

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965167	(X3) DATE SURVEY COMPLETED 04/27/2017
NAME OF PROVIDER OR SUPPLIER ABOVE THE REST ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2360 MADRID AVENUE S.E. PALM BAY, FL 32909	

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

0000 - Initial Comments

The re-licensure survey with Limited Nursing Services (LNS) was conducted on . Above The Rest Assisted Living Facility license # 9646 had deficiencies at the time of the visit.

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

Based on observations and interview the facility failed to ensure the unlicensed staff who assisted 1 of 1 sampled resident (#21) with self-administration of medications followed the correct procedure.

Findings:

Observations on at 2 PM noted the staff checked the Medication Observation Record (MOR) and retrieved a plastic container that held the medications for resident #1. She brought the container to the resident, who sat at the dining . She put the 2 pills in a cup. She then told him "This is you medications "/> and attempted to say the other medication. The resident took the medications and then signed the MOR.

In a telephone interview with the administrator on at 1:40 PM who said the staff was trained, maybe she was nervous.

Class III

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

Based on observations and interviews the facility failed to ensure that except with respect to the use of pill organizers no individual other than a pharmacist may transfer medications from one storage container to another subsection (2), for 1 of 2 sampled resident #1.

Findings:

Observations on at 2 PM noted that staff checked the Medication Observation Record (MOR) and retrieved a plastic container that held the medications for resident #1. She brought the container to the resident, who sat in the dining . She retrieved 2 prescription bottles of one tablet 3 times a day and poured the contents of one bottle into the other. The prescription bottles were dated and

In a telephone interview with the administrator on at 1:40 PM who said the staff was trained.

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

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Class III 0078 - Staffing Standards - Staff - 58A-5.019(2) FAC Based on interviews and record review, the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation and allowed unlicensed staff to apply and remove compression stocking to 1 of 2 sampled residents (1). Findings: Observations during the facility tour on at 10 AM noted resident #1 had knee high compression stockings on. He said that he just got them and were trying to see if they helped him walk. He added the staff who was in the facility (A) put them on for him. Resident #2 confirmed his statement. Personnel record review for staff A revealed she was hired on 2013 and was a caregiver. The review revealed she was not a nurse. In an interview with staff A on at 11AM who stated she put on the compression hose on and the wife removed at night. In a telephone interview with the administrator on at 1:40 PM who said hospice must jut have ordered the compression hose. Class III 0081 - Training - Staff In-Service - 58A-5.0191(2) FAC Based on personnel record review and interview the facility did not provide or arrange for 1 of 3 sampled staff (B) to attend the mandated in-service training. Findings: Personnel record review for staff # B revealed she was hired in 2016 and was a caregiver. Continued review revealed no evidence to confirm she attended a 1-hour in-service training in control, including universal precautions and facility sanitation procedures before providing personal care to residents. 3-hours of in-service training regarding: Resident behavior and needs. Providing assistance with the activities of daily living. There was no evidence she was a nurse, Home Health Aide (HHA), or Certified Nursing Assistant (CNA) exempt from the above listed in-services. The review revealed a Home Health Aide certificate from The State of New York.		

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In an interview on at 1:45 PM with staff A, who stated that staff B was an HHA.

In a telephone interview with the administrator on at 1:40 PM who said the staff was an HHA in New York, she was not aware that HHA training from out of state was not acceptable.

Class III

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

Based on personnel record review and interview, the facility failed to ensure that 1 of 3 sampled staff (A) received at least 1- hour of training in the facility's policies and procedures regarding ().

Findings:

Personnel record review for staff A revealed she was hired on 2013 and was a caregiver. The review revealed no evidence to confirm she attended at least 1- hour of training in the facility's policies and procedures regarding ().

In a telephone interview with the administrator on at 1:40 PM who said the staff was trained and the certificate was most likely misplaced.

Class III

N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on observations, record review and interview the facility did not make sure that Limited Nursing Services (LNS) were only be provided as authorized by a health care provider's order, a copy of which must be maintained in the resident's file for 1 of 2 sampled residents (#1).

Findings:

Observations during the facility tour on at 10 AM noted resident #1 had knee high compression stockings on. He said that he just got them and was trying to see if they helped him walk. He added the staff who was in the facility (A) put them on for him. Resident #2 confirmed his statement.

Resident record review that included the hospice record revealed no evidence that a healthcare provider's order for the application and removal of the compression hose was not available.

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In a telephone interview with the administrator on at 1:40 PM who said hospice must jut have ordered the compression hose. Class III		