STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942986	01/06/2017
NAME OF PROVIDER OR SUPPLIER **NURSE'S HELPING HANDS ALF INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **7191 71ST STREET NORTH PINELLAS PARK, FL 33781**	

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

0000 - Initial Comments

Assisted Living Facility

On / , an abbreviated biennial relicensure survey was conducted at Nurse's Helping Hands ALF, Inc. (Lic. #8372) Deficient practice was identified during the survey.

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

Based on observation and interview, the assisted living facility failed to follow the protocol of assistance with self-administration of medications by not reading the label in the presence of four of four residents sampled (#11, #12, #13, #14).

Findings included:

From between approximately 11:30am to 12:30am on / the following was observed: At approximately 11:30 am on / , Staff B Medical Technician was observed preparing the noon time medication for Residents #11, #12, #13, and #14 who were seated at the dining table. After sanitizing his hands, Staff B placed the medication DR 12000CR capsule into a small soufflé cup, then placed the cup next to the Resident #11. Staff B watched the resident take the medication and swallow with a cup of water. Staff B then proceeded to document in the medication observation record (MOR). Staff B repeated the same steps for Resident #12. He first placed a tablet of Balzalazide 500mg into a small soufflé cup, and then placed this next to Resident #12. Staff B watched the resident take the medication and swallow with a cup of water; the employee then proceeded to document in the MOR. Staff B then went to assist Residents #13 and #14 one at a time--sanitizing his hands between residents. Staff B placed a capsule of Resident #13 ' s medication, Reguloid 500mg, into a small plastic cup with applesauce. Staff B then put the medication next to the resident with a spoon and watched the resident swallow the medication-apple sauce mixture. This was repeated with Resident #14 who received / 5-325 mg tab and Mecline 25mg tab--both with apple sauce--in a small plastic cup. Staff B then placed these medications next to the resident with a spoon and observed the resident consume both medications with the apple sauce. At no time did Staff B read the label of any of the medications in the presence of four of four residents.
An interview with Staff B conducted at approximately 1:30pm on / revealed that " he believed the residents know their own medications. " He stated further that " most of the residents at the facility were aware of their meds, and this was why staff didn ' t read them the pharmacy labels, nor tell them what meds were being given. " Random interviews with Residents #1, #2, #3, #4, #5, #6, #7, #9, and #10 conducted throughout the / / survey revealed that at no time did Staff B nor any of the staff read

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them the medication labels when being provided medication assistance.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Nurse's Helping Hands ALF Inc.
7191 71st Street North
Pinellas Park, FL 33781

Dear Administrator:

This letter reports the findings of an abbreviated biennial state licensure survey that was conducted on , 2017, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 deficiency. Submit summary and documents to the Field Office no later than , 2017.** 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 deficiency 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://anca.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

PRC/kpr
Enclosure: State Form 5000-3547

XG90

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