STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911240	03/13/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Heritage Alf, Inc (the)	4406 N Melton Ave Tampa, FL 33614	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D
St - A - 0161 - 58a-5.024(2) Fac - Records - Staff S-S= D

Specific Tag Findings:

Assisted Living Facility

AMENDED

Three unannounced complaint surveys, CCR# 2014000735, CCR# 2014000980 & CCR# 2013012988, were conducted on .

The Heritage ALF, Inc., assisted living facility, had deficiencies at the time of the visit. Tag A 030 was administratively deleted on .

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

Based on observation, interview, and record review, the facility failed to properly provide residents with assistance with self-administration of medications in accordance with Rule 58A-5.0191, F.A.C. and procedures described in Section 429.256, F.S. The facility is placing all 48 current residents at risk of adverse medical consequences by not ensuring that physician-ordered medications are provided to residents as prescribed.

Findings include:

On beginning at approximately 11:10am, Surveyor conducted a limited employee record review of 5 facility employees who provide residents with assistance with self-administration of medications. All 5 " Resident Care/Medication Assistants " are listed on the Employee schedule as responsible for providing residents with assistance with self-administration of medications; all 5 employees are unlicensed personnel; in training documented in Citation Tag #0084.

Surveyor observed Resident Care/Medication Assistant (Staff A) signing Medication Observation Records at 10:26am for meds given at 8am on day of visit ( ). When Surveyor asked Staff A to describe her process for providing residents with medications, staff replied: " Residents get in line. I give meds for 8am, pop meds into cup and water <from insulated jug> into <other> cup. I put on counter and resident takes. I sign <the MORs> when all residents are done getting meds, sign some of them at the time, didn ' t finish signing. " Staff A

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showed Surveyor her system and explained: She puts the Morning pack in back of residents' daily meds in the med cart so she knows what meds were given, then later (when done providing all residents their meds), Staff A stated she " check packs one by one to make sure sign for all meds given. Sometimes med is missing, so don ' t sign <don ' t initial as given>. " When asked what she does when a med is missing, Staff A stated she makes a list of missing meds for the pharmacy so they can call the pharmacy to reorder.

Surveyor observed Medication Observation Records and found considerable spaces where there is no indication of residents getting medications as prescribed. Staff A stated (at 10:45am) that " Med Techs need to sign for spaces, " that she only signs hers. Surveyor selected 4 Medication Observation Records for further review -- 4 of the 4 Medication Observation Records contained considerable errors and omissions, as documented in Citation Tag #0054. Additional concerns were identified:

Assistance with self-administration of medications provided by unlicensed personnel does not allow provision of medications ordered by physicians with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, or medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

Resident #9 ' s Medication Observation Record (MOR) for / through / contains an order written " XS 500 MG-Take one tablet by mouth as needed (PRN) " -- Initialed as provided on / / & -No time specified, no indication of what the medication is for or parameters for provision, no notes re. times and reason for giving or results-Initials crossed out and " Finished " written with line across entire month-no indication of if/when the medication was discontinued per physician order.

Resident #5 ' s Medication Observation Record (MOR) for through contains 2 orders for the same " as needed " medication. Per Page 2 of medication charting, Resident #5 ' s medication includes SUL ER 30 MG-Take 1 tablet by mouth every 8 hours as needed-8am, 3pm, & 8pm--Initialed as provided at 8am on / , , & and initialed as provided at 3pm on , , , , , , & and initialed as provided at 8pm on --No indication of what the medication is for, no parameters for provision, and no notes re. reason for giving or results. Per Page 3 of medication charting, the same Resident (#5) ' s medication includes: SUL IR 30 MG-Take 1 tablet by mouth every 6 hours as needed (PRN)--Initialed as provided 4 times on / & , 2 times on , , , , , & and 1 time on , & --No times provided re. when the medication was provided, no indication of what the medication is for, no parameters for provision, and no notes re. reason for giving or results. There is also no indication that the facility contacted the doctor or pharmacy about this medication order possibly being duplicated.

Surveyor observed a " Disciplinary Action Report " dated in Staff C ' s Employee record. Staff C was " written up " for giving a resident the wrong medication when he went on a home pass. There was no indication of which resident received the incorrect medication or which other resident ' s medication the resident received.

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Per interview conducted with Resident #6 ' s Case Manager (. _ /. . at 2:50pm), Resident #6 had to be on and was hospitalized, experiencing paranoia, persecutory thoughts, heighted , I thought content, and abnormal eye movements upon case manager ' s visit at 3pm. After being hospitalized the first time, the resident stated he still was not getting his meds properly. After his 3rd hospitalization, resident left the facility (at the end of , 2014) because he did not trust staff to give him his meds correctly. Case Manager observed Resident #6 ' s , 2014, Medication Observation Record (MOR) and told facility staff that the record showed Resident #6 was not receiving his medications as prescribed. When Case Manager visited the facility a second time, the medications not previously initialed as given were filled in on the MOR as having been given by one Staff at all times of the day & evening, including dates Resident #6 was in the hospital.

Facility Owner acknowledged during exit conference conducted beginning at approximately 2:00pm that medication records contain considerable errors, and stated: " That ' s why staff <A> is working on them. "

The facility has clearly demonstrated widespread and ongoing failure to provide accurate assistance with self-administration of medications in accordance with state-mandated policies and procedures.

Class III

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

Based on observation, interview, and record review, the facility failed to provide accurate assistance with self-administration of medications and properly maintain accurate daily Medication Observation Records (MOR) for each resident who receives assistance with self-administration of medications, including recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors, and immediately updating each time a medication is offered or administered. The facility is placing all 48 current residents at risk of adverse medical consequences by not ensuring that physician-ordered medications are provided to residents as prescribed.

Findings include:

Surveyor observed Resident Care/Medication Assistant (Staff A) signing Medication Observation Records at 10:26am for meds given at 8am on day of visit ( ). When Surveyor asked Staff A to describe her process for providing residents with medications, staff replied: " Residents get in line. I give meds for 8am, pop meds into cup and water <from insulated jug> into <other> cup. I put on counter and resident takes. I sign <the MORs> when all residents are done getting meds, sign some of them at the time, didn ' t finish signing. " Staff A showed Surveyor her system and explained: She puts the Morning ' pack in back of residents ' daily meds in the med cart so she knows what meds were given, then later (when done providing all residents their meds), Staff A stated she " check packs one by one to make sure sign for all meds given. Sometimes med is missing, so don ' t sign <don ' t initial as given>. " When asked what she does when a med is missing, Staff A stated she makes a list of missing meds for the pharmacy so they can call the pharmacy to reorder.

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Surveyor observed Medication Observation Records and found considerable spaces where there is no indication of residents getting medications as prescribed. Staff A stated (at 10:45am) that " Med Techs need to sign for spaces, " that she only signs hers. Surveyor selected 4 Medication Observation Records for further review -- 4 of the 4 Medication Observation Records contained considerable errors and omissions, as follows:

Resident #9 ' s Medication Observation Record (MOR) for / through contains the following medications and errors/omissions: 325 MG - Take 1 tablet by mouth every day - 8am: Not initialed as provided on and ; 2 MG -Take one tablet by mouth twice a day--8am & 3pm: Not initialed as provided on at 8am and Not initialed as provided on at 8am & 3pm; 10 MG - Take one tablet by mouth twice a day--8am & 3pm: Not initialed as provided on at 8am and Not initialed as provided on at 8am & 3pm; 200mg-Take one capsule by mouth every day 8am: Not initialed as provided on and ; DR 500 MG-Take one tablet by mouth twice a day--8am & 3pm: Not initialed as provided on at 8am and Not initialed as provided on at 8am & 3pm; 180 MG - Take 1 tablet by mouth at bedtime-8pm: Not initialed as provided on ; 1MG - Take 1 tablet by mouth in the morning-8am: Not initialed as provided on and ; 88 MCG - Take 1 tablet by mouth every day-8am: Not initialed as provided on and ; 500 MG -Take 1 tablet by mouth three times a day 8am, 3pm, 8pm-: Not initialed as provided on at 8am; Not initialed as provided on at any time 8am, 3pm, 8pm; Not initialed as provided on at 8pm; Not initialed as provided on / at 8pm; Tart 25MG-Take 1 tablet by mouth twice a day-8am & 8pm-: Not initialed as provided on at 8am; Not initialed as provided on at any time 8am, 8pm; Not initialed as provided on at 8pm; Not initialed as provided on / at 8pm; , DR 40 MG -Take one capsule by mouth every morning 8am: Not initialed as provided on at 8am and Not initialed as provided on at 8am; 3 MG -Take 2 tablets by mouth at bedtime - 8pm: Not initialed as provided on ; 8.6 MG-Take 2 tablets by mouth at bedtime - 8pm: Not initialed as provided on & Not initialed as provided on / ; 100 MG - Take 1 & 1/2 tablet by mouth every day - 8am: Not initialed as provided on & Not initialed as provided on ; 50MG- Take 1 tablet by mouth three times a day 8am, 3pm, 8pm: Not initialed as provided on at 8am; Not initialed as provided on at any time 8am, 3pm, 8pm; Not initialed as provided on at 3pm & 8pm; 5MG-Take 1 tablet by mouth twice a day - 8am & 3pm Not initialed as provided on at 8am; Not initialed as provided on at any time 8am & 3pm; Not initialed as provided on / at 3pm. There are no Medication Notes on the reverse side of the Medication Observation Records --No explanation was provided for any of the above missing dosages.

Additional errors were also found on Resident #9 ' s Medication Observation Record (MOR) for / through / : , 500 MG-Take 1 tablet by mouth twice a day-8am & 4pm--Initialed as provided on / at 8am & 4pm, at 8am & 4pm, and at 4pm-Initials crossed out and " Finished " written with line across entire month-no indication of if/when the medication was discontinued per physician order. Doxycline 100 MG-Take 1 capsule by mouth twice a day-8am & 8pm--Initialed as provided on / at 8am, at 8am, and at 8pm-Initials crossed out and " Finished " written with line across entire month-no indication of if/when the medication was discontinued per physician order. 2%-Apply to Right Great Toe twice a day for 14 days- 8am & 8pm--Initialed as provided on / at 8am & 8pm, at 8am,

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at 8pm, at 8pm and at 8pm -Initials crossed out and " Finished " written with line across entire month-no indication of when the medication was started and when the 14 day period ended and no continuity of provision per MOR. 25 MG-Take 1 tablet by mouth three times a day-8am, 3pm, 8pm: Initialed as provided on at 8am & 3pm, at 8am & 3pm, and at 3pm & 8pm -Initials crossed out and " Not continued on last 1823 " written across remainder of the month-no indication of if/when the medication was discontinued per physician order. " XS 500 MG-Take one tablet by mouth as needed (PRN) " -- Initialed as provided on & -No time specified, no indication of what the medication is for or parameters for provision, no notes re. times and reason for giving or results-Initials crossed out and " Finished " written with line across entire month-no indication of if/when the medication was discontinued per physician order.

Resident #15 ' s Medication Observation Record (MOR) for I/ through I/ contains the following medications and errors/omissions: XL 300 MG (Generic of XL)- Take 1 tablet by mouth daily in the morning- 8am: Not initialed as provided on ; 0.5 MG Tablet (Generic of) - Take one tablet by mouth daily at bedtime- 8pm: Initialed as provided twice on -at 8pm & at an unspecified time; 50 MG-Take 1 tablet by mouth daily- 8am: Not initialed as provided on & Not initialed as provided on ; 100 MG (Generic of) -Take 2 tablets by mouth daily - 8am: Not initialed as provided on ; 1000 MCG - Take 1 tablet by mouth daily - 8am: Not initialed as provided on . There are no Medication Notes on the reverse side of the Medication Observation Records --No explanation was provided for any of the above missing dosages.

Resident #5 ' s Medication Observation Record (MOR) for through contains the following medications and errors/omissions: XL 300 MG -Take 1 tablet by mouth every morning- 8am: Not initialed as provided on I/ , & ; 15 MG - Take one tablet by mouth three times a day--8am, noon, 5pm: Not initialed as provided at 8am and at noon on I/ , & and Not initialed as provided at 5pm on ; 0.2 MG-Take 1 tablet by mouth three times a day-8am, 3pm, 8pm: Not initialed as provided at 8am on I/ , & and Not initialed as provided at 3pm on & I/ ; 60 MG- Take one capsule by mouth at bedtime- 8pm: Not initialed as provided on I/ , & ; 40MG Tablet -Take 1 tablet by mouth every day -8am: Not initialed as provided on I/ , & ; 300 MG-Take 1 capsule by mouth 3 times a day 8am, 3pm, 8pm: Not initialed as provided at 8am on I/ , & and not initialed as provided at 3pm on , & / and not initialed as provided at 8pm on ; 1000 MG -Take 1 tablet by mouth twice a day-8am & 3pm: Not initialed as provided at 8am on I/ , & and not initialed as provided at 3pm on , & I/ ; Tar 50 MG-Take 1 tablet by mouth twice a day- 8am & 3pm: Not initialed as provided at 8am on , & and not initialed as provided at 3pm on , & I/ ; 500 MG-Take one tablet by mouth twice a day-8am & 8pm: Not initialed as provided on I/ , & and not initialed as provided at 8pm on ; CL 20 MEQ - Take 1 tablet by

mouth every day - 8am: Not initialed as provided on , , , , , , , / , , & ; 100 MG- Take 1 tablet by mouth every morning and two tablets every night at bedtime - 8am, 10pm: Not initialed as provided at 8am on , , , , , / , & . There are no Medication Notes on the reverse side of the Medication Observation Records--No explanation was provided for any of the above missing dosages.

Per Page 2 of medication charting for through , Resident #5 ' s medication includes SUL ER 30 MG-Take 1 tablet by mouth every 8 hours as needed-8am, 3pm, & 8pm--Initialed as provided at 8am on , , & and initialed as provided at 3pm on / , , , , , , & and initialed as provided at 8pm on --No indication of what the medication is for, no parameters for provision, and no notes re. reason for giving or results. Per Page 3 of medication charting for / through , the same Resident (#5) ' s medication includes: SUL IR 30 MG-Take 1 tablet by mouth every 6 hours as needed (PRN)--Initialed as provided 4 times on / & , 2 times on , , , , , & and 1 time on , & --No times provided re. when the medication was provided, no indication of what the medication is for, no parameters for provision, and no notes re. reason for giving or results. There is no indication that the facility contacted the doctor or pharmacy about this medication order possibly being duplicated.

Resident #3 ' s Medication Observation Record (MOR) for / through contains 18 handwritten medications with times for provision; other MORs observed were typed by the pharmacy. As of at approximately 11:00am, the record contains initials and staff signature provided by Staff A only, with no comments on reverse sides of the MORs. On page 1 of 2, 5 medications are listed to be provided 4 times a day (8am, 12pm, 3pm, & 8pm)--Staff A initialed as providing these 5 medications at 8am on & only, 4 of the 5 medications at 12pm on & only, 1 of the 5 at 12pm on only, 2 of the 5 medications at 3pm on only, 5 of the 5 medications at 8pm on only, and 1 of the 5 also at 8pm on . On page 1 of 2, 3 medications are listed to be provided once daily at 8am--Staff A initialed as providing 1 of these 3 medications at 8am on & only and 2 of these 3 medications at 8am on only. On page 1 of 2, 1 medication is listed to be provided once daily at 8am--Staff A initialed as providing this medication on only. There are no other days/times the above daily medications were initialed as having been provided. On page 2 of 2, 9 medications are handwritten to be provided: 3 at 8am, 3 at 8am & 3pm, 1 at 8am, 12pm, & 3pm, and 2 at 8am, 3pm, & 8pm--Staff A initialed as providing all 8am medications on only and 3pm medications on only. There are no other days/times these daily medications were initialed as having been provided.

A Facility Owner acknowledged during exit conference conducted beginning at approximately 2:00pm that medication records contain considerable errors, and stated: " That ' s why staff <A> is working on them. "

Per interview conducted with Resident #6 ' s Case Manager (/ at 2:50pm), Resident #6 had to be on and was hospitalized. After hospitalized the first time, the resident stated he still was not getting his meds properly. After his 3rd hospitalization, resident left the facility (at the end of , 2014) because he did not trust staff to give him his meds correctly. Case Manager observed Resident #6 ' s ,

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2014, Medication Observation Record (MOR) and told facility staff that the record showed Resident #6 was not receiving his medications as prescribed. When Case Manager visited the facility a second time, the medications not previously initialed as given were filled in on the MOR as having been given by one Staff at all times of the day & evening, including dates Resident #6 was in the hospital.

Surveyor observed a " Disciplinary Action Report " dated in Staff C's Employee record. Staff C was " written up " for giving a resident the wrong medication when he went on a home pass. There was no indication of which resident received the incorrect medication or which other resident ' s medication the resident received.

The facility has clearly demonstrated widespread and ongoing failure to provide accurate assistance with self-administration of medications and proper maintenance of accurate resident Medication Observation Records.

Class III

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

Based on observation and interview, the facility failed to keep all centrally stored medications in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times, and failed to dispose of abandoned or expired medications within 30 days of being determined abandoned or expired, with disposition documented in residents' records.

Findings include:

Surveyors entered an unlocked door (non-locking type) across the hall from the facility ' s front counter/medications area on at approximately 9:45am. A sign on the door states Employees only/Employee /Do Not Enter. There are 2 small -first upon entry has electrical wires hanging along wall-observed large plastic tote box on floor, unlocked, with one of the 2 top halves open: Medication packs observed from 2nd where toilet & sink are located. Further observation revealed the box was stocked full of resident medications - 4 packs randomly selected were dated & , 2013.

Surveyor also observed a partially used pack on top of lockers in the Employee .

Surveyor asked Med Tech on duty if she ever leaves the front counter/nursing station (at 12:57pm) to assist Aides or if she does meds only-- Med Tech stated she normally does housekeeping but she ' s doing meds because the meds person is not here today. When asked if meds person assists with resident care or does meds only, the Owner stated that " the Med Tech helps out with meals, helps out on the first floor " and " When she ' s done with meds, she assists Aide. " The Owner confirmed that the unlocked , where unsecured medications were found, is not always attended and therefore accessible to residents and visitors as well as staff. The Owner stated (at approximately 11:00am) that the medications in the tote box are going to be returned to the pharmacy.

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Class III

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

Based on observation and record review, the facility failed to contact residents ' health care providers for revised instructions for medications prescribed " as needed " to include the circumstances under which it would be appropriate for the resident to request the medication and any specified limitations, and failed to ensure revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, are noted in the medication record and a revised label obtained from the pharmacist.

Findings include:

Surveyor observed Medication Observation Records and found considerable spaces where there is no indication of residents getting medications as prescribed. Staff A stated (at 10:45am) that " Med Techs need to sign for spaces, " that she only signs hers. Surveyor selected 4 Medication Observation Records for further review -- 4 of the 4 Medication Observation Records contained considerable errors and omissions, as documented in Citation Tag #0054. Additional concerns were identified:

Resident #9 ' s Medication Observation Record (MOR) for through contains an order written " XS 500 MG-Take one tablet by mouth as needed (PRN) " -- Initialed as provided on & -No time specified, no indication of what the medication is for or parameters for provision, no notes re. times and reason for giving or results-Initials crossed out and " Finished " written with line across entire month-no indication of if/when the medication was discontinued per physician order.

Resident #5 ' s Medication Observation Record (MOR) for through contains 2 orders for the same " as needed " medication. Per Page 2 of medication charting, Resident #5 ' s medication includes SUL ER 30 MG-Take 1 tablet by mouth every 8 hours as needed-8am, 3pm, & 8pm--Initialed as provided at 8am on , & and initialed as provided at 3pm on , & and initialed as provided at 8pm on --No indication of what the medication is for, no parameters for provision, and no notes re. reason for giving or results. Per Page 3 of medication charting, the same Resident (#5) ' s medication includes: SUL IR 30 MG-Take 1 tablet by mouth every 6 hours as needed (PRN)--Initialed as provided 4 times on & , 2 times on , , , , & and 1 time on , & --No times provided re. when the medication was provided, no indication of what the medication is for, no parameters for provision, and no notes re. reason for giving or results. There is also no indication that the facility contacted the doctor or pharmacy about this medication order possibly being duplicated.

Facility Owner acknowledged during exit conference conducted beginning at approximately 2:00pm that medication records contain considerable errors, and stated: " That ' s why staff <A> is working on them. "

The facility has clearly demonstrated widespread and ongoing failure to provide accurate assistance with

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self-administration of medications in accordance with state-mandated policies and procedures.

Class III

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC

Based on record review and interview, the facility failed to ensure that 3 of 5 staff who provide assistance with self-administration of medications have successfully completed the initial 4-hour training on providing assistance with self-administration of medications and safe medication practices in an assisted living facility. The facility also failed to ensure that 2 of 5 staff who provide assistance with self-administration of medications have successfully completed annual 2-hour updates on providing assistance with self-administration of medications. Providing assistance with self-administration of medications without completing the required trainings places residents at risk of adverse medical consequences.

Findings include:

On beginning at approximately 11:10am, Surveyor conducted a limited employee record review of 5 facility employees who provide residents with assistance with self-administration of medications. All 5 " Resident Care/Medication Assistants " are listed on the Employee schedule as responsible for providing residents with assistance with self-administration of medications.

Surveyor review of the personnel record for staff A (date of hire:) revealed there was no evidence of staff A completing 4 hours of initial medication training; there was evidence of completing a 2-hour medication training on /

Surveyor review of the personnel record for staff C (hired) revealed there was no evidence of staff C completing 4 hours of initial medication training.

Surveyor review of the personnel record for staff D (hired) revealed there was no evidence of staff D completing a 2-hour medication training update. Staff D 's record contained an initial 4 hour medication training dated (Florida Medical Prep certificate states " recognizes this certificate as valid for one (1) year from completion date ")-there was no evidence of 2 hour update due by .

Surveyor review of the personnel record for staff E (hired) revealed there was no evidence of staff E completing 4 hours of initial medication training and no evidence of completing a 2-hour update. Staff E ' s record contained a 2 hour medication training dated - there was no evidence of staff E completing a 2 hour update due by in addition to no evidence of the initial 4-hour training.

When asked about meds training, Staff A stated: " I remember training at facility last year for all med techs, class here in building. " Record review conducted on beginning at approximately 11:10am confirmed Staff A participated in a 2 hour medication training on / . When asked about attending 4 hours of meds training any time before that training, Staff A repeated having the " training in the building last year. "

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Facility Owner acknowledged during exit conference conducted beginning at approximately 2:00pm that medication records contain considerable errors, and stated: " That ' s why staff <A> is working on them. " Owner also stated that all the Med Techs have been trained. Per record review, only one of the 5 staff providing residents with medication assistance is in compliance with state-mandated training requirements: Surveyor review of the personnel record for Staff B (date of hire: / :) revealed completion of initial 4 hour medication training on , prior to beginning facility employment.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC

Based on observation, record review, and interview, the facility failed to ensure a safe living environment for facility residents and failed to ensure that linens provided by the facility are free of stains. The facility is failing to properly address ongoing bedbug infestation throughout the facility.

Findings include:

Surveyor asked facility Owner (at 10:02am) if he has a bedbug problem at the facility-Owner responded, " Before, but not right now. I have a Maintenance person who works here who knows better. I think he has to close the .! fumigate. He did so a while ago, but I don ' t have the specifics. " Maintenance person arrived at approximately 10:05am and stated: " We take all clothes out of the , spray with chemical, leave , for 24 hours. If the mattress is , we throw it out or spray the bed. Then we clean the bleach and water before the resident returns. Another guy who works for me <Housekeeper> actually does the spraying. " Maintenance person did not know how long ago the Housekeeper last sprayed. Owner stated he has no record of mattresses he threw out " a few months ago. " Maintenance person showed Surveyors the product (" bedbug spray ") used by the Housekeeper: " Hot Shot Bedbug & Flea " -- and stated that the product was purchased at Home Depot. Maintenance person stated: " Sometimes one time is not enough, and we need to take all the resident ' s clothes and wash them and put them in plastic bags and take them to the laundry. " The Owner stated that he has commercial washers at another facility (owned by same owner group) and can take clothes there to wash. When asked if the facility has a policy/procedures pertaining to bedbug prevention or treatment, the Owner stated: "A policy was spoken of, but I don ' t know where the Administrator has it. " Owner stated " residents go on home passes and return with bugs and new admissions ' belongings are inspected before they come in, try to wash their clothes, on a case by case basis. " Owner stated the facility has a contract with Steritech. Surveyors requested a copy of that contract; the Owner stated he will find it by the end of the day/visit. At 1:40 pm, the Owner stated that facility ' s contract with Steritech is for pest control only, but that he could contract with them to do bedbug treatment. During exit interview conducted on the same day (beginning at approximately 2:00pm), the Owner stated that he had previously inquired re. bedbug treatment with the pest control company and was told a high price. The Owner faxed ( ) a copy of the facility ' s contract with Steritech for Pest Prevention services, verifying the contract is for pest control only,

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911240	03/13/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Heritage Alf, Inc (the)	4406 N Melton Ave Tampa, FL 33614	

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

not bedbug prevention or treatment.

Surveyor interviewed resident #3 on at approximately 9:20am: Resident stated she has bedbug bites and showed red marks on her arm -- stated she has lived at the facility for 4 months and that she sees bedbugs all the time and steps on them to smash them. Resident stated the facility " sprays and puts powder down-the bugs die but return. They travel on clothes from one the next. I see them on other residents when we stand in line for meds. I don ' t even want to be in my bed. They come out of the baseboards. The facility sprays for bedbugs; pest control company sprays for roaches. This is a dirty place. It needs a good Spring cleaning. "

Surveyor conducted facility tour and resident interviews specifically for bedbug activity on from approximately 1:00pm-1:50pm, accompanied by Maintenance person, who provided Spanish to English translation as needed and allowed Surveyor to conduct private interviews as well.

Surveyor interviewed resident #8--foul odor emitting from entry-- resident stated re. bedbugs: " They do something to treat them every other week. " Surveyor observed spots on sheet -- Resident stated: " That ' s from me squashing them. They keep putting down boric l, which works great on roaches, but that ' s it. They ' re never going to get rid of them unless they do correct treatment. There ' s no company that does it-one of the Housekeepers does it. "

Surveyor interviewed resident #7-Resident stated she " used to get a lot of bites, but the situation has improved ' cuz they put down powder-still a few bugs-very little of them. "

Surveyor interviewed resident #1 and observed l spots on sheets of both (2) beds in the . Resident stated: " I was bothered and am still bothered by bed bugs. "

Surveyor observed l spots on sheets of both (2) beds in the by Residents #10 & #14.

Surveyor interviewed resident #12 and observed spots on sheets of both (2) beds in the . Resident stated he hasn ' t seen any bugs and does not have any bites, but his has seen bugs and has bite marks.

Surveyor observed resident #13 ' s - l bedbugs observed on bed pillow.

Surveyor observed resident #3 ' s -Live bedbug observed in l out of the woodwork/baseboard. Per resident, she also finds live bedbugs in the . Bedbug bites, both fresh and partially healing, were observed on resident #3 on as indicated above.

Class III

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911240	03/13/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Heritage Alf, Inc (the)	4406 N Melton Ave Tampa, FL 33614	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Based on record review and interview, the facility failed to ensure the maintenance of an up-to-date admission and discharge log listing the names of all residents and each resident's date of admission and the place from which the resident was admitted, date of discharge, the reason for discharge, and identification of the facility to which the resident is discharged or home address.

Findings include:

AHCA Surveyor reviewed the facility Admission/Discharge Log on beginning at approximately 11:15am and compared the Log with the facility ' s list of current residents.

The Admission/Discharge Log indicated 50 current residents at the facility; the facility's list of current residents and census provided by the Owner and verified by Staff A indicates a current census of 48 residents.

The facility Admission/Discharge Log contained additional omissions/missing data: 27 of 86 residents admitted to the facility are missing place admitted from; 17 of 36 residents discharged from the facility are missing reason for discharge and where discharged to; 1 missing complete date of discharge (" 12- " written only).

Per record review, Resident # 5 had been a resident of the facility by at least . . . . . Resident # 5 is not listed on the facility ' s Admission/Discharge Log; Medication Observation records provide an admission date of / ; Surveyor copied sample Medication Observation records for review, including for the month of , 2013, verifying residency by at least .

Class III

0161-Records - Staff 58A-5.024(2) FAC

Based on record review and interview, the facility failed to ensure that personnel records for each staff member contain verification of freedom from communicable including . Failing to ensure residents receive direct services from persons free from communicable including ., places residents at risk of adverse medical consequences.

Findings include:

On beginning at approximately 11:10am, Surveyor conducted a limited employee record review of 5 facility employees who provide residents with direct services. There was no evidence of annual testing found in 2 of 5 records reviewed.

Staff D's record (date of hire: /) contained evidence of negative . . . . . test & freedom from communicable dated -There was no record of 2013 annual testing for .

Staff E's record (date of hire:) contained no evidence of testing for and no verification of

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

freedom from communicable . Surveyor observed a document in the employee ' s file entitled " Health Statement, " with " Physician ' s Signature " and dated . There is no identifying physician information to determine who signed the document. The document certifies that Staff E " was given a physical and appears to be free from any communicable including . "

Facility Owner stated during exit conference conducted beginning at approximately 2:00pm that all employees are -free.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Amended

Administrator
Heritage ALF, Inc (The)
4406 N Melton Ave
Tampa, FL 33614

Dear Administrator:

Re: **CCR# 2014000735, CCR# 2014000980, CCR# 2013012988**

This letter reports the findings of three complaint surveys that were conducted on , 2014, 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. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey. Please be advised that Tag A 030 was administratively deleted on .

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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161