STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942870	**02/16/2017**
NAME OF PROVIDER OR SUPPLIER **PARK PLACE ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **541 PARK STREET** **DUNEDIN, FL 34698**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

Assisted Living Facility

On , 2017, a biennial in conjunction with a complaint survey, (CCR# 2016041777), was conducted at Park Place Assisted Living. Deficiencies were found during the visit.

(License # 8284)

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

Based on observation and interview, the facility failed to ensure that qualified staff, (administrator) used control techniques by handling medications with their bare hands for two (#3 and #7) of three sampled residents, read the applicable medication labels, and removed the medications from primary packaging in the presence of the residents for three (#3, #7 and #9) of three sampled residents.

Findings included:

During an observation of assistance with self-administration of medication with the Administrator, conducted on from 12:14 p.m. to 12:47 p.m., the Administrator was observed removing medications by pushing the medication from the primary packaging (bubble pack), catching the individual tablets with her bare hands, and then placing the medications in a cup. The Administrator did not wash her hands or sanitized her hands prior to beginning medication pass. Resident #7 was not present while the medications were removed from primary packaging, nor did the administrator informed the resident of medication given.
At 12:30 p.m., The Administrator was observed administering one tablet orally for Resident #7, by placing the cup containing the tablet and tipping it towards the resident's mouth so that the resident could receive the oral dosage. The resident's hands did not make contact with the medication, or the cup of water given after oral dosage.

During continued medication assistance observation with the Administrator, on at 12:33 p.m., the administrator was observed removing Resident #3's medications by pushing the medication from the primary packaging (bubble pack), catching the individual tablets with her bare hands, and then placing the medications in a cup. The Administrator did not wash her hands or sanitized her hands prior

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to beginning medication pass. Resident #3 was not present while the medications were removed from primary packaging, nor did the administrator informed the resident of medication given. The Administrator was observed administering one tablet orally for Resident #3, by placing the cup containing the tablet and tipping it towards the resident's mouth so that the resident could receive the oral dosage. The resident's hands did not make contact with the medication, or the cup of water given after oral dosage.

During continued medication assistance observation with the Administrator, on at 12:38 p.m., the Administrator was observed removing Resident #9's medication from primary packaging while the resident was not near her, and handed the medication to the resident without informing Resident #9 of the medication being given.

During interview with the Administrator, on at 12:51 p.m., she confirmed that she handled the medication tablets with her bare hands, and that she administered the medication for Residents #7 and #3. Administrator stated that she did not understand why she should remove the medication from its primary packaging in the presence of the residents.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observation, interview and record review, the facility failed to ensure that the Administrator, who was observed administering oral dosage medication for two resident (#3 and #7) of three observed residents, was qualified to perform their assigned duties consistent with their level of education, training, preparation and experience (qualified to administer medication.)

Findings included:

During medication assistance observation with the Administrator, conducted on at 12:30 p.m., the Administrator was observed administering one tablet orally for Resident #7, by placing the cup containing the tablet and tipping it towards the resident's mouth so that the resident could receive the oral dosage. The resident's hands did not make contact with the medication, or the cup of water given after oral dosage.

On at 12:33 p.m., the Administrator was observed administering one tablet orally for

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Resident #3, by placing the cup containing the tablet on the resident's lips, and tipping the cup towards the resident's mouth so that the resident could receive the oral dosage. The resident's hands did not make contact with the medication, or the cup of water given after oral dosage.

During interview with the Administrator, on at 12:51 p.m., she confirmed that she administered the medication for Residents #7 and #3. The Administrator confirmed that she was not licensed to administer medication for the residents.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on records review and interview, the facility failed to ensure that staff were adequately trained for 2 (Staff A) of 4 staff members sampled.

Findings included:

Staff Member A's records were reviewed at 3:30pm on . The review revealed that the employee record did not show evidence for Staff A's required in-service training for elopement, emergency preparedness and incident reporting.

Staff A's employment record did not contain any information indicating a start date for employment.

In an interview with Staff A, the staff member could not recall when the start date of employment was.

In an interview at 6:00pm the Administrator was presented with this finding and had no comment.

Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on interview and record review, the facility failed to ensure that one (Staff C) employee of four employees, who works shifts alone, maintained and up-to-date First Aid and ( ) status.

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Findings included:

Employee record review, conducted on , revealed that Staff C, completed First Aid Training on . Printed on the certification of completion was "recommended renewal: ." There were no documentation of First Aid or certification renewal.

During interview with the Administrator, on at 01:31 p.m., the administrator stated that Staff C works the night shift from 9:00 p.m. to 8:00 am, or 07:00 a.m.

Class III

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

Based on interview and record review, the facility failed to ensure that one (Staff C) employee of four employees, who provide assistance with self-administration of medication, completed the 2 hour training update for assistance with self-administration of medication.

Findings included:

Employee record review, conducted on , revealed that Staff C, completed Medication training on . There were no documentation of updated training for Medication Assisting with self-administration.

Review of the Medication Observation Record (MOR) book revealed that Staff C signed the MOR for the 8:00 a.m. medication pass for multiple residents from to .

During interview with the Administrator, conducted on at 05:42pm., she confirmed that Staff C initialed the morning MOR and Staff #C passed the morning medication on the shift that he works.

Class III

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0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, record review and interview, the facility failed to provide doctor ordered therapeutic diet to 1 resident (Resident #11) of 2 sampled residents and facility failed to have portion sizes noted on the menus.

Findings included:

At 12:30pm on , a review of Resident #11's record was conducted. Resident #11's 1823 assessment dated , and signed by a physician, stated the consistency of the diet ordered as being "mechanical soft." At 12:32pm Resident was observed eating a lunch that consisted of sliced ham, and cooked green beans, along with a roll and some mashed potatoes. At 12:35pm, in an interview with Staff A and Staff B regarding the therapeutic diet that Resident #11 should be eating, they both stated they were unaware on any residents having any therapeutic diets. They both stated they did not know what a mechanical soft diet was and that the resident had been eating regular consistency food all along, while she was in the facility. The Administrator was informed at 6:00pm that Resident #11 was not being provided with a mechanical soft therapeutic diet as ordered and had no comment.

At 1:00pm a review of the facility's food service operation was conducted. In an interview with the Administrator and Staff B, when asked if the facility had menus with portions sizes noted on it, they both stated they did not have any menus with portion sizes in the facility. At 2:00pm, the Administrator stated that they had request the registered dietician to provide them with menus with portion sizes noted on them.

Class III

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

Based on observations, records review and interviews, the facility failed to provide an up-to-date and accurate admission and discharge log listing the names of all residents for 2 (Residents # 11 and #12) out of 12 residents in the facility.

Findings Included:

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In an interview with the Administrator at 9:35am, it was stated that the facility did not carry list of current resident's names and , however the Admission and Discharge log was a reliable source to find the list of current residents and their admission dates. The Administrator provided the facility's Admission and Discharge log for surveyors to review and refer to for census information. The Admission and Discharge log was review at 9:40am and it revealed 10 residents were currently in the facility. The Administrator confirmed that there were 10 residents in the facility, residents #1 through #10. At 10:00am, during a tour of the facility, a resident was observed sleeping in a . The Administrator was asked the name of the resident. The resident that was named by the Administrator was not on the list of current residents previously provided (the Admission and Discharge Log). The Admission and Discharge Log was again reviewed and it revealed that the named resident, Resident #11, was marked as being discharged from the facility to a long term care facility on due to "significant change". In an interview with Resident #11's family member at 12:00pm noon, the family member could not recall the resident being discharged from the facility at any time other than going to the hospital and returning back to the facility. In an interview with the Administrator at 1:00pm, it was stated that the Admission Discharge Log had an error and then proceeded to place the blame on the previous owner of the facility for having incorrect records.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on interview and record review, the administrator of a facility failed to maintain personnel records for each staff member (#A, #B and #C) which contain at a minimum a copy of the employment application, with references furnished, and documentation on verifying freedom from signs or symptoms of a communicable and documentation of compliance with staff training.

Finding included:

Employee record review for Staff C, conducted on , revealed that there was no application for employment, to include references, and work history. There was also no documentation found that verified communicable status for Staff C.

During interview with the Administrator, conducted on at 03:54pm., she confirmed Staff C did not have an application in their records.

An attempt was made to review records for staff #B. Staff B did not have a record to review in the

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facility.

In interview with the administrator, they stated staff #B did not have a record to review.

In review of the , 2017 staffing schedule on , Staff b was scheduled Monday-Friday nightly at 9:00 pm.

Staff Member A's records were reviewed at 3:30pm on . The review revealed that the employee record did not show a hire date for Staff A's employment, an employment application with references, a job description or title for Staff A's duties in the facility or proof of freedom from or communicable , as required.

In an interview with Staff A, the staff member could not recall when the start date of employment was.

In an interview at 6:00pm the Administrator was presented with this finding and had no comment.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on interview and record review, the facility failed to produce and maintain any documentation for one resident (#12) of 12 sampled residents.

Findings included:

During facility tour, on at 09:17 a.m. one observed in the "Cottage," the stand-alone building with three . The furnished observed with male clothing, television, and other things (liquor, male cologne, condoms and powered cell phone) that belonged to an unknown person. The of freshly sprayed cologne.

During interview with the Administrator, on at 10:39 a.m., she stated that the the cottage belonged to a man named "G" that no longer lives at the facility. She stated that after she purchased the facility in of 2016, she saw a man entering the cottage at night. "I yelled at him and told him, I am the new owner and he is not allowed to stay here."

During interview with the Administrator's husband, on at 11:29 a.m., he stated that Resident

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#12 was homeless and was allowed to live at the facility in , of 2017. He did not know anything about Resident #12, other than the single letter that he went by.

Interview with Resident #8, on at 03:00 p.m., she confirmed that Resident ##G still lives in the third the cottage, and that she shared the common area with Resident #12.

Review of the Admission Discharge log revealed no documentation of Resident 12. Additional record review revealed that the facility did not maintain any record of Resident 12.

Class III