STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943123	10/19/2016
NAME OF PROVIDER OR SUPPLIER **HEARTLAND HEALTH CARE CENTER-K**	STREET ADDRESS, CITY, STATE, ZIP CODE **9400 SW 137TH AVENUE KENDALL, FL 33186**	

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

0000 Initial Comments

A complaint (CCR #2016010665) survey was conducted on 18 and 19, 2016. Heartland Health Care Center-Kendall with standard license (license number 7307) had the following deficiencies identified at the time of the survey:

0010 Admissions - Continued Residency

Based on record review and interview, the facility failed to provide a completed Health Assessment (AHCA form 1823) documenting what type assistance with medication administration needed two (Resident #11 and #15) out of the 15 sampled residents.

Finding include:

Review of Resident #11's record revealed that Health Assessment completed on / for Resident #11 was incomplete and it did not show if Resident #11 needed help taking the medications.

In an interview on at 12:28 PM the Assistant Administrator revealed that Resident #11 almost left to , and that Resident #11 received help with medications.

Review of Resident #15's record revealed that Health Assessment completed on / for Resident #15 was incomplete and it did not show if Resident #15 needed help taking the medications.

The findings regarding Resident #15 were reviewed during the exit conference on at 2:40 PM with the Administrator, Assistant Administrator, and the Director of Nursing. The facility was unable to provide a completed Health Assessment for Resident #15.

Class III

0025 Resident Care - Supervision

Based on record review and interview, the Assisted Living Facility failed to maintain an updated written record for one (#11) out of 15 sampled residents.

Findings included:

Review of Resident #11's record revealed that progress note completed on at 9:40 PM revealed that " resident informed nurse that her left (L) has an . Resident to see Dr on

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Monday ( ) regarding on L . Resident medicated for pain in hip. Continue to monitor and assis with needs."

Review of Resident #11's record revealed there was a progress note for that showed care completed that date and doctor order followed was left anterior thigh cleansed with normal applied bactrobam and ointment mix , covered with a no adherent gauze and secure with tegaderm. " There is a hardness on top of the that when you squeeze, there is pus and liquid coming out." measured from revealed that it was 2 cm x 1.5 cm x 0.1 cm. There was a doctor order for keep left AKA (above knee amputation) covered for 2 weeks more signed on .

Review of Resident #11's record revealed that ALF (Assisted Living Facility) Monthly Assessment completed on revealed that Resident #11's skin did not have any problems.

In an interview on at 12:04 PM the Licensed Practical Nurse (LPN) A was questioned about the discrepancy between the only nursing note from home health agency and the ALF monthly assessment completed in but LPN A did not answer.

Class III

0031 Resident Care - Third Party Services

Based on record review, interview and observation, the Assisted Living Facility failed failed to have care documentation from a third party provider for one (#5) out of 15 sampled residents. The Assisted Living Facility also failed to ensure that third party services had been provided to meet the resident's needs for one (#11) out of 15 sampled residents.

Findings included:

Record review found Resident #5's records revealed the facility observed a on Resident #5 on / . Facility note stated patient ( ) with open on his left . Record review revealed Resident #5's hospice log showed care started on . The facility did not have any other documentation regarding the care such as the order and care notes from hospice. The last available hospice care plan at the facility was dated prior to Resident #5's .

The findings regarding Resident #5 were reviewed during the exit conference on / at 2:40 PM with the Administrator, Assistant Administrator, and the Director of Nursing. The facility was unable to provide the care information from hospice for Resident #5

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Review of facility's record revealed that Resident #11 received care with a home health agency.

Resident #11's home health record was requested on / / at 2:30 PM to Assistant Administrator and at 2:37 PM to Administrator.

In an interview on at 12:30 PM the Assistant Administrator revealed "haven't they bring you the record yet, let me find out", when Assistant Administrator was questioned for Resident #11's home health record.

Review of Resident #11's home health record revealed that there was no documentation in facility.

Review of Resident #11's record revealed there was a progress note for that showed care completed that date and doctor order followed was left anterior thigh cleansed with normal applied bactrobam and ointment mix . covered with a no adherent gauze and secure with tegaderm. " There is a hardness on top of the that when you squeeze, there is pus and liquid coming out." measured from revealed that it was 2 cm x 1.5 cm x 0.1 cm. There was a doctor order for keep left AKA (above knee amputation) covered for 2 weeks more signed on .

Observation on at 1:57 PM revealed that Director of Nursing and Assistant Administrator were receiving documentation from home health agency via fax in the nursing station.

Class III

0056 Medication - Labeling and Orders

Based on record review, interview and observation, the Assisted Living Facility failed to ensure that doctor's order was followed for one (#3) out of 15 sampled residents. The Assisted Living Facility failed to obtain a signed written medication order from the health care provider within 10 working days for three (#3, #5 and #12) out of 15 sampled residents.

Findings included:

Review of Resident # 3's record revealed that there was a verbal doctor's order received on / by Licensed Practical Nurse (LPN) B for a resident consult, and it was signed by physician on (signed 12 weeks later) . There was no documentation in record that showed Resident #3 was consulted by .

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In an interview on at 12:28 PM the Assistant Administrator revealed that Assistant Administrator did not know why it took that long for doctor order to be sign and the Director of Nursing (DON) was finding out if the consult was followed.

In an interview on at 12:40 PM the DON was not sure if someone followed the consult order for Resident #3.

Review of Resident #5's Medication Observation Record (MOR) revealed that there was a handwritten order for (Same as) 0.5 mg tab ordered to take one tablet by mouth every six hours for dated but initialed just at 7 AM, 1 PM, and 7 PM.

In an interview on at 12 PM LPN A revealed that when facility received a verbal doctor order and it was usually signed by physician within two weeks. LPN A revealed that maybe the hospice nurse for Resident #6 changed the doctor order for on The nurse who received the right order but did not write the four scheduled times on the MOR and the rest of the nurses continued following the mistake.

Review of Resident #6's medicines on at 1:56 PM revealed that there was a bottle with a label showing 0.5 mg take one tablet by mouth every four hours as needed for agitation.

In an interview on at 1:56 PM in the Nursing Station the LPN A revealed that the label on Resident #6's medicine, was the previous doctor order.

Review of Resident #12's record revealed that there was a verbal doctor order for 500 mg one tablet by mouth twice a day for ten days, 2 mg one tablet by mouth after each loose stool no more of eight tablets in twenty-four hours as needed received on / by LPN A and as the time of the survey it was not signed. Also there was a verbal doctor order for X-ray of right lower back/lumbar spine complaint of pain/ received on / and as the time of the survey it was not signed.

Class III

0091 Training - Documentation & Monitoring

Based on record review and interview, the Assisted Living Facility failed to ensure that employees providing direct care to residents received one hour in-service training that covered resident rights in an assisted living facility, and one hour in-service training that covered recognizing and reporting , neglect, and , for five (CNAs A, B, C, D, and E) out five Certified Nursing Assistants (CNAs)

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records reviewed.

Findings included:

Review of CNA A's personnel record revealed there was no evidence of a completed one hour in-service training that covered resident rights in an assisted living facility, and recognizing and reporting neglect, and . CNA A hired date was / .

Review of CNA B's personnel record revealed there was no evidence of completed one hour in-service training that covered resident rights in an assisted living facility, and recognizing and reporting neglect, and . CNA B hired date was / .

Review of CNA C's personnel record revealed there was no evidence of completed one hour in-service training that covered resident rights in an assisted living facility, and recognizing and reporting neglect, and . CNA C hired date was .

Review of CNA D's personnel record revealed there was no evidence of completed one hour in-service training that covered resident rights in an assisted living facility, and recognizing and reporting neglect, and . CNA D hired date was .

Review of CNA E's personnel record revealed there was no evidence of completed one hour in-service training that covered resident rights in an assisted living facility, and recognizing and reporting neglect, and . CNA E hired date was .

In an interview on at 3:47 PM the Administrator stated " let me find out."

Record review on found the facility did not have any documentation of the training hours and the trainer's information.

Class III

Z813 Results of Screening & Notification in File

Based on record review, interview, and observation, the Assisted Living Facility failed to maintain in the employee's personnel file the eligibility results of employee's Level II background screening for two (CNAs B and E) out five Certified Nursing Assistants (CNAs) records reviewed.

Findings included:

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Review of Certified Nursing Assistant (CNA) B's personal record revealed that results of Level II Background screening showed / .

In an interview on at 2:32 PM the Assistant Administrator revealed that acknowledged CNA B had the new background screening done but Assistant Administrator was unable to find it in CNA B's personnel record.

On at 2:42 PM the Assistant administrator requested to the Administrator to print out the current background screening for CNA B.

Observation on at 2:45 PM revealed that Administrator brought the new background screening result.

Review of Certified Nursing Assistant (CNA) E's personal record revealed that results of Level II Background screening showed / .

In an interview on at 3:59 PM the Assistant Administrator stated " I don't know" when asked why new background screening result was not in the record.

Unclassified

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

|, 2016

Administrator
Heartland Health Care Center-K
9400 Sw 137th Avenue
Kendall, FL 33186
RE: CCR #2016010665

Dear Administrator:

This letter reports the findings of a Complaint licensure survey that was conducted on 19, 2016 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than |, 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

XG90

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