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	AL11965464	R 11/13/2018
NAME OF PROVIDER OR SUPPLIER **M H TENDER CARE I**	STREET ADDRESS, CITY, STATE, ZIP CODE **9 WAINWOOD PLACE** **PALM COAST, FL 32164**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A second unannounced revisit to the relicensure survey was conducted at MH Tender Care I on . MH Tender Care I (License #9901) had deficient practice identified during the survey.

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

Based on a review of resident records, and interview with staff, the facility failed to ensure the AHCA form 1823 (Resident Health Assessment) accurately reflected the resident's capability for medication self-administration for 1 of 1 residents reviewed for self-administration (Resident 4).

The findings include:

1. Observation of Resident 4 was conducted at 8:38 am on in her room. Her medications were stored on the overbed table to the left of her bed.

A record review for Resident 4 revealed an AHCA form 1823 dated which indicated Resident 4 required assistance with the self-administration of her medications. A new resident health assessment was completed on and signed by the resident's physician. The section asking if the resident required assistance with her medications, or could self-medicate, still indicated she required assistance with self-administration. Photographic evidence was obtained.

An interview was conducted with Employee A at 9:56 am on . She confirmed that Resident 4 was independent in the management of her own medications, and that those were here medications at her bedside. She explained Resident 4 was very independent. Employee A reviewed the AHCA 1823 dated , and confirmed the assessment still indicated Resident 4 required assistance with the self-administration of her medications.

This was previously cited by a representative of this office during the biennial licensure survey conducted , and the revisit to the biennial survey conducted on .

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Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on a review of facility records, and interview with staff, the facility failed to ensure the participation of 1 of 3 sampled employees (Employee B) in semi-annual resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S..

The findings include:

A review of the facility schedule revealed there were 3 employees actively working in the facility; Employees A, B and C. Employee A, Caregiver, confirmed in an interview at 9:47 am on . . . that those were the only 3 staff who worked in the home.

A review of the facility elopement drills revealed the last drill was conducted on . . . . It had been signed by Employee A, Caregiver, and Employee C, owner. Employee B was not included, and had not signed as participating in the elopement drill, as required.

An interview was conducted with Employee A at 10:40 am on . . . . She said she did not know why Employee B had not participated in any elopement drills since the last survey.

This was previously cited by a representative of this office during the biennial licensure survey conducted , and the revisit to the biennial survey conducted on . . .

Class III

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

Based on observation, resident and facility record review, and interview with staff, the facility failed to maintain a daily medication observation record (MOR) for 1 of 4 residents (Resident 1) who received

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assistance with self-administration of medications.

The findings include:

An observation of Resident 1 was conducted at 8:35 am on . Employee A, Caregiver, was providing assistance with the self-administration of her medication at the breakfast table. She obtained and prepared a medication pack containing the following: , 81 milligrams (mg), ( ) 20 mg, (cognition enhancer) 10 mg, Sundown 1000 micrograms (mcg), , 500 mg, , (treats high ,) 25 mg, , ( ) 0.25 mg, (supplement) 10 milliequivalents (meq) ER, and Ferrex (treats) 150 mg.

A review of the medication observation record (MOR) binder revealed there was no MOR in place for Resident 1 that alerted staff of any known , the name of the health care provider, or the health care provider's telephone number. There was no sheet listing the name, strength, or directions for use for Resident 1's medication, and no chart for recording each time the medication was taken, any missed dosages, refusals, or errors.

An interview was conducted with Employee A at 9:53 am on . She confirmed there was no MOR for Resident 1, explaining she was just readmitted to the facility from another sister facility last night.

Review of the admission and discharge log revealed Resident 1 was readmitted to the facility on ; 8 days prior to this survey.

This was previously cited by a representative of this office during the the revisit to the biennial survey conducted on .

Class III

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0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observations and interview with staff, the facility failed to ensure that all medications were kept in a locked cabinet at all times, that keys were not accessible to residents, and that sharps were properly stored or disposed of after use.

The findings include:

1. An observation of the medication cabinet in the facility's kitchen and dining nook on at 8:30 am revealed the key was in the top cabinet drawer's lock. Employee A, Caregiver, was in the room with the residents 1, 3 and 5, assisting with medication self-administration. Resident 3 became agitated over this surveyor's presence, and loudly exclaimed "Oh no!" She stood abruptly, began whispering to Employee A, and quickly walked to her bedroom. Resident 3 continued to move in and out of the kitchen, then retreated to her room to make a phone call. She could be heard yelling into the phone, and was obviously agitated. Employee A went in to calm her at approximately 8:45 am, leaving the key in the medicine cabinet, and Residents 1 and 2 at the table.

By 9:15 am the key was observed still in the cabinet lock, as Employee A moved through the kitchen and dining nook assisting the residents. She then walked to the . . . of the facility to feed another resident breakfast. Residents 1 and 5 remained at the table, while the key remained in the lock. Employee A returned to the kitchen at 9:24 am and assisted Resident 5 by pushing him in his wheelchair to the . . . porch. She remained outside with him for a few moments, while Resident 1 stayed the table, just 4 from the unsecured medication cabinet. The keys were still in place. Employee A returned to the table at 9:27 and provided stand-by assistance and support for Resident 1 to walk out to the porch.

Observations of the medication cabinet throughout the survey revealed the key was never removed from the lock. At 10:25 am on , the medication cabinet was observed to now have the top drawer open, all medications exposed. Employee A was in the rear of the facility with another resident. Resident 4 was in her room, and Residents 1 and 5 were on the screen porch. (Resident 3 had departed for her day activity program). Photographic evidence was obtained. Employee A returned from the rear of the facility at 10:32 am but did not close the drawer.

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Employee A assisted Residents 1 and 5 indoors from the porch at 10:38 am and took them to the living room. She then went into the rear of the facility at 10:45 am to check on another resident. The medication drawer was still open with all medications visible. She finally closed the drawer at 10:46 am, leaving the key in the lock. Photographic evidence of the unsecured medication storage cabinet was obtained.

In an interview with Employee A at 11:35 am on , she confirmed the key was left in the lock and the medications left unsecured. She stated she should have kept the key on her. She acknowledged the requirement to keep the medications secured at all times.

This was previously cited by a representative of this office during the revisit to the biennial survey conducted on .

2. An observation of the laundry room was conducted at 11:00 am on . The room was doorless, and located just off of the kitchen. A wire shelf was affixed to the wall above the washer and dryer. On the shelf, a clear plastic Blue Diamond almond container was discovered. The container was filled with approximately a half dozen syringes, and approximately 2 dozen used, uncapped needles. The container was easily opened for full access to the contents of the container. Photographic evidence was obtained.

An interview with Employee A at 11:09 am on confirmed the presence of the unsecured container. She stated it needed to be discarded, that those were old needles and syringes for a Resident 1 used to receive. Discussion was held with Employee A involving the dangers of used, unsecured needles.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observations, staff interviews, and facility and resident record reviews, the Administrator failed to exercise operational direction over the facility as required by Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter by failing to ensure corrections were made

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in response to the relicensure survey conducted on , and the revisit to the licensure survey conducted on including: Facility failure to ensure staff participation in elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(i), F.S.; failure to ensure resident safety related to medication and sharps storage, and environmental control in the event of power loss; and failure to ensure services provided to 3 of 3 residents met the standards set forth in Chapter 429, F.S., and 58A-35, F.A.C. relating to the accuracy of health assessments, maintenance of admission and discharge information, and of employee training and health records necessary to verify compliance.

The findings included:

1. Observation of Resident 4 was conducted at 8:38 am on in her room. Her medications were stored on the overbed table to the left of her bed.

A record review for Resident 4 revealed an AHCA form 1823 dated which indicated Resident 4 required assistance with the self-administration of her medications. A new resident health assessment was completed on and signed by the resident's physician. The section asking if the resident required assistance with her medications, or could self-medicate, still indicated she required assistance with self-administration. Photographic evidence was obtained.

An interview was conducted with Employee A at 9:56 am on . She confirmed that Resident 4 was independent in the management of her own medications, and that those were here medications at her bedside. She explained Resident 4 was very independent. Employee A reviewed the AHCA 1823 dated , and confirmed the assessment still indicated Resident 4 required assistance with the self-administration of her medications.

2. A review of the facility schedule revealed there were 3 employees actively working in the facility; Employees A, B and C. Employee A, Caregiver, confirmed in an interview at 9:47 am on that those were the only 3 staff who worked in the home.

A review of the facility elopement drills revealed the last drill was conducted on . It had been signed by Employee A, Caregiver, and Employee C, owner. Employee B was not included, and had not signed as participating in the elopement drill, as required.

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An interview was conducted with Employee A at 10:40 am on . She said she did not know why Employee B had not participated in any elopement drills since the last survey.
3. An observation of Resident 1 was conducted at 8:35 am on . Employee A, Caregiver, was providing assistance with the self-administration of her medication at the breakfast table. She obtained and prepared a medication pack containing the following: , 81 milligrams (mg), ( ) 20 mg, (cognition enhancer) 10 mg, Sundown 1000 micrograms (mcg), , 500 mg, , (treats high ,) 25 mg, , ( ) 0.25 mg, (supplement) 10 milliequivalents (meq) ER, and Ferrex (treats) 150 mg.

A review of the medication observation record (MOR) binder revealed there was no MOR in place for Resident 1 that alerted staff of any known , the name of the health care provider, or the health care provider's telephone number. There was no sheet listing the name, strength, or directions for use for Resident 1's medication, and no chart for recording each time the medication was taken, any missed dosages, refusals, or errors.

An interview was conducted with Employee A at 9:53 am on . She confirmed there was no MOR for Resident 1, explaining she was just readmitted to the facility from another sister facility last night.

Review of the admission and discharge log revealed Resident 1 was readmitted to the facility on ; 8 days prior to this survey.
4. An observation of the medication cabinet in the facility's kitchen and dining nook on at 8:30 am revealed the key was in the top cabinet drawer's lock. Employee A, Caregiver, was in the room with the residents 1, 3 and 5, assisting with medication self-administration. Resident 3 became agitated over this surveyor's presence, and loudly exclaimed "Oh no!" She stood abruptly, began whispering to Employee A, and quickly walked to her bedroom. Resident 3 continued to move in and out of the kitchen, then retreated to her room to make a phone call. She could be heard yelling into the phone, and was obviously agitated. Employee A went in to calm her at approximately 8:45 am, leaving the key in the medicine cabinet, and Residents 1 and 2 at the table.

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By 9:15 am the key was observed still in the cabinet lock, as Employee A moved through the kitchen and dining nook assisting the residents. She then walked to the of the facility to feed another resident breakfast. Residents 1 and 5 remained at the table, while the key remained in the lock. Employee A returned to the kitchen at 9:24 am and assisted Resident 5 by pushing him in his wheelchair to the porch. She remained outside with him for a few moments, while Resident 1 stayed the table, just 4 from the unsecured medication cabinet. The keys were still in place. Employee A returned to the table at 9:27 and provided stand-by assistance and support for Resident 1 to walk out to the porch.

Observations of the medication cabinet throughout the survey revealed the key was never removed from the lock. At 10:25 am on , the medication cabinet was observed to now have the top drawer open, all medications exposed. Employee A was in the rear of the facility with another resident. Resident 4 was in her room, and Residents 1 and 5 were on the screen porch. (Resident 3 had departed for her day activity program). Photographic evidence was obtained. Employee A returned from the rear of the facility at 10:32 am but did not close the drawer.

Employee A assisted Residents 1 and 5 indoors from the porch at 10:38 am and took them to the living room. She then went into the rear of the facility at 10:45 am to check on another resident. The medication drawer was still open with all medications visible. She finally closed the drawer at 10:46 am, leaving the key in the lock. Photographic evidence of the unsecured medication storage cabinet was obtained.

In an interview with Employee A at 11:35 am on , she confirmed the key was left in the lock and the medications left unsecured. She stated she should have kept the key on her. She acknowledged the requirement to keep the medications secured at all times.

5. An observation of the laundry room was conducted at 11:00 am on . The room was doorless, and located just off of the kitchen. A wire shelf was affixed to the wall above the washer and dryer. On the shelf, a clear plastic Blue Diamond almond container was discovered. The container was filled with approximately a half dozen syringes, and approximately 2 dozen used, uncapped needles. The container was easily opened for full access to the contents of the container. Photographic evidence was obtained.

An interview with Employee A at 11:09 am on confirmed the presence of the unsecured

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container. She stated it needed to be discarded, that those were old needles and syringes for a Resident 1 used to receive. Discussion was held with Employee A involving the dangers of used, unsecured needles.

6. A review of the facility schedule found there were 3 employees working in the facility; Employees A and B, Caregivers, and Employee C, the owner. Employee A confirmed in an interview at 9:47 am on that those were the only 3 staff who worked in the home.

Review of the employee files found there was no personnel record on site for the owner. There was no level 2 background screening clearance, no health clearance, and no evidence of continuing education, as required.

In an interview with Employee A at 10:38 am on , she confirmed the owner's file was not in the facility. She stated the owner always took her file with her, but she did not know why. The requirement to maintain all employee files in the facility was explained to her. Employee A stated she understood the requirement.

7. An observation of the facility schedule posted on the wall in the kitchen revealed is was dated , . There was no or schedule. The , schedule reflected Employee A working to on all 30 days in . . , ... Employee B, Caregiver, was also scheduled on Thursdays and Fridays; , , 7, 13, 14, 20, 21, 27 and 28, 2018. Photographic evidence was obtained.

An interview was conducted with Employee A 9:47 am on . She confirmed there were only the 3 employees working in the facility; herself, Employee B (Caregiver), and the owner. When asked if she ever had received a day off, she replied "Yes" and explained she had just returned from a 3 week trip to Jamaica. She stated Employee B worked her shift while she was gone. She confirmed there was not a current employee schedule, and that the owner was responsible for making them. She acknowledged the requirement for a current and accurate schedule to be maintained in the facility. Employee A said "I guess I understand that, but it is just the three of us working."

8. In an interview with Employee A, Caregiver, at 8:30 am on . . . . , she stated there were 5 residents in the home; Residents 1, 2, 3, 4, and 5. During a facility tour at 8:40 am, this report was

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confirmed and all 5 residents were observed.

A review of the facility's admission and discharge log revealed there were 6 residents in the home; Residents 1, 2, 3, 4, 5, and 8. Resident 8 was noted as admitted on . There was no date of discharge, reason of discharge, or discharge location. Photographic evidence was obtained.

An interview was conducted with Employee A at 9:53 am on . She stated Resident 8 lived here for just a short while, and was moved to MH Tender Care . Employee A stated the owner moved the residents around a lot between the facilities.

9. A review of agency records submitted by the facility owner revealed a policy on the facility's Emergency Power Plan and generator. The policy stated generator fuel would be stored to maintain the required reserve of 96 hours or more in advance of the pending storm season. The facility owner signed the policy on .

A typed "Generator Addendum to (facility's) Comprehensive Emergency Management Plan" signed by the facility owner on stated the facility had a portable generator as an alternate power source. The generator was powered by gasoline. The hours of runtime with onsite fuel was noted as 48. The number "48" had been -written over an original typed number, which was no longer legible. A handwritten letter authored and signed by the owner explained a correction had been made from 96 to 48 hours of fuel. The letter was not dated.

An observation of the facility garage was conducted with Employee A, Caregiver, at 10:55 am on . The portable generator was observed under a cover, and Employee A showed this surveyor 2 (two) 5-gallon containers of gasoline at the of the garage. She confirmed this was the total amount of fuel stored at the facility.

A review of the manufacturer's specifications for the generator (https://www.electricgeneratorsdirect.com/Generac-6672-Portable-Generator/p17680.html) and revealed the unit contained a 6.7-Gallon Extended Run Fuel Tank with a Built-In Fuel Gauge. The tank allowed for up to 11 hours of runtime at load (approximately .61 gallons per hour used). Mathematical for the 10 gallons of gasoline on site suggested sufficient fuel for approximately 16.4 hours of

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runtime. This did not meet the requirement of storing 48 hours of fuel onsite, and was inconsistent with the facility's policy.

Employee A acknowledged at the time of observation that insufficient amounts of fuel were stored and did not meet the requirements for fuel storage. She was asked for the policy and procedures for the facility's Emergency Power Plan (EPP). She showed me the facility records, and the Comprehensive Emergency Management Plan book. Review of the book found no emergency power addendum or policies and procedures. Employee A searched through facility records and files with this surveyor, but was unable to locate any EPP information.

A telephone call was placed to the facility owner at 11:00 am on . She was asked about the location of her EPP policies and procedures. She stated they should be in the facility. Each section of the Comprehensive Emergency Management Plan was reviewed with her over the phone. The Administrator had no explanation as to why the EPP was not in the facility, as required. Before the interview could continue, she stated she was so tired and was driving, and to please discuss the remainder of my findings with Employee A. The call was ended.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on observation, review of facility records, and interviews with staff, the facility failed to maintain an up-to-date admission and discharge log that included the date, reason, or location of the discharge for 1 of 1 discharged residents reviewed (Resident 8).

The findings include:

In an interview with Employee A, Caregiver, at 8:30 am on , she stated there were 5 residents in the home; Residents 1, 2, 3, 4, and 5. During a facility tour at 8:40 am, this report was confirmed and all 5 residents were observed.

A review of the facility's admission and discharge log revealed there were 6 residents in the home;

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Residents 1, 2, 3, 4, 5, and 8. Resident 8 was noted as admitted on . There was no date of discharge, reason of discharge, or discharge location. Photographic evidence was obtained.

An interview was conducted with Employee A at 9:53 am on . She stated Resident 8 lived here for just a short while, and was moved to MH Tender Care . Employee A stated the owner moved the residents around a lot between the facilities.

This was previously cited by a representative of this office during the biennial licensure survey conducted

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on a review of employee records, and interview with staff, the facility failed to maintain personnel records for 1 of 3 employees (Employee C, the owner) which contained, at a minimum, documentation of background screening and documentation of compliance with all training and health screening requirements. The facility also failed to maintain a current written work schedule for staff as required by Rule 58A-5.019, F.A.C.

The findings include:

1. A review of the facility schedule found there were 3 employees working in the facility; Employees A and B, Caregivers, and Employee C, the owner. Employee A confirmed in an interview at 9:47 am on that those were the only 3 staff who worked in the home.

Review of the employee files found there was no personnel record on site for the owner. There was no level 2 background screening clearance, no health clearance, and no evidence of continuing education, as required.

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In an interview with Employee A at 10:38 am on , she confirmed the owner's file was not in the facility. She stated the owner always took her file with her, but she did not know why. The requirement to maintain all employee files in the facility was explained to her. Employee A stated she understood the requirement.

This was previously cited by a representative of this office during the biennial licensure survey conducted , and the revisit to the biennial survey conducted on .

2. An observation of the facility schedule posted on the wall in the kitchen revealed is was dated , . There was no or schedule. The , schedule reflected Employee A working to on all 30 days in . Employee B, Caregiver, was also scheduled on Thursdays and Fridays; , , 7, 13, 14, 20, 21, 27 and 28, 2018. Photographic evidence was obtained.

An interview was conducted with Employee A 9:47 am on . She confirmed there were only the 3 employees working in the facility; herself, Employee B (Caregiver), and the owner. When asked if she ever had received a day off, she replied "Yes" and explained she had just returned from a 3 week trip to Jamaica. She stated Employee B worked her shift while she was gone. She confirmed there was not a current employee schedule, and that the owner was responsible for making them. She acknowledged the requirement for a current and accurate schedule to be maintained in the facility. Employee A said "I guess I understand that, but it is just the three of us working."

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on facility record review and staff interview, the facility failed to store sufficient amounts of fuel to cool the facility for 48 hours in the event of a loss of power, and failed to maintain written policies and procedures in a manner that made them readily available at the licensee's physical address, or if maintained in an electronic format, ensure that facility staff were able to access the policies and procedures and produce the requested information.

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The findings include:

A review of agency records submitted by the facility owner revealed a policy on the facility's Emergency Power Plan and generator. The policy stated generator fuel would be stored to maintain the required reserve of 96 hours or more in advance of the pending storm season. The facility owner signed the policy on .

A typed "Generator Addendum to (facility's) Comprehensive Emergency Management Plan" signed by the facility owner on stated the facility had a portable generator as an alternate power source. The generator was powered by gasoline. The hours of runtime with onsite fuel was noted as 48. The number "48" had been -written over an original typed number, which was no longer legible. A handwritten letter authored and signed by the owner explained a correction had been made from 96 to 48 hours of fuel. The letter was not dated.

An observation of the facility garage was conducted with Employee A, Caregiver, at 10:55 am on . The portable generator was observed under a cover, and Employee A showed this surveyor 2 (two) 5-gallon containers of gasoline at the of the garage. She confirmed this was the total amount of fuel stored at the facility.

A review of the manufacturer's specifications for the generator (https://www.electricgeneratorsdirect.com/Generac-6672-Portable-Generator/p17680.html) and revealed the unit contained a 6.7-Gallon Extended Run Fuel Tank with a Built-In Fuel Gauge. The tank allowed for up to 11 hours of runtime at load (approximately .61 gallons per hour used). Mathematical for the 10 gallons of gasoline on site suggested sufficient fuel for approximately 16.4 hours of runtime. This did not meet the requirement of storing 48 hours of fuel onsite, and was inconsistent with the facility's policy.

Employee A acknowledged at the time of observation that insufficient amounts of fuel were stored and did not meet the requirements for fuel storage. She was asked for the policy and procedures for the facility's Emergency Power Plan (EPP). She showed me the facility records, and the Comprehensive Emergency Management Plan book. Review of the book found no emergency power addendum or

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965464	R **11/13/2018**
NAME OF PROVIDER OR SUPPLIER **M H TENDER CARE I**	STREET ADDRESS, CITY, STATE, ZIP CODE **9 WAINWOOD PLACE** **PALM COAST, FL 32164**	

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

policies and procedures. Employee A searched through facility records and files with this surveyor, but was unable to locate any EPP information.

A telephone call was placed to the facility owner at 11:00 am on . She was asked about the location of her EPP policies and procedures. She stated they should be in the facility. Each section of the Comprehensive Emergency Management Plan was reviewed with her over the phone. The Administrator had no explanation as to why the EPP was not in the facility, as required. Before the interview could continue, she stated she was so tired and was driving, and to please discuss the remainder of my findings with Employee A. The call was ended.

This was previously cited by a representative of this office during EPP monitoring survey conducted on .

Class III