21 days left must be reordered and any punch card with only 7 days of medication left must be reported by the med techs to the Administrator, Resident Care Coordinator and Wellness Director.

Class III

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

Based on interviews and a review of personnel files and documentation provided by the facility related to staff training and health exams of all staff, the facility failed to ensure that 3 of 27 staff who had been employed for more than 30 days had been examined by a health care provider within the last 6 months.

Findings include:

The facility was not able to provide evidence that the following staff were do not have signs or symptoms of a communicable , including . . . . . .

Staff A hired . .
Staff B hired . . . . .
Staff C hired . . . .

Class III

0079-Staffing Standards - Levels 58A-5.019(4) FAC

Based on observations, interviews and record reviews, the facility failed to ensure they meet all resident needs and provide services required.

Findings include:

During interviews with the Administrator and various staff, residents, and families it was revealed that the medication technicians do not leave the 1st floor medication . . . . . provide services to residents. They do not

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provide any hands on care other than supervision and assistance with medication administration. Although the facility meets the required minimum numbers of staffing, the residents, families and staff do not feel that there is enough staff working, especially on the first shift, to meet resident needs.

On there was observed to be one Resident Care Aide per shift per floor (3 floors) from 7 A.M. to 3 P.M. The resident census was 73. The Resident Care Aides are responsible for assisting residents with care, including showers and toileting, cleaning the resident's , assisting them to meals, assisting with meals, and ensuring that the residents get to the medication their meds when scheduled. During the survey, the Resident Care Aides were frequently being summoned by the Med Tech to bring residents to the med various times of the day. This was happening while the Resident Care Aides were attempting to provide care and supervision to residents.

On at approximately 10:00a.m. during a tour on the first floor the sound of someone crying and asking for help could be heard. The resident called for anyone to please come in and help her but no one responded. After approximately 6 minutes had passed the surveyor entered the residents The resident was sitting in a chair crying and stated she had been asking for help for a long time.
The resident stated she has pushed her pendent but there has not been any response. There were two aides in one residents to finish his ADLs and no one else was available. After approximately 15 more minutes went by an aide came into the I spoke to the resident and found out she had injured her foot. The aide went to get the ARNP who ordered a portable x-ray to come to the facility.
During an interview with Resident #8, she stated she pushes the pendent when she needs help and has waited up to 20 minutes for someone to respond. She understands they are busy with other residents on the floor. The resident stated there is one aide on each floor to care for everyone. That is the only issue she has with the facility.
During the noon meal there were three residents still waiting for their lunch when the staff was serving desserts to others. The lunch was served without advising the residents that they had a choice between chicken or Several residents did not like the and were surprised to hear that they had a choice.
During an interview with Resident #4's family member on at 5:00 P.M. she stated that she especially has concerns with residents not getting their medications as prescribed and on time. She stated that the facility was short on staff and the Med Tech was working a 16 hour shift. She stated that the Resident Care Aides do not have time to spend with the residents and get to know them and what their needs are. She has heard from several staff members that they feel overworked and the morale is extremely low.
An interview was conducted with Staff D on at approximately 10:30 A.M. She stated that she was working a double shift because staff had called in sick. She stated that the day shift is always short on staff and that there doesn't seem to be "teamwork" involved. Everyone is just doing what they have to do to get the job done. They can't even get to know the residents. She has heard from residents and family members that they are not happy with the facility. There is also a need for more help during meals. The Resident Care Aides can't get their work done plus help in the dining I assist residents to the medication all hours.
An interview with Staff G was conducted on at approximately 2:30 P.M. He stated that the med techs do not assist with resident care. The Resident Care Aides assist residents to the dining I helps with serving the meals. They also have duties in the dining include, sweeping the floor or wiping the tables off before or after meals. They spend a lot of time transporting residents in the one elevator that is used for 73 residents. He stated that the day shift has to get residents up in the morning to start care and some residents don't want to get up early. He stated that in order to get everyone ready for the day, some residents are gotten up to get cleaned and dressed and then they go back to bed until breakfast.
An interview was conducted with Resident #10 at 4:00 P.M. She stated that her bed had not been made for the day yet and this has happened for 3 days in a row.

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Resident #11 was interviewed at 4:15 P.M. and stated "there is so little help, they don't have enough". Staff H was interviewed at approximately 4:30 P.M. on and stated that the facility used to have 2 med techs per shift and that person also helped on the floor. She stated that first shift is "crazy" and "we need more staff". A "floater" is needed to help in the dining to clean and resupply resident Resident #9 was interviewed at 5:40 P.M. in the dining She stated that she has not yet gotten her dinner nor has her bed been made in her She feels that the facility needs more help.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC

Based on interviews and a review of personnel files and additional documentation provided by the facility, the facility failed to ensure that all staff had received the required in-service training within 30 days of hire.

Findings include:

A review of 4 personnel files was completed along with a review of documentation provided to the surveyors of all staff (30) and what training has or has not been completed. Training was incomplete for direct caregivers. The Assistant Administrator/Human Resources Director explained that she tells staff what they are required to complete on line and to then take a test and return the results to her. Some staff have not handed in their test results or any evidence that they had completed the training. The facility does not provide direct training by holding training classes. The facility is switching to a new program that will alert them as to who has completed their training and when, and the staff will not be allowed to work after 30 days without evidence of it.

The following is a list of direct care staff who have not received training required

ELOPEMENT TRAINING, TRAINING and , NEGLECT, TRAINING

Staff A Date of Hire (DOH)
Staff B, DOH
Staff C, DOH
Staff D, DOH
Staff I, DOH

CONTROL, RESIDENT RIGHTS, ADL AND RESIDENT BEHAVIOR, and EMERGENCY PROCEDURES TRAINING

Staff A Date of Hire (DOH)
Staff B, DOH
Staff C, DOH
Staff D, DOH
Staff I, DOH

Class III

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0150-Physical Plant - New Facilities 58A-5.023(1) FAC

Based on record reviews and interviews the facility failed to ensure they were in compliance with 69 A-40.036 fire exit drills (2) that states a new or existing sprinkled ALF shall conduct at least 6 fire drills a year, one every two months with a minimum of two drills conducted when the residents are asleep. A facility in compliance with other safety standards is not required to conduct more than one fire drill between 11p.m. and 7 a.m. per year.

Findings include:

A review of the facility's fire drills revealed that the last drill was conducted on . . . . . The fire was to have taken place in the laundry . . . . . the 1st floor at 8:15 pm. Facility records state it took 15 minutes to evacuate the residents to a safe place.

The facility's documentation shows they also conducted a drill on , which took place in apartment 119 on the 1st floor at 4:00 p.m. The residents were taken to a safe place within 15 minutes.

On . . . . a drill was conducted at 10:00 a.m. in the first floor beauty shop and the time was 15 minutes for the residents to evacuate to a safe place. The stairwells are the area this facility uses as their safe place as those areas are fire retardant.

The facility has not conducted fire drills for each floor and on each shift, nor have they conducted drills during the hours of 11 p.m. to 7 a.m. The facility has only one aide on each floor so any drill or real fire would require the aide to assist approximately . . . residents, and several residents require the use of walkers and wheelchairs. Based on the lack of staff training related to emergency procedures and the timeframes of the past fire drills, the safety of the residents and staff is in question.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Grace Manor Suites, LLC
4620 Socrum Loop Rd
Lakeland, FL 33809

Dear Administrator:

Re: **CCR# 2013013185**

This letter reports the findings of a complaint survey that was conducted on , 2014, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

FOR Patricia Reid Kaufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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