STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932406	02/04/2019
NAME OF PROVIDER OR SUPPLIER **GREENLEAF ASSISTED LIVING LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **509 W. VERONA STREET** **KISSIMMEE, FL 34741**	

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

0000 - Initial Comments

A Change of Ownership (CHOW) survey was conducted on . Greenleaf Assisted Living, LLC. with Limited Mental Health (LMH); Provisional License #8051 had deficiencies at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on interview and record review the facility failed to ensure that an licensed hospice, in consultation with the facility, developed and implemented an interdisciplinary care plan that specified the services being provided by hospice and those being provided by the facility and that documentation of the requirements was maintained in the resident's file for 1 of 4 sampled residents (#7).

Findings:

During the entrance interview on at 9 AM resident #7 was identified by the administrator as being under the care of hospice.

Resident record review for resident #7 revealed a health assessment report 1823 dated . A hospice interdisciplinary plan of care/update plan indicated the start of care was . The plan did not address the services provided by hospice and those being provided by the facility. There was no evidence to confirm an updated health assessment report 1823 was obtained when he experienced a significant change and was admitted to hospice.

In an interview on at with the Regional Manager and administrator 4 PM, who confirmed the findings.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, resident record review, Medication Observation Record (MORs) review and interview, the facility failed to maintain safe supervision for 1 of 4 sampled resident (#1) as required.

Findings:

Observation on at 9:15 AM, a prescription bottle of sterile , and , , B and , Suspension eardrops on resident #1's nightstand table next to bed.

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Immediately, asked resident #1, how did he get access to the eardrops? Resident #1 stated that the nurse giving medications this morning handed it to him.

On ... at 10:07 AM, an interview with the Administrator and the Licensed Practical Nurse (LPN) Administration Manager about resident #1 having possession of prescription eardrops in his room. The LPN stated that she would go and speak with the resident and retrieve the eardrops to store them securely into the medication cart. The Administrator stated that she would get the Lead Med Tech to come explain how resident #1 got the prescription eardrops in his room.

On . at 10:13 AM an interview with the Lead Med Tech and she identified that staff A was on the medication cart for the 8 AM medication assistance and would speak with her and further stated that she will have staff A take a refresher medication training course.

On . at 10:25 AM, an interview with staff A confirmed that she completed assistance with oral medications for resident #1 this morning around 9 AM, and she took out the prescription bottle eardrops and laid it on top of the medication cart to assist resident #1 but got distracted when another co-worker was calling her name and she turned her . She stated that was when resident #1 must have taken it and she did not realize it.

Reviewed , Medication Observation Record (MORs) at 10:32 AM, revealed staff A signed and initial giving the prescription eardrops at 8:59 AM on .

Resident #1's record review revealed date admission and a 1823 AHCA form Health Assessment dated by the physician documenting required assistance with self-administration of medications.

On at 2 PM, an interview with the Administrator confirmed the findings.

Photographic evidence obtained

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observations, record review and interview the facility failed to ensure the use of physical restrains (half-bed rails) was used with a healthcare provider's order for 1 of 4 sampled residents #7.

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Findings:

During the entrance interview on at 9 AM resident #7 was identified by the administrator as being under the care of hospice.

Observations on at 11:45 AM noted resident # 7 was in his room. His bed had half-bed rails.

Resident record review revealed a health assessment report 1823 dated that listed diagnoses of memory loss and . The no evidence to confirm that a healthcare provider's order for the use of half-bed rails had been obtained.

In an interview on at with the Regional Manager and administrator 4 PM, who confirmed the findings.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observations and interview the facility failed to ensure the unlicensed staff (A) who assisted 2 residents (# 12 and 6) with self-administration of medications followed the correct procedure.

Findings:

Observations on at 11:25 noted unlicensed staff A, assisted resident #12 in the following manner: She checked the Medication Observation Record (MOR). She took the medications from medication cart, put the pills in a cup and told resident the "Your and ". She observed resident take medications and signed the MOR.

Continued observations of the medication pass at 11:35 noted staff A, assisted resident #6 in the following manner: She checked the MOR, took the medications from the medication cart, put medications in cup and told resident "You know what you take', . She observed the resident take the medication and then signed the MOR.

She did not read the label out loud in front of the resident before pouring the medication in the cup.

In an interview on with the Regional Manager and the administrator at 4 PM, who said the

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staff was spoken to about the medication pass.

Class III

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

Based on observation and interview, the facility failed to maintain medications in a safe manner stored in a central location, kept in a locked cabinet; locked cart; or other locked storage receptacle room at all times required for 1 of 1 sampled resident (#1).

Findings:

Observation on at 9:15 AM, a prescription bottle of sterile and B and Suspension eardrops on resident #1's nightstand table next to bed. Immediately, asked resident #1, how did he get access to the eardrops? Resident #1 stated that the nurse giving medications this morning handed it to him.

On at 10:07 AM, an interview with the Administrator and the Licensed Practical Nurse (LPN) Administration Manager about resident #1 having possession of prescription eardrops in his room. The LPN stated that she would go and speak with resident and retrieve the eardrops to store them securely into the medication cart. Administrator stated that she would get the Lead Med Tech to come explain how resident #1 got the prescription eardrop in his room.

On at 10:13 AM an interview with the Lead Med Tech and she identified that staff A was on the medication cart for the 8 AM medication assistance and would speak with her and further stated that she will have staff A take a refresher medication training course.

On at 10:25 AM, an interview with staff A confirmed that she completed assistance with oral medications for resident #1 this morning around 9 AM, and she took out the prescription bottle eardrops and laid it on top of the medication cart to assist resident #1 but got distracted when another co-worker was calling her name and she turned her . She stated that was when resident #1 had taken it and she did not realize it.

On at 2 PM, an interview with the Administrator confirmed the finding.

Class III

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

Based on personnel record review and interview the facility failed to ensure 1 of 4 newly hired staff (A&B) received a pre-service orientation that included 1. Resident's rights; and, 2. The facility's license type and services offered by the facility.

Findings:

1. Personnel record review for staff A, hired revealed a statement dated that indicated that upon hire staff A received a 2- hour pre-service orientation that included new hire orientation packet, tour of the facility, general overview of an assisted living and job expectation. There was no evidence the pre-service included, in addition to topics chosen by the facility administrator, the pre-service orientation must cover: 1. Resident's rights; and,
2. The facility's license type and services offered by the facility (Limited Mental Health).

In an interview on at with the Regional Manager and administrator 4 PM, who confirmed the findings.

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record review and interview the facility failed to ensure 2 of 4 sampled residents (#2 & #7) contract contained all the required information.

Findings:

Individual resident record review for resident #7 revealed the contract did not contain a refund policy that conformed to the requirements of Chapter 429.24(3), F.S; and did not indicate that if the facility intended to make a claim against a refund due to the resident, the facility must notify the resident or responsible party in writing of such claim and give at least 14 days to respond to such claim.

In an interview on at with the Regional Manager and administrator 4 PM, who confirmed the findings.

Resident #2's record review revealed a contract agreement signed on but no written documentation about the 14-day notice of claim for refund provided and not included.

On at 2:45 PM, an interview with the Administrator and the Regional Corporate Manager

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confirmed the findings.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on resident record review and interview, the facility failed to notify in writing each resident and the resident's legal representative within five (5) business days for submission of the Emergency Power Plan (EPP) to the local emergency management agency and that the plan had been submitted for review and approval as required for 2 of 2 sampled residents (#2 & #7).

Findings:

Resident #2's record review revealed an incomplete required EPP letter from the facility notifying the residents and/or legal representatives. (Photographic evidence obtained)

On [redacted] at 2:55 PM, an interview with the Administrator and the Regional Corporate Manager confirmed the findings.

Photographic evidence obtained

Class III

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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on personnel record review, Background Screening (BGS) Clearinghouse website review and interview the facility failed to ensure 2 of 4 staff (A&E) whom were in a role that required a background screening (BGS) did not have any disqualifying offenses and was allowed the staff to continue to work without the screening results.

Findings:

1. In an interview with staff A on at 11:15 AM who said she had worked in the facility for 3 months now and was a medication tech/care giver.

Personnel record review for staff A, hired revealed a background screening result printed that indicated "awaiting privacy policy". On at 1:28 PM indicated she was eligible as of .

The facility allowed the staff to work without knowledge of her eligibility status.

The administrator printed a copy on 02/ after the Agency Representative informed her of the findings.

An interview on at 2:45 PM who said she thought the staff did not need to be re-screened.

2. Staff E's personnel record revealed he/she was the Food Manager and newly hired within 30 days ago.

On at 2:30 PM, a review of the BGS Clearinghouse website revealed a new screening for Level 2 BGS is required.

On at 4 PM, an interview with the Administrator and Regional Corporate Manager confirmed the finding.

Unclassified