STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932598	11/23/2015
NAME OF PROVIDER OR SUPPLIER **RESIDENCE OF STUART, INC. (THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1048 N. FORK ROAD** **STUART, FL 34994**	

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

0000 Initial Comments

An unannounced Standard Relicensure survey was conducted on 11/23/2015 at The Residence of Stuart, Inc. The facility had deficiencies at the time of the visit.

0052 Medication - Assistance with Self-Admin

Based on observation, interview, and record review, it was determined that the facility failed to ensure the appropriate techniques were utilized when providing assistance with the self administration of eye drops for 3 of 3 sampled residents prescribed eye drops (Resident #1; Resident #5; and Resident #7).

The Findings Included:

1) During observation of Staff A providing assistance with the self administration of eye drops on / beginning at approximately 8:17 AM she was not observed to apply gloves prior to providing assistance with eye drops for Resident #1. Resident #1 was provided with the following eye drops without waiting between eye drops for the application of the other prescribed eye drops (per Medication Observation Record and medication label):

a) 0.3% opth place 1 drop in right eye four times a day for dry eyes
b) 2% opth solution 15ml 1 drop in left eye four times a day for
c) 0.2% 1 drop both eyes two times daily for
d) opth solution 2.23%-/0.68% 1 drop both eyes every twelve hours

2) During observation of Staff A providing assistance with the self administration of eye drops on / beginning at approximately 8:40 AM she was not observed to apply gloves prior to providing assistance with eye drops for Resident #7. Resident #7 was provided with the following eye drops (per Medication Observation Record and medication label):

a) Mal 0.5% opth solution 1 drop each eye twice daily: Staff A was observed to place 3 drops Resident #7's right eye and 1 drop in Resident #7's left eye.

3) During observation of Staff A providing assistance with the self administration of eye drops on / beginning at approximately 8:45 AM she was not observed to apply gloves prior to providing assistance with eye drops for Resident #5. Resident #5 was provided with the following eye drops without waiting between eye drops for the application of the other prescribed eye drops (per Medication Observation Record and medication label):

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932598	**11/23/2015**
NAME OF PROVIDER OR SUPPLIER **RESIDENCE OF STUART, INC. (THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1048 N. FORK ROAD STUART, FL 34994**	

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

a) Dorzolam/ 2%/0.5% opth Solution 1 drop each eye daily
b) Prednolisone 1% opth 1 drop each eye daily

During interview conducted with the Administrator (also a Registered Nurse), on 11/23/2015 beginning at approximately 12:00 PM, she was asked for the facility's policy and procedure related to providing assistance with the self administration of eye drops. She stated that the facility does not have this policy and procedure. She was informed of the observation of Staff A not applying gloves prior to providing assistance to 3 residents with eye drops. She acknowledged that gloves should be worn. She was informed that Staff A did not wait any length of time between the application of individually prescribed eye drops for Resident #1 and for Resident #5. The Administrator acknowledged that time should lapse between the application of eye drops for these residents. She stated she would review these concerns with her staff.

Class III

0078 Staffing Standards - Staff

Based on interview and record review, it was determined the facility failed to ensure that each staff member within 30 days after beginning employment, must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable , for 3 of 4 sampled staff records (Staff A; Staff B; and Staff C)

The Findings Included:

During personnel record review and interview conducted with the Administrator on / beginning at approximately 11:00 AM, she was provided the opportunity to locate documentation from a health care provider for the following staff members that indicated these individuals do not have signs or symptoms of communicable :

1) Staff A with a date of hire noted as
2) Staff B with a date of hire noted as
3) Staff C with a date of hire noted as

The Administrator stated she thought that the results was all that was required. She stated that each of the above noted staff members has a negative note from a Registered Nurse in their personnel file. The regulatory requirement that upon hire, each staff member must have a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable was reviewed at this time. She stated she was not aware of this

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932598	11/23/2015
NAME OF PROVIDER OR SUPPLIER **RESIDENCE OF STUART, INC. (THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1048 N. FORK ROAD** **STUART, FL 34994**	

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

requirement that she though a negative was sufficient. She acknowledged that Staff A; Staff B; and Staff C do not currently have documentation from a health care provider that they do not have signs or symptoms of communicable .

Class III

0162 Records - Resident

Based on interview and record review it was determined the facility failed to ensure that residents that are receiving assistance with the activities of daily living had their weight recorded on a semi-annual basis for 1 of 2 sampled residents (Resident #5).

The Findings Included:

During interview and record review conducted with Staff A on / beginning at approximately 10:00 AM, she was provided the opportunity to locate weight records for Resident #5. She was unable to locate weight records for Resident #5. Staff A acknowledged Resident #5's 1823 form (health assessment), dated , did not note any weight information and his weight record sheet was not filled out with anything other than his first name. This resident was noted to have been admitted to the facility in of 2014 per review of admission log and his demographic record. The most recent 1823 form for this resident, dated , reflected he requires supervision with activities of daily living (i.e. ambulation; bathing; dressing; eating; and self care/).

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Residence of Stuart, Inc. (The)
1048 N. Fork Road
Stuart, FL 34994

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2015 by a representative 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 representative. Should you have any questions please call this office at 561 381-5840.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD/
Enclosure

XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com