STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967533	**03/29/2017**
NAME OF PROVIDER OR SUPPLIER **VINTAGE VILLAGE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **701 E VIRGINIA AVENUE** **TAMPA, FL 33603**	

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

0000 - Initial Comments

Assisted Living Facility

On , 2017 an abbreviated biennial re- licensure survey was conducted at Vintage Village Inc. an assisted living facility.
Deficient practice was identified during the survey.
License # 11572

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

Based on observationand interview the facility failed to provide 2 of 2 (Residents 1 and 2) sampled residents assistance with self-administered medications in accordance with procedures described in Section 429.256 F.S.

Findings Included:

During the 10:00: am medication pass med-tech A, put on a pair of disposal gloves, She opened the locked medication cart and removed a bubble pack with medication. She checked the medication label against the MOR. Pushed the pill into her hand. Walked over to Resident #1 and put the pill into the residents' mouth, gave her a cup of water and returned to the cart to initial the MOR.
The med-tech did not speak one word to the resident during the process. The med-tech showed the resident she was holding her pill and the resident opened her mouth. The med-tech did not identify the medication to the resident she administered the medication to the resident.

At 10:30AM, the med-tech removed the bubble pack from the locked medication cart. She compared the label against the MOR. The med Tech pushed the pill into a soufflé cup went to Resident #2 handed him a cup of water and put the soufflé cup to the resident's mouth then titled it to allow the pill to slide into the residents' mouth. The resident swallowed the pill. The med tech returned to the MOR and wrote her initials.
The med-tech administered the medication to the resident, did not tell the resident the name of the medication he was taking.
An interview with the administrator on at 11:00AM it was stated during an observation of the med pass that the med-tech was not passing the medication correctly. It was explained to the administrator how the residents received their medications. The administrator stated she has gone over

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this many times and will conduct another in-service and hope her staff stop making medication errors.
Class III

Class III