STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968333	**02/24/2017**
NAME OF PROVIDER OR SUPPLIER **ALLEGRO AT ABACOA, (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **1031 COMMUNITY DRIVE** **JUPITER, FL 33458**	

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

0000 - Initial Comments

An unannounced Relicensure survey was conducted on , 23-24, 2017 at The Allegro At Abacoa (License #12270). The facility had deficiencies identified at the time of the survey.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observations and interviews, the facility failed to maintain appurtenances to provide residents with a safe and sanitary living environment by use of an excessively soiled medication device for 1 of 4 sampled Residents (#6) .

The findings include:

During medication systems review conducted with Employee D, a Medications Technician (MT) on at 10:45 AM, and with Employee F, a MT, on at 11:25 AM, both were asked and stated Resident #6 receives crushed medications on a regular basis. The MT's stated they are instructed to clean the surface and surrounding area of the pill crusher's "crushing , " with wipes or with Q-tips every shift. They confirmed this was the only pill crusher in the assisted living side of the facility. At the times of interviews, both MT's observed and acknowledged the medication crushing , had significant debris build-up, to the point where white powdery substance was present in the center of the crushing , . The rear and sides of the unit were soiled also. This was discussed with the Administrator and Resident Services Director on at 1:20 PM.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on interviews and record review, the facility failed to ensure adequate written Health Care Provider (HCP) orders were received related to changes for use of medications for unlicensed staff who assist residents with self-administration of medications, for 1 of 3 sampled Residents (#6) by not obtaining written HCP orders with medication-specific directions for crushing the medications.

The findings included:

Review of Resident #6's records conducted revealed she was admitted to the facility on . Her AHCA Form 1823 (medical examination) dated documented diagnoses including chronic kidney , hematoma, , high , , , and history of and . She requires assistance with self-administration of medications. The facility's functional needs assessment dated

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SUMMARY STATEMENT OF DEFICIENCIES
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documented she needs assistance with self-administration due to difficulty opening medication bottles and unable to coordinate medication orders. Further review revealed:

1. A signed HCP order dated called for " Crush Medications Unless Contraindicated".

2. On her 2017 medication observation record (MOR), the top right-hand corner included the words, " Crush Meds" in red letters and large font.

3. The MOR included an order for " 50 MG [milligrams] *DNC* take 1 tablet by mouth once daily : For: ". Interviews conducted with Employee D on at 10:45 AM and Employee F on at 10:11 AM revealed they regularly crushed medications for Resident #6. Neither of them knew what "DNC" meant. On at 1:20 PM, the Resident Services Director ( ) stated "DNC" referred to Do Not Crush.

4. Review of the 2017 MOR revealed none of the 10 other medications listed provided directions related to crushing.

There was no documentation showing written HCP orders were received that were medication-specific. This was discussed with the Administrator and on at 1:20 PM.

Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(6) FAC

Based on interviews and record reviews, the facility failed to ensure their written Food Service Designee (FSD) obtained the required annual training in nutrition and food service in an assisted living facility. This has the potential to affect all 71 current residents of the facility.

The findings included:

Review of the facility's dining and food service operations was conducted and . In an interview conducted on at 9:45 AM, the Administrator and Assistant Dining Services Director were asked and stated the Dining Services Director was the Food Service Designee. On at 11:07 AM, the Dining Services Director stated, he was the facility's FSD and was hired about 2 years earlier. The Administrator later provided a written statement designating the Dining Services Director as the FSD.

The FSD's pertinent training records revealed a certificate from the National Registry of Food Safety

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Professionals issued , expiring declaring the FSD "Has Successfully Satisfied the Requirements for the Food Safety Manager under the Conference for Food Protection Standards". There was no documentation available showing the FSD received the required 2 hours of annual training in topics related to nutrition and food service in an assisted living facility, provided by either a Certified Food Manager, Licensed Dietitian, Registered Dietary Technician, or a Health Department Sanitarian.

On at 9:45 AM, the Administrator was asked and stated there was no additional training documentation for review.

Class III

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on record review and an interview, the facility failed to ensure that 1 of 3 sampled staff (Staff A) who has regular contact with or provides direct care to residents with ADRD (and Related) in this facility that maintained a secured area had obtained 4 hours of contiuing education annually in ADRD.

The findings included:

The personnel file for Staff A was reviewed for training in ADRD and did not contain documentation of 4 hours of continuing education in ADRD dated within the previous year. The following training was documented and available for review; Staff A-Date of Hire , last 4 hour ADRD training certificate dated .

During interview with the Administrator at 1:00 PM on , he acknowledged this finding. No additional documentation was presented at this time.

Class III