STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964980	06/10/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Orange Park	1248 Kingsley Avenue Orange Park, FL 32073	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
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 - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0082 - 58a-5.0191(3) Fac - Training - / S-S= D
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0086 - 58a-5.0191(9) Fac - Training - Adrd S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced biennial re-licensure survey was conducted at Emeritus at Orange Park, in Orange Park, Florida on , 2014. Licensure deficiencies were identified as a result of the survey.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation and staff and family interview, the facility failed to provide personal supervision as appropriate for each Residents #18,# 19, and #20 for dining, 6 of 19 residents in the Memory Care Unit.

The findings include:

On at 12:07 p.m., residents were observed in the Memory Care Dining lunch. There were two employees, Employees E and F assisting residents to the dining passing out the food trays. Residents #18, #19, and #20 were observed sitting at one table and none of them had drinks in front of them. Employee E stated that she removed their drinks because they were drinking out of each other's cup and and one of them was on thickened liquids. At some points during the lunch observation, there was only one staff member present. The other staff member had to leave at times to escort other residents to and from the dining personal care.

On at 11:15 a.m. the son of Resident #9 was interviewed. He believed that there was not enough staff to take care of the residents in the Memory Care Unit. If a staff member was doing laundry, it would leave only one person to take care of all the other residents.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation and interview, the facility failed to provide a decent living environment for 2 out of 11 sampled residents (Resident #10 & #14).

The findings include:

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On at 9:40 a.m., Employee F entered the Resident #10 ( ) to assist with medication assistance. The resident was sitting in her there was a strong smell of stool. The hot. The resident stated that it was hot in her the smell was coming from her laundry basket in her closet. The laundry basket was full of clothes. Employee F stated the air conditioner was off in her .

Another observation was made to on at 12:40 p.m (Resident #10) accompanied by the Memory Care Director. She confirmed there was still a smell of stool in her . The resident's chair that she was sitting in had a smear of brown stool like substance on it. The resident's blanket was pulled down from her bed and there was a stool like substance on several areas of the sheets, covering approximately 50% of the area of her bed. The Memory Care Director stated the Resident #10 had accidents and the daughter put up sign for stools to be collected at the doctor's office. (photographic evidence obtained)

2. On at 12:42 pm an observation of (resident #14's) revealed a very strong smell of . Emplovee E. a Medication Technician was assisting a resident in the Resident #14 was walking in her pull up briefs on and no pants. Employee E stated she had to get both residents cleaned up for lunch. Observation of the Resident #14's bed revealed a big wet spot covering approximately 50% of the surface area of the bed. Employee E confirmed that it was soaked in . Employee E stated that Resident #14 was . There was also a chair in her had a brown, stool like substance on it.

The Administrator was interviewed on at 12:45 p.m. He stated that the housekeeper only cleans Memory Care on Tuesday and Thursday. The Medication Technicians have to do the cleaning the rest of the time.

Employee K, the Resident Care Director was interviewed on at 1 pm. He stated that the Memory Care Unit only had two Medication Technicians working today. Usually there was a third person to help with personal care but because there was medication training today, the Memory Care Director was not present. There was a total of 19 residents in the memory care unit.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation and staff interview, the facility failed to have unlicensed staff assist with medication administration appropriately for 3 of 6 sampled residents, Residents # 10, #11, and #16.

The findings include:

1. On at 9:40 a.m., Employee F, a Medication Technician was observed to prepare medications for Resident #10 She placed each medication (6 in total) in a paper medication cup and carried the cup into the resident's . She handed the resident the medication cup and stated "here is your medication". She did not inform the resident what medications she was assisting with. She did not read the labels in front of the resident.

2. On at 10 a.m. Employee F performed the same procedure for Resident #11. She placed the 4 medications in a paper cup and brought it down to the resident's . She handed her the cup and the resident

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took it. She did not tell the resident what she was giving her. She confirmed she did not read the labels in front of the residents.

On 6/10/2014 at 10:45 a.m. Employee F confirmed she just handed both residents their medications in a cup. She confirmed she did not bring the medication cards to the residents and read the label to them.

3. at 11:13 AM an observation of Employee #B, Medication Technician, revealed she handed Resident #16 , 2 milligram (mg), 2 capsules in a medication cup. The labels on the medication card for Resident #16 read, . 2 mg by mouth, take 1 capsule by mouth every 6 hours as needed.

Review of the 2014 Medication Observation Record (MOR) for Resident #16 reads, 2 mg caplet give 1 tablet by mouth every 6 hours as needed for .

Review of the physicians ordered dated 2014 reads, AD 2 mg by mouth, give 1 caplet by mouth every 6 hours as needed for .

On at 1:15 PM an Interview with Employee #B revealed, "I gave her two because when I give her one tablet, she always comes back and asks for another within 30 minutes. I just give her 2 because she wants it."

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on record review and staff interview, the facility failed to maintain a daily medication observation record for 1 of 6 sampled residents, Resident #12.

The findings include:

The Medication Observation Record (MOR) for 2014 for Resident #2 on at 11:50 a.m. revealed that 9 a.m medications were initialed as given. They were , , , (2) , Therems- M, and .

Employee F , a Medication Technician was interviewed on at 11:55 a.m stated she had not assisted Resident #2 with her medications yet. She stated she should not nave signed the MOR.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and staff interview, the facility failed to keep medications secured at all times.

The findings include:

1. Upon entrance to the facility on at 9 a.m. there were two medication cards located on a table observed through an open door. There was no staff member present.

2. Employee F, a Medication Technician was observed on at approximately 10:30 am to prepare medications for Resident #12 and then leave the medication cart and walk down the hallway. She did not lock the medication cart. This was in the Memory Care Unit (locked) and there were 10 residents in close proximity to the

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cart including one family member. On at 10:45 a.m. Employee F confirmed she left the medication cart unlocked.

3. Employee E, A Medication Technician was observed on at 11:35 a.m. She was holding a medication cup with a crushed medication in applesauce. Employee E placed the medication cup on the cart and walked over to the center of the began assisting another resident. The medication cart was unlocked. Her back was turned away from the medication cart. Resident #13, a wandering resident with on at 11:40 a.m. walking up this medication cart and stand there. The Memory Care Director (MCD) was told of this medication on top of the cart and the unlocked medication cart on at 11:41 a.m. with Resident #13 nearby. The MCD locked the medication cart and threw out the medication cup with medication in it.

4. Employee E was interviewed on at 11:45 a.m. She stated that she was not assisting with medications. She was showing Employee F how to crush medications. Employee F crushed and placed it into the applesauce. Employee F the then left to get a spoon. Employee E did confirm she left the cart unlocked.

On at 4:15 pm, Employee K, the Resident Care Director handed the the two medication cards that was living on the conference table and he was told that it was accessible to anyone walking by. He stated that this have been locked this morning if no one was in there.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Record review of 2014 MOR revealed Resident #21 was circled on , 2014 and , 2014. On the back of the 2014 MOR was written code 2 on and code 2 on 6/ . Review of the codes on the back of the MOR revealed code 2 - Drug Temporarily Unavailable.

Record review of the 2014 MOR revealed Resident #21 was circled on , 2014 and , 2014. On the back of the 2014 MOR was written code 2 on and code 2 on . Review of the codes on the back of the MOR revealed code 2 - Drug Temporarily Unavailable.

On at 3:45 PM an interview with Employee K, Resident Care Director (RCD) revealed, he said Resident #21 ran out of his . He said the facility didn't get the prescriptions in time.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on record review and staff interview, the facility failed to ensure that within 30 days of hire, a staff member submitted a statement from a health care provider documenting that the staff member was free from communicable , including ( ) 2 of 4 sampled employees. (Employees C and D)

The findings include:

A review of the personnel files for Employees C and D revealed that Employee C was hired on and, Employee D was hired on . There was no documentation of freedom from communicable in either of the two employee files.

A interview with Employee I at 1:03 p.m. confirmed that Employees C and D did not have statements of

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freedom from communicable in their files. Employee I stated that she had the appropriate forms prepared for the physician to sign when he was next in the facility. Employee I clarified that the facility's physician was who completed this task for their new employees.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on record review and staff interview, the facility failed to maintain appropriate documentation of the completion of required staff education for 1 of 4 sampled employees. (Employee C)

The findings include:

A review of the personnel files for Employee C revealed that her date of hire was . The training certificate related to activities of daily living (ADLs) and behavioral needs was not available for review in this employee's file.

A interview with Employee I at approximately 1:00 p.m. confirmed that the required training was not completed. Employee I stated that the missing training would be addressed right away.

Class III

0082-Training - HIV/AIDS 58A-5.0191(3) FAC
Based on record review and staff interview, the facility failed to ensure that employees completed a one-time education course on ( ) within 30 days of employment for 2 of 4 sampled employees. (Employees C and D)

The findings include:

A review of the personnel files for Employees C (Date of Hire) and D (Date of Hire) revealed that the certificates related to / training were not available for review.

An interview with Employee I on at approximately 1:00 p.m. confirmed that the required training had not yet been completed. Employee I stated that the issue would be addressed right away.

Class III

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC
Based upon record review and staff interview, the facility failed to ensure that 1 of 4 employees (Employee B), obtained 2 hours of annual training in assisting with the self-administration of medications before performing the task for the residents.

The findings include:

A review of personnel record for Employee B revealed that her date of hire was . Her current title was Resident Assistant/Medication Technician. The most recent documentation of the required 2-hour medication training was dated .

A interview with Employee I at approximately 1:00 p.m. confirmed that Employee B's medication training

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was not current. Employee I explained that the facility was holding the required training on the date of the survey, however, Employee B was unable to attend. Discussion with Employee I clarified that the required 2-hour annual medication training should have been completed on or before in order to maintain compliance. She confirmed Employee B assisted with self-administration with medication.

Class III

0086-Training - ADRD 58A-5.0191(9) FAC
Based on observation, record review and staff interview, the facility failed to ensure that facility staff who had regular contact with or who provided direct care to residents with and related (ADRD) obtained four hours of initial training (Level I) within 3 months of employment and four hours of additional training (Level II) within 9 months of employment for 1 of 4 sampled employees. (Employee A)

The findings include:

A facility tour was conducted at approximately 9:10 AM on during the biennial re-licensure survey. At the time of the tour, a locked memory care unit was observed.

A review of the personnel file for Employee A revealed that her date of hire was . Further review of the personnel file for Employee A revealed that there was no documentation of completion of the initial 4 hours of required training (Level I) or the additional 4-hour required training (Level II) in her file.

An interview with the Employee I on at approximately 1:00 p.m. confirmed that the required training had not been completed.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation and staff interview, the facility failed to maintain a 3 day supply of non-perishable foods to serve the current census.

The findings include:

The emergency food supply was kept in a separate the resident hallway. The Dining Services Director (DSD) was present during review of the emergency food supply on at 2:50 pm. There was an Emergency Supply List taped to the shelving units in the . This list was compared to what the facility actually had on hand. The supply list had 2 cases of 6 jar peanut butter. There was only 3 jars on the shelf. The DSD stated they have been using the supply to serve food to the residents. The supply list also had 1 case 6 #10 chilli and beans. This was not located on any of the shelves. The DSD confirmed she did not have this case. She stated that there have been budgetary cut backs and she has had to make due with what she had. She stated she needed enough emergency food supply for 82 residents. The current census was 92.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC
Based on record review and staff interview, the facility failed to file and maintain an adverse incident report related to resident elopement for 1 of 2 sampled residents. (Resident # 21)

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The findings include:

A review of the clinical record for Resident # 21 revealed that he was admitted to the facility on . Resident #21's health care assessment dated , and signed by a physician stated that Resident # 21's diagnoses included and . It also stated that Resident # 21 had "occasional hallucinations", a "tendency to wander", and that general oversight was required related to observation of whereabouts "continuously". A nurse's note dated (the date of admission) at 12:10 p.m. stated that Resident # 21 was placed in the "Memory Care Unit this shift due to wandering". The next two nurses' notes dated / and stated that the resident was . A nurse's note dated stated that Resident # 21 "had gotten out of the building last night and was found by JSO (Jacksonville Sheriff's Office) walking up on Kingsley Avenue at 11:00 p.m. Med Tech states he was wandering last evening and put on Memory at 8:00 p.m., and doesn't know how he got out. Resident remains on Memory Care Unit. A little agitated this morning." A nurse's note dated revealed that Resident # 21's "wife called, aware of elopement". A review of the Individualized Service Plan dated revealed that Resident # 21 was able to ambulate independently, required , , medication side effect monitoring, had periods of forgetfulness and , required occasional reminders to find places within the community, required a safety check every shift. "This applies, but not limited to a resident at risk for wandering." "Agitation may cause occasional interference with everyday functioning." Documentation related to "change in condition" and dated revealed that Resident # 21 "cannot remember multiple items or cannot follow through on a direction given 5 minutes earlier." (Copies obtained of all above-mentioned information)

A review of the facility's adverse incident reports revealed that there was no report filed related to Resident # 21's elopement.

A email received from the AHCA Area 04 Office at 4:13 p.m. confirmed that no adverse incident report had been filed related to Resident # 21's elopement.

A review of the facility's Unsupervised Absence Management Policy revealed that the Resident Care Director (RCD) or designee was to evaluate a resident for potential to leave unsupervised by using the comprehensive evaluation tool.

An interview with Employee K (Resident Care Director) on at approximately 4:45 p.m. revealed that the facility had no documented form of resident elopement assessment. Employee K stated that he assessed each resident on admission and determined whether they were at risk. He stated that he did not document anywhere in the resident's record that they were considered "at risk". Employee K stated that this assessment process was ongoing, and that if a resident actually eloped, that resident was placed on the Memory Care Unit. Employee K stated that Resident # 21 was not deemed "at risk for elopement" upon admission to the facility. Employee K could not provide any documentation indicating that Resident # 21 had been assessed for elopement.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Emeritus At Orange Park
1248 Kingsley Avenue
Orange Park, FL 32073

Dear Administrator:

This letter reports the findings of a state biennial licensure survey that was conducted on 10, 2014 by representatives 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 after 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 surveyors. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JG/JM/sm
Enclosure

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