STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910731	05/21/2019
NAME OF PROVIDER OR SUPPLIER **ST JOSEPH RESIDENCE**	STREET ADDRESS, CITY, STATE, ZIP CODE **3485 NW 30TH STREET** **LAUDERDALE LKS, FL 33311**	

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

0000 - Initial Comments

An Abbreviated relicensure survey was conducted at St. Jospeh Residence, Inc on . The facility had deficiencies identified at the time of survey.

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

Based on interview and record, the facility failed to have 1 out of 9 sampled residents (Resident #8) reassessed for continue residency due to the facility direct care staff and physician identifying significant behavioral changes.

The findings included:

Record review revealed Resident #8 was admitted into the facility on . Further record review revealed the Resident Health Assessment form (AHCA form 1823) dated on noted the resident was diagnosed with , , , , , , , , fecal impaction and legally . The or behavior status noted Resident #8 is alert and oriented with modified independence in decision making, gentle and pleasant.

Record review also revealed the facility failed to document any changes of behavior inside of the resident file. Progress notes dated to present indicated by facility direct care staff that Resident #8 was alert, stable and having wonderful days. However, the Healthcare Provider notes indicate a signficant behavior change for Resident #8. The following was noted.

a) On , a monthly assessment was conducted by the Physician Assistant (PA) for Resident#8, the , progress notes stated the PA was informed by the facility nursing staff that Resident #8 is irritable, and . The PA noted current medications were , 25 mg and 25 mg for , . Recommendations and new orders section of the form stated to continue medication and monitor the resident.

b) On , a monthly assessment was conducted by the Physician Assistant (PA) for Resident#8, the , progress notes stated the PA was informed by the facility nursing staff that Resident #8 continue to be very , agitated and , . The PA listed a new diagnosis for the resident stating the resident is experiencing , and , increasing the resident intake of 25 mg to 50 mg and to continue , 25 mg with specific instructions to continue to monitor the resident.

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c) On , and , a monthly assessment was conducted by the Physician Assistant (PA) for Resident#8, the PA was informed by the nurse on duty that Resident #8 continue to be agitated, , and loud at times. The PA listed the same diagnosis (and) for Resident #8 and noted for the nursing staff to continue to monitor the resident and to continue the current medication regimen.

An interview conducted on at 1:35 PM with the Physician Assistant (PA) confirming the resident was diagnosed with , and due to having frequent episodes of sadness, , bouts of agitation, yelling and being hard to tame by nursing staff. The PA further stated when she visit the facility, the staff members inform her of the behavior and she have experienced the resident behavior in person as well. The PA also confirmed that she requested to have the resident monitored by the facility nursing staff while taking the new medication was ordered in (exact date unknown). The PA stated she started Resident #8 on a very low dosage in hopes that his behavior would improve. After a couple months with the behavior not improving, she decided to increase the to 50 mg. It was further stated that she was completely unaware that the resident was not receiving her prescribed medication regimen and that would explain the reason for the resident behavior.

An interview conducted with the Director of Nursing (DON) on at 2:05 PM, confirmed the resident behavior described by the PA physician notes documented from to . The DON stated she is in charge to ensure the PA notes are reviewed on a monthly basis and to ensure that all physician medication orders are being filled and given as ordered. At this time, the DON stated she was not aware of the change in medication for Resident #8 to start receiving , and increased dosage of ; also further stating the staff who was given the physician orders failed to communicate the change in medication for Resident #8. The DON also confirmed the findings of the facility failure to document resident behavior as specifically requested by the doctor to monitor resident behavior since , to present due to behavior and new medication regimen.

An interview was conducted with the Risk Manager on at 2:30 PM, it was stated there is a breakdown in communication between the facility and the PA. After the Risk Manager reviewed Resident #8 file an order from the PA was dated on to begin , 25 mg on , however on the visit the PA stated to start , 25 mg and increased the from 25 to 50 mg. The Risk Manager confirmed and acknowledged at this time that in either instance the facility is at fault for not following physician orders, not documenting resident behavior and not updating facility records to reflect current medication regimen and diagnosis. Furthermore, the facility also failed to have the resident reassessed by his/her Healthcare Provider and the findings(results) documented on an AHCA form 1823.

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Class III

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

Based on record review and interview, the facility failed to follow physician orders and failed to make an effort to ensure prescribed medications are filled in a timely manner, for 1 out of 9 sample residents (Resident #8).

The findings included:

On , a monthly assessment was conducted by the Physician Assistant (PA) for Resident#8. The , progress notes stated the PA was informed by the facility nursing staff that Resident #8 is irritable, and . The PA noted current medications were , 25 mg and 25 mg for , . Recommendations and new orders section of the form stated to continue medication and monitor the resident.

On , a monthly assessment was conducted by the Physician Assistant (PA) for Resident#8. The , progress notes stated the PA was informed by the facility nursing staff that Resident #8 continues to be very , , agitated and , . The PA listed a new diagnosis for the resident stating the resident is experiencing , and , increasing the resident intake of 25 mg to 50 mg and to continue , 25 mg; specific instructions to continue to monitor the resident.

On , and , a monthly assessment was conducted by the Physician Assistant (PA) for Resident#8. The PA was informed by the Nurse on duty that Resident #8 continues to be agitated, and loud at times. The PA listed the same diagnosis (and) for Resident #8 and noted for the nursing staff to continue to monitor the resident and to continue the current medication regimen.

Record review of the Medication Observation Records for , to , revealed the following. Resident #8, although prescribed since , ; only received (25mg) as prescribed only in the month of and , of 2019 (1st to 21st). Resident #8 never received (25 mg) as physician order since . However, according to physician progress notes and medications orders (copies provided by PA); 25 mg (50mg as of) and , 25 mg was ordered since of 2018 as a part of the resident medication regimen to remedy the new diagnosis of , and , . However, interview with the facility staff (DON and Risk Manager) revealed Resident #8 did not receive the medication as physician ordered.

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An interview conducted on at 1:35 PM with the Physician Assistant (PA) confirming the resident was diagnosed with , and , due to having frequent episodes of sadness, , bouts of agitation, yelling and being hard to tame by nursing staff. The PA further stated when she visit the facility, the staff members informed her of the behavior and she have experienced the resident behavior in person as well. The PA also confirmed that she requested to have the resident monitored by the facility nursing staff while taking the new medication was ordered in (exact date unknown). The PA stated she started Resident #8 on a very low dosage in hopes that his behavior would improve. After a couple months with the behavior not improving, she decided to increase the to 50 mg. It was further stated that she was completely unaware that the resident was not receiving her prescribed medication regimen and that would explain the reason for the resident behavior.

An interview conducted with the Director of Nursing (DON) on at 2:05 PM, confirmed the resident behavior described by the PA physician notes documented from to . The DON stated she is in charge to ensure the PA notes are reviewed on a monthly basis and to ensure that all physician medication orders are being filled and given as ordered. At this time, the DON stated she was not aware of the change in medication for Resident #8 to start receiving , and increased dosage of ; also further stating the staff who was given the physician orders failed to communicate the change in medication for Resident #8. The DON also confirmed the findings of the facility failure to document resident behavior as specifically requested by the doctor to monitor resident behavior since , to present due to behavior and new medication regimen.

An interview was conducted with the Risk Manager on at 2:30 PM, it was stated there is a breakdown in communication between the facility and the PA. After the Risk Manager reviewed Resident #8 file an order from the PA was dated on to begin , 25 mg on , however on the visit the PA stated to start , 25 mg and increased the from 25 to 50 mg. The Risk Manager confirmed and acknowledged at this time, which in either instance the facility is at fault for not following physician orders, not documenting resident behavior and not updating facility records to reflect current medication regimen and diagnosis.

Class III

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

Based on employee record review, the facility failed to ensure 1 of 3 sampled direct care staff (Staff C) received the required in-service training with a certificate of completion dating the name of the staff, title

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of the in-service, date, duration time, and signed by the presenter.

The findings include:

On at 2:30 PM, during employee record review with the Assistant Administrator for Staff C (hire date of), revealed there was no documentation contained within the employee files, showing certificates of completion of the following regulatory required in-service training completed including the duration of the in service.
1) Incident Reporting -1 hour in service
2) Resident Rights - 1 hour in service
3) Recognizing and Reporting Resident , Neglect, and/or , - 1 hour in service

An opportunity was provided during the survey conducted on for the facility to offer any additional documentation or information to review. The Assistant Administrator, Administrator and Risk Manager acknowledged and confirmed the findings.

Class III

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

Based on employee record review and staff interview, the facility failed to ensure 1 of 3 sampled direct care staff (Staff C) received the required one hour in-service training in the facility's policies and procedures regarding ( ) with a certificate of completion dating the name of the staff, title of the in-service, date, duration time, and signed by the presenter.

The findings include:

On , during employee record review with the Assistant Administrator, for Staff C (hire date), revealed there was no documentation contained within the employee files, showing certificate of completion of the following regulatory required in-service training completed including the name of the staff, title of the in-service, date, duration time, and signed by the presenter.

1 hour in service

An opportunity was provided during the survey conducted on for the facility to offer any additional documentation or information to review. During an interview with the Assistant Administrator,

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Administrator and Risk Manager, on . . . at 3:00 PM, they acknowledged and confirmed the findings.

Class III