STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966444	12/13/2015
NAME OF PROVIDER OR SUPPLIER **LANGDON HALL, INC** **INDEPENDENT & ASSISTED**	STREET ADDRESS, CITY, STATE, ZIP CODE **1120 33 AVENUE WEST** **BRADENTON, FL 34205**	

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

0000 Initial Comments

Assisted Living Facility

An unannounced Complaint survey (CCR#2015010173 & 2015010362 & 2015010666) was conducted on & .

The Langdon Hall, Assisted Living Facility, had deficiencies at the time of this visit specific to Complaints CCR# 2015010362 & 2015010666. Complaint CCR#2015010173 was not substantiated and no deficiencies cited.

0052 Medication - Assistance with Self-Admin

Based on observation, interview, and record review, the facility failed to provide assistance with self-administered medications in accordance with procedures described in Section 429.256, F.S., for 8 of 8 residents observed being provided their medications. (Residents #19, 27, 28, 15, 8, 12, 13, and 9)

Findings included:
Surveyor entered the facility Wellness Center (1st floor) / :00pm and observed Resident #19 sitting with water cup & medication soufflé cup. Resident #19 stated there were 5 meds in the cup, stated she knew what 2 were, so took them, but does not know what the additional 3 medications are. Surveyor observed 2 aides in the : 1 on break from 3rd floor and 1 med tech using copy machine for other resident, with back to Resident #19. Surveyor observed Resident #19 spit medication back into cup. Surveyor asked Med Tech (Staff A) why Resident does not know what she ' s taking; Staff A responded: " I don ' t know. She usually does. " Staff A returned to med cart, disregarded Resident #19 still in process of taking meds. Staff A had already initialed the MOR for all 5 medications when she placed the meds into a soufflé cup. Staff A did not follow proper procedures for providing the Assisted Living Facility resident assistance with self-administration of medications.
Surveyor observed Staff A providing 8:00pm medications for 2 residents on beginning at 7:30pm. Staff A checked Resident #27 ' s Medication Observation Record (MOR), unlocked med cart, retrieved bottle, poured liquid medicine into soufflé cup to 30ml line, initialed MOR, and returned bottle to med cart drawer. Staff A then retrieved a medication pack from the cart, popped medication into soufflé cup, initialed MOR, and returned pack to med cart drawer. Staff A then retrieved another med pack, popped medication into soufflé cup, initialed MOR, and returned pack to med cart drawer. Staff A handed 2 med cups to Resident #27 and proceeded to take phone call, then returned to cart to provide next resident ' s medications. Staff A did not tell Resident #27 what medications were in the cup, did not observe resident taking medications, and did not wash or sanitize hands before, during, or after the meds distribution. Staff A did not follow proper procedures for

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providing the resident assistance with self-administration of medications.
Staff A checked Resident #28 ' s Medication Observation Record (MOR), unlocked med cart, retrieved medication pack from separately locked controlled substance box in med cart, popped medication into soufflé cup, initialed MOR & recorded in Count Log, and returned pack to med cart drawer. Staff A then retrieved 3 medication packs, popped medication from each pack into soufflé cup, initialed MOR, returned pack to med cart drawer, and handed cup to resident. Staff A did not tell resident what medications were in the cup, did not observe resident taking medications, and did not wash or sanitize hands before or during the meds distribution. Staff A did not follow proper procedures for providing the resident assistance with self-administration of medications.
On @4:50pm Surveyor observed residents seated at the dining in the 3rd floor Memory Care Unit. Surveyor observed Medication Observation Records and saw that 4:00pm medications had not been provided. Per interview / at 4:50pm, Staff C stated he would provide residents with their medications in the Memory Care Unit but thought Staff E would be providing the 4:00pm medications. Staff C further stated he provided residents with their medications on his first day back employed at the facility. Surveyor went to the 1st floor med (Wellness Center) and asked Staff E who would be providing the 4:00pm medications on the 3rd floor (MCU). Staff E stated Staff C is providing the 4:00pm medications; when informed that Staff C thought Staff E was providing the 4pm meds, Staff E stated she would provide the MCU residents with their medications and immediately headed to the 3rd floor. Surveyor observed Staff E provide medications beginning at 4:55pm. Given the late start, there was only enough time for Staff E to provide 1 resident with 1 (of 4) 4pm medications by 5pm.
Surveyor observed Staff E check Resident #15 ' s Medication Observation Record (MOR), unlock med cart, retrieve 3 medication packs, pop meds from med packs into soufflé cup with bare hands-no handwashing or sanitizing & no gloves, returned packs to med cart, poured water into drinking cup, brought meds cup & water to resident, stated: " Here ' s your meds, " observed resident swallow, returned to med cart and initialed MOR. Staff E did not inform resident of what medications were being provided. Staff E did not follow proper procedures for providing the resident assistance with self-administration of medications.
Surveyor observed Staff E check Resident #8 ' s Medication Observation Record (MOR), unlock med cart, retrieve bottle of medication, pour the liquid medication into a cup with measured lines to the correct level. Staff E then retrieved med pack from separately locked controlled substance box in med cart, popped med into soufflé cup, and returned pack to med cart drawer. Staff E stated to Resident #8, who was slouched over to the left in his wheelchair at the dining , to sit up. Staff E handed Resident #8 the liquid medication and placed the soufflé cup containing the other medication on the table. Staff E continuously prompted the resident to drink. Resident #8 started shaking and spilling the liquid medication on self and the floor while coughing. Staff E handed the resident a cup of water and prompted the resident to drink. Staff E handed the resident the med cup containing the other medication and told resident to take his other med. Resident #8 continued to lean to the left and spill

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the water, but was able to consume the 2nd medication. Staff E handed the resident a towel to wipe self and again handed the resident the liquid medication and prompted resident to drink; at best, the resident actually consumed ½ of the prescribed dose, as Resident #8 continued to lean to the left and spill the liquid medication. Staff E continued to instruct the resident to sit up and drink, but provided no hands on assistance. Staff E did not tell Resident #8 what medication was in the cup and did not wash or sanitize hands before providing the medications. Staff E did wash hands after wiping self of the spilled medication. Staff E returned to the med cart and initialed meds as having been provided. Staff E did not follow proper procedures for providing the resident assistance with self-administration of medications.

On , Surveyor observed Staff E provide 5:00pm medications for 3 residents:

Staff E checked the MOR, retrieved medications from med cart, popped meds into soufflé cup, poured cup of water, brought meds & water to Resident #12 and stated: "Here's your meds." Staff E returned to med cart & initialed MOR. Staff E had not washed or sanitized her hands and was not wearing gloves, did not inform Resident #12 of what medications were being provided, and did not observe Resident #12 taking her medications. Staff E did not follow proper procedures for providing the resident assistance with self-administration of medications.

Staff E checked the MOR, retrieved medications from med cart, popped meds into soufflé cup, poured cup of water, brought meds & water to Resident #13 and stated: "Here, <resident first name>." Staff E returned to med cart & initialed MOR. Staff E had not washed or sanitized her hands and was not wearing gloves, did not inform Resident #13 of what medications were being provided, and did not observe Resident #13 taking her medications. Staff E did not follow proper procedures for providing the resident assistance with self-administration of medications.

Staff E checked the MOR, retrieved medication from med cart, popped med into soufflé cup, poured cup of water, brought med & water to Resident #9 and stated: "I need you to take this." Staff E returned to med cart & initialed MOR. Staff E had not washed or sanitized her hands and was not wearing gloves, did not inform Resident #9 of what medication was being provided, and did not observe Resident #9 taking her medication. Staff E did not follow proper procedures for providing the resident assistance with self-administration of medications.

Class III

0054 Medication - Records

Based on record review and interview, the facility failed to ensure proper maintenance of a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications, recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.

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Findings included:
Per .../ review of , 2015 Medication Observation Records, 3 of 4 residents (#8, 12, and 15) randomly selected for further review did not receive physician-ordered medications as follows:
Resident #8 was prescribed 125mg capsule with physician orders to take 3 capsules by mouth every night at bedtime - 8pm. Per review of Medication Observation Records, this medication was not initialed as provided and , and the reverse page is blank-- the medication is not listed and no reason is given for having not been provided.
Resident #8 was prescribed 0.5mg tablet with physician orders to take ½ tablet by mouth every 8 hours - 6am, 2pm, & 10pm. Per review of Medication Observation Records, this medication was not initialed as provided at 10pm, and the reverse page is blank-- the medication is not listed and no reason is given for having not been provided.
Resident #12 was prescribed 1.5mg capsule with physician orders to take one capsule by mouth twice daily for - 8am & 8pm. Per review of Medication Observation Records, this medication was not initialed as provided at 8pm, and the reverse page is blank-- the medication is not listed and no reason is given for having not been provided.
Resident #12 was prescribed Levetiraceta 7.5mg tablet with physician orders to take one tablet by mouth twice daily for - 8am & 8pm. Per review of Medication Observation Records, this medication was not initialed as provided at 8pm, and the reverse page is blank-- the medication is not listed and no reason is given for having not been provided.
Resident #12 was prescribed 10mg tablet with physician orders to take one tablet by mouth every night at bedtime - 8pm. Per review of Medication Observation Records, this medication was not initialed as provided at 8pm, and the reverse page is blank-- the medication is not listed and no reason is given for having not been provided.
Resident #15 was prescribed Tamulosin 0.4mg capsule with physician orders to take one capsule by mouth every night at bedtime - 8pm. Per review of Medication Observation Records, this medication was not initialed as provided at 8pm, and the reverse page is blank-- the medication is not listed and no reason is given for having not been provided.
Resident #15 was prescribed 40mg tablet with physician orders to take one tablet by mouth every night at bedtime - 8pm. Per review of Medication Observation Records, this medication was not initialed as provided at 8pm, and the reverse page is blank-- the medication is not listed and no reason is given for having not been provided.
Resident #15 was prescribed Spironolact 25mg tablet with physician orders to take one tablet by mouth every night at bedtime - 8pm. Per review of Medication Observation Records, this medication was not initialed as provided at 8pm, and the reverse page is blank-- the medication is not listed and no reason is given for having not been provided.
Resident #15 was prescribed 30mg tablet with physician orders to take one tablet by mouth every night at bedtime - 8pm. Per review of Medication Observation Records, this medication was not initialed as provided at 8pm, and the reverse page is blank-- the medication is not listed and no

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reason is given for having not been provided.
Per interview, Staff A stated on at 4:30pm that she had already given the 4:00pm medications on the 3rd floor (MCU). Per observation of Staff A providing medications for 1st & 2nd floor residents, Staff A routinely initials provision of meds as she places medications into a soufflé cup, which she has pre-labeled with resident ' s name. It is therefore unlikely that the meds above not initialed as provided were actually given to the residents as prescribed.

Class III

0077 Staffing Standards - Administrators

Based on observation, interview, and record review, the facility failed to ensure that the facility is under the supervision of an Administrator or Manager who has satisfied the same qualifications, background screening, core training and competency test requirements, and continuing education requirements of an Administrator for 3 of 7 days per week.

Findings included:
Surveyors conducted an unannounced Complaint survey at the facility on Saturday, , beginning at 3:30pm and Sunday, , beginning at 3:00pm. Per Interview on at 4:30pm, when Surveyor asked Staff A who is in charge of the facility, Staff A stated: " Nobody ' s in charge. There ' s no administration here. "
Per observation and staff interviews on beginning at 3:45pm and telephone interview with the Administrator on at 7:30pm, the Administrator works and stays at the facility from Sundays through Thursdays and is out of town from Thursday at 5:00pm until Sunday afternoon.
Surveyor observed the Business Office Manager posted as Manager on Duty / at 3:40pm and the same posting upon arrival at 3:00pm on . When Administrator showed Surveyors (/ at 6:00pm) the posting of Designee when she is not in the building, the Administrator stated " The Med Tech is Manager on Duty when office personnel are gone, so the sign should have been changed to <Staff A> when the Business Office Manager left / at 4:30pm. " Surveyor asked Administrator if any of the Managers On Duty have been CORE trained; the Administrator stated that one (Business Office Manager) may have been, but the Lead Med Techs are not. The Administrator stated she was not aware that Managers On Duty need CORE training.
Per focused record reviews conducted at 6:15pm, the Staff Med Techs (including Staff A) serving as facility Managers from Friday afternoons through Sunday afternoons have not attended CORE training and passed competency tests as required.

Class III

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0084 Trainina - Assis Self-Admin Meds & Med Mamt

Based on observation, record review, and interview, the facility, with an in-house census of 59 residents, failed to ensure that 2 of 6 (Staff E & C) unlicensed staff who provide residents assistance with self-administered medications have completed the required initial 4-hour training in providing assistance with self-administration of medications and safe medication practices in an Assisted Living Facility.

Findings included:
Surveyors conducted a survey at the facility on / & . Per record reviews and interviews, all personnel who provide residents assistance with self-administration of medication are unlicensed Resident Aides/Medication Techs.
Per review of Employee files for training in providing Assisted Living Facility residents assistance with self-administration of medication, there was no evidence of 2 of 6 staff providing assistance having completed required training.
Surveyor observed Staff E providing medications to residents in need of assistance with self-administration of medication. Per record review, Staff E ' s personnel file contained a certificate for a 2-hour update in providing residents assistance with self-administration of medication dated . Staff E ' s personnel file also contained a certificate for 6 hours of training in " Medication Administration for Medicaid Waiver Services " dated / with Validation Certificate dated / - / that includes " tube. " There was no evidence of initial 4-hour training in providing residents assistance with self-administration of medication in an Assisted Living Facility.
Per interview on at 4:50pm, Staff C stated he would provide residents with their medications in the Memory Care Unit but thought Staff E would be providing the 4:00pm medications. Staff C further stated he provided residents with their medications on his first day back employed at the facility. Per review of Medication Observation Records, Staff C has provided residents with medications throughout the month of , 2015. Per employee record review, there was no evidence of any training in providing assistance with self-administration of medication in Staff C ' s personnel record.
Per interview with the Administrator on at 5:45pm, the Administrator stated that Staff C was not providing medications; when told that Staff C has been providing medications, the Administrator stated she was not aware of that. Per interview with the Administrator on at 7:00pm, she stated that Staff C was employed here before so probably has a training certificate in his previous personnel file.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Langdon Hall, Inc Independent & Assisted Living
1120 33 Avenue West
Bradenton, FL 34205

RE: CCR #2015010173, 2015010362 & 2015010666

Dear Administrator:

This letter reports the findings of three state licensure surveys that was conducted on , 2015 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. **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 , 2016.** 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 surveyor(s). Should you have any questions please call **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

For Patricia Reid Caufman
Field Office Manager

St. Petersburg Field Office
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St. Petersburg, FL 33701
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PRC/clt
Enclosure; State (5000-3547) Form