STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966444	**03/27/2017**
NAME OF PROVIDER OR SUPPLIER **LANGDON HALL OF BRADENTON**	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

On , 2017, a change of ownership (CHOW) licensure survey was conducted at Langdon Hall of Bradenton, assisted living facility. Deficient practice was identified during the survey.

(License # 10661)

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 assist with self- administration of medications by reading the label in the presence of two of three residents sampled (#10 and #13).

Findings included:

At approximately 12:00 pm on , Staff G was observed assisting with the self - administration of the noon - time medications for Residents #10 and #13 respectively who were seated in the Medication . Staff G washed her hands and identified Resident #10 by name. Staff G reviewed the medication observation record (MOR) and located medications, , -levo 25-250mg, , 800mg and , in the medication cart. Staff G compared the medication label to the MOR but staff G did not read the medication label and tell Resident #10 what the medication was for. Staff G then popped the medications into a small plastic cup and placed the cup next to the resident with a cup of water. Staff G watched the resident take the medication and then documented in the MOR that the medication had been given.

Staff G repeated the same steps for Resident #13 by washing her hands and identifying resident #13 by name. Staff G reviewed the MOR and located the medication 1mg in the medication cart. Staff G compared the label to the MOR but did not read the medication label and tell Resident #13 what the medication was for, Staff G popped the medication into a small plastic cup and placed the cup next to resident with a cup of water. Staff G watched resident take medication and documented in MOR that the medication had been given.

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SUMMARY STATEMENT OF DEFICIENCIES
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An interview with staff G was conducted at approximately 12:30pm on . Staff G stated that the residents know their own medications, hence the reason for not re-stating the medications that were being given to them. Interviews with residents #10 and #13 on revealed that at no time did staff read or explain the medications to them.

Class III