| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11966595 | 05/17/2017 |
| NAME OF PROVIDER OR SUPPLIER<br>**SPRING OAKS** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**7251 GROVE RD**<br>**BROOKSVILLE, FL 34613** | |

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

**0000 - Initial Comments**

An unannounced monitoring visit was conducted on at Spring Oaks Assisted Living Facility in Brooksville, Florida. License #10763 in conjunction with complaint survey CCR #2017004513. Deficient practice was identified during the survey.

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

Based on observation, interview and facility policy review, the facility failed to prevent potential spread of by failing to perform hand hygiene/hand washing before and after handling medications, after picking up an object from the floor during assistance with self- administration of medication by 2 of 2 staff (Medication Technician A and B).

Findings:

# 1 - Observation on at 12:30 PM revealed a Medication Technician (Med. Tech. A) is preparing to assist a resident with her medications. Med. Tech. unlocked the medication cart, opened her computer. Did not observe the Med. Tech. washed her hands or use hand sanitizer prior to assisting with self-administration of medication. Med. Tech pulled a bubble pack from the drawer. Poured water in a cup, grabbed a medication cup and entered the resident's . Med. Tech. punched the pill from the bubble pack, placed it in a medication cup and handed it to the resident. Med. Tech. exited signed the Medication Observation Record (MOR). Med. Tech failed to use a hand sanitizer or wash her hands.

# 2 - Observation on at 12:34 PM revealed the same Med. Tech. (Med. Tech. A) is preparing to assist in medication administration for another resident. Med. Tech. unlocked the medication cart, opened her computer. Med. Tech pulled a bubble pack from the drawer. Poured water in a cup, grabbed a medication cup and entered the resident's . The surveyor did not observe the Med. Tech. sanitize her hands between residents. Med. Tech. punched the pill from the bubble pack, placed it in a medication cup and handed it to the resident. Med. Tech. exited signed the MOR. When asked what went wrong in the process during an interview at 12:36 PM, she replied; I did not wash my hands in between residents.

# 3 - Observation on at 12:52 PM with a Med. Tech. (Med. Tech. B) in Memory Care Unit is preparing to assist in self-administration of medication. Med. Tech. unlocked the medication cart, opened her computer. Med. Tech pulled a bubble pack from the drawer and proceeded to punched it in a paper cup. The surveyor did not observe the Med. Tech. wash her hands or use the hand sanitizer prior to medication pass. Med. Tech. poured water in a cup, grabbed the medication cup walked outside the

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porch patio where resident was seated. Med. Tech. leaned down to give the medication to the resident when she accidentally dropped the pill on the floor. She picked it up from the floor and returned to her cart. Med. Tech crushed the pill and disposed of it. Did not observe the Med. Tech. wash her hands after picking up the pill from the floor. Med. Tech proceeded to give medication to another resident.

During an interview with Med. Tech. B on at 1:15 PM she confirmed that she failed to wash her hands. Med. Tech. further stated that she should have washed her hands when she dropped and picked up the pill from the floor.

Review of the facility's Personal Care Control - General Policy and Procedure provided by the Executive Director on at 2:35 PM has a review date of . Policy on page 1 of 7 reads: Staff shall perform all tasks in the community involving exposure to and bodily fluids as if all and specified body fluids and excrements were with , , or other . Page 2 of 7 of the policy reads: item # 6 - Staff are expected to wash their hands immediately and thoroughly in the following situations: Before and after handling any medications and / or treatments.

Class III

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

Based on observation, interview and record review, the unlicensed staff providing assistance with self administration of medication failed to read the label, failed to announce the name of the medication, to 2 of 4 sampled residents observed during medication pass (Resident #1 and #7).

Findings:

# 1 - Observation on at 12:52 PM with the Medication Technician (Med. Tech.) is preparing to assist in self-administration for Resident #7. Med. Tech. unlocked the medication cart, opened her computer. Med. Tech pulled a bubble pack from the drawer and proceeded to punch it in a paper cup. Med. Tech. placed the bubble pack back in the medication cart drawer. Med. Tech. poured water in a cup, grabbed the pre-poured pill in a medication cup, walked outside the porch patio where Resident #7 was seated. Med. Tech. accidentally dropped the pill on the floor. She picked it up from the floor and returned to her cart. Med. Tech crushed the pill and disposed of it. Med. Tech. proceeded to assist another resident with her medications. (Resident #1).

At 1:10 PM, Med. Tech. proceeded to give the medication to Resident #7 with the same technique of pre-pouring the pill in a medication cup. Med. Tech. handed the cup to the resident and stated; "take your medication." The Med. Tech. did not verbalize the name of the medication and failed to bring the

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bubble pack to read the label of the medication prior to handing the pill to the resident.

During an interview with the Med. Tech on at 1:15 PM, she confirmed that she failed to read the label or name of the medication to the resident. Med. Tech. stated she is aware of the requirement and had recently attended the 6 hours training on assistance with medication administration 2 weeks ago.

# 2 - Observation on at 1:03 PM with the Med. Tech. in the memory care unit is preparing to give Resident #1 her medications. Med. Tech. unlocked the medication cart, opened her computer. Med. Tech. pulled a bubble pack from the drawer. Med. Tech. proceeded to punch the pill in a paper medication cup, placed the bubble pack back in the cart drawer. She then poured water in a cup, grabbed the medication cup and approached Resident #1, who is seated in the main dining . Med. Tech. stated, "take your medicine." Med. Tech. failed to read the label and announce the name of the medication. Med. Tech. stayed with the resident for a while until she was able to swallow the medication. Med. Tech. signed the medication observation record (MOR).

During an interview with the Med. Tech on at 1:15 PM, she confirmed that she failed to read the label or name of the medication to Resident #1. Med. Tech. stated she is aware of the requirement and had recently attended the 6 hours training on assistance with medication administration 2 weeks ago.

Review of the Assisting with Routine Medications Policy and Procedure provided by the Executive Director on at 2:35 PM, showed has a review date of . Policy on page 1 of 2 reads:
Staff shall assist residents with the Administration of routine medications in a manner according to established procedures.
Procedure: When delegated by Wellness Director/Director of Nursing, staff assisting a resident with a medication should: Read the information regarding the medication in the resident's medication record (i.e. the medication name, dosage and time the medication is to be taken). Read the medication label (i.e. the medication name, dosage and time the medication is to be taken). Read the information in the medication record - again - and on the label - again.

Class III