RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Cranes View Lodge
1601 Hooks St
Clermont, FL 34711

Dear Administrator:

This letter reports the findings of a complaint (CCR#2016002249) inspection survey conducted on , 2016, through , 2016, by representatives of the Agency for Health Care Administration (Agency). Enclosed is the provider's copy of the Statement of Deficiencies which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) as stated below:

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0028 - 58a-5.0182(4) Fac - Resident Care - Activities Of Daily Living S-S=Class III

The facility failed to provide assistance with activities of daily living, specifically with showering, for a resident who was documented as not having had a shower in over a week's time due to staff not being available to assist the resident with showering.

St - A - 0052 - 58a-5.0185 (3) - Medication - Assistance With Self-Admin S-S=Class III

The facility failed to ensure that unlicensed staff were preparing the medications in the presence of the residents, to include reading the medication labels to the resident, while assisting residents with self-administration of medications.

St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S=Class II

The facility failed to ensure that a licensed practical nurse (LPN) followed physician's orders by administering to a resident whose sugar level was less than 200. The LPN administered 7 units of after a glucose reading of 181 resulting in acute and hospitalization of the resident.

Directed Corrective Actions:

1. The Assisted Living Facility is required to is required to hire a consultant pharmacist, pursuant to Section 465.0125, Florida Statutes, to conduct quarterly on-site consultations in the facility until notified in writing by the Agency. All records and results from the consultation must remain in the facility for Agency review. **The first visit by the pharmacist must take place no less than 10 days from receipt of the Directed Plan of**

**Correction.**

2. The Assisted Living Facility is required to conduct an audit of all residents diagnosed with having physician's orders for sliding scale to ensure that the orders, medication observation records, and medication labels correspond accurately. Furthermore, any discrepancies must be addressed immediately upon discovery, and the resident's physician must be notified. Documentation of the above must be maintained and available for review upon Agency request. **This must be completed by** .

3. The Assisted Living Facility is required to develop a policy and procedure for assisting residents with self-administration of medication. The policy and procedure must include an initial audit of all residents' medication observation records to check for accuracy, followed by a bi-weekly review of medication observations records to check for accuracy. All staff whose duties include assisting residents with the self-administration of medication or medication administration must be trained on this policy. Documentation of the above must be maintained and available for review upon Agency request. **This must be completed by** .

4. The Assisted Living Facility is required to have a licensed pharmacist provide four (4) hours of training on assisting with the self-administration of medications in accordance with 58A-5.0185, Florida Administrative Code to all unlicensed staff responsible for assisting residents with the self-administration of medication. Staff must be able to show the ability to read medication labels, orders, and accurately transcribe them on medication observation records. Documentation of the above must be maintained and available upon Agency request. **This must be completed by** .

5. The Assisted Living Facility is required to conduct an audit of all residents' records, specifically to include the Resident Health Assessments (AHCA Form 1823), to determine the need for assistance in conducting activities of daily living (ADLs) for all residents. Any residents requiring assistance with any ADLs must be identified and a system developed to ensure the required assistance is provided by staff. Specifically, the Health and Wellness Director must review with all direct care staff the protocol for assisting residents with completion of their ADLs, including a system of documentation of assistance provided to residents. The Health and Wellness Director must audit the resident records on a weekly basis to ensure that needed ADL assistance is being provided. Documentation of the above must be maintained and available upon Agency request. **This must be completed by** .

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Alachua Area 3 Office Supervisor, Chuck Bory, at 386-462-6201.

Sincerely,

Charles Bory for

Kriste J. Mennella
Field Office Manager

Cranes View Lodge
, 2016

KJM/CB

Received by

Date

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

Alachua Field Office
14101 N W Hwy 441, Suite 800
Alachua, FL 32615-5669
Phone (386) 462-6201; Fax (386) 418-5300

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11968651 | 04/22/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**CRANES VIEW LODGE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**1601 HOOKS ST**<br>**CLERMONT, FL 34711** | |

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

**0000 Initial Comments**

On 21-22, 2016 a complaint (CCR#2016002249) survey was conducted at Cranes View Lodge Assisted Living Facility. Deficient practice was identified during the survey. The facility was not in compliance at this time.

**0028 Resident Care - Activities of Daily Living**

Based on interview and record review, the facility failed to provide assistance with showers for 1 of 1 residents (Resident #3).

Findings;

On at 2:08 PM, an interview was conducted with a family member of Resident #3. The family member stated that Resident #3 is suppose to get assistance with her showers and the last time she had a shower was on and she does not know why.

On at approximately 2:35 PM, an interview was conducted with Resident #3, who stated it was two weeks ago since she has gotten a shower because no one has come to assist her. She stated she told the Administrator two weeks ago she was not getting her showers.

On a record review was conducted on resident #3 shower log, which is kept in the nurses station, with LPN K. The shower log showed that Resident #3 was not receiving showers for the month of , 2016.

On at approximately 3:34 PM, an interview was conducted with LPN K, who stated the shower log for Resident #3 shows she has not been getting her scheduled showers. She said it was just reported to her yesterday and she has placed a shower log in the staff to record showers when she gets one.

Class III

**0052 Medication - Assistance with Self-Admin**

Based on observations and interview, the facility failed to ensure unlicensed staff assisted residents with self-administration of medication as required for 4 of 4 residents reviewed (Residents #11, #12, #13, and #14).

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

Findings:

On / at approximately 3:43 PM, a medication observation was conducted with unlicensed Staff D, while she assisted residents #11, #12, #13, and #14 with self-administration of medication. During the observation it was observed that she pre-poured the medication at the medication cart and then took the medication to each resident listed. She did not read the medication label in the presence of the residents for Residents #11, #12, #13 and #14.

On / at approximately 3:57 PM, Staff D was asked if she had demonstrated to the Administrator that she could assist residents with self-administration of medication. She stated that she demonstrated to the Health Director who is an Licensed Practical Nurse (LPN). She stated that the LPN trained her.

On / at approximately 5:08 PM, an interview was conducted with Staff A/LPN/ Health Director in reference to Staff D pre-pouring medication and not reading the label in the presence of the residents. The LPN stated she did not know the staff had to read the label in the presence of the residents and could not pre-pour medication. She stated she was from Ohio and unlicensed staff there cannot handle medication.

Class III

**0053 Medication - Administration**

Based on interview and record review, the facility failed to administer medication as ordered for 1 of 10 residents (Resident #3).

Findings:

On at approximately 2:08 PM, family member of Resident #3 stated that during the first or the end of last month, a nurse gave Resident #3 too much and she had to be sent out to the hospital. The family member stated Resident #3 is on a sliding scale for and she is only to receive it if the glucose is greater than 200. The family member further stated that when the nurse checked Resident #3's glucose it was 185, and she gave the which caused the resident's sugar to bottom and she had to be sent out to the hospital.

On a record review was conducted on Resident #3's medication observation record. It was observed that Resident #3 receives per sliding scale. If the number is 200 or lower no is to be given.

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SUMMARY STATEMENT OF DEFICIENCIES
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On a record review was conducted on the Resident #3's log. It was observed that on Resident #3's glucose was recorded to be 181 and the nurse gave 7 units of .

On a review of the observation record shows on at 12 PM Licensed Practical Nurse (LPN) B responded to Resident #3's she was unresponsive to staff. When the LPN checked the resident's sugar it was at 36. Emergency personal were called and the resident was transported to the hospital for medical treatment.

An interview was conducted on at 9:39 AM with the Health and Wellness Director/LPN. She stated the LPN L received verbal training after the incident with Resident #3, and was scheduled to take online training, but quit before taking the training.

On , a review of medical records from South Lake Hospital, dated , showed that on , Resident #3 was sent to the emergency department after with episode of glucose in the 20's. Further review of the medical records showed emergency department impression of acute . Resident #3 was admitted to South Lake Hospital.

Class II