STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911325	**05/15/2017**
NAME OF PROVIDER OR SUPPLIER **HPLS ASSISTED LIVING INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **300 EAST KALEY AVENUE** **ORLANDO, FL 32806**	

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

0000 - Initial Comments

The Re-licensure survey with Limited Nursing Services (LNS) was conducted on . HPLS Assisted Living, Inc. license #5886 had deficiencies found at the time of the visit.

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

Based on medication pass observations and interview the facility failed to ensure the unlicensed staff who assisted 1 of 1 sampled residents (5) with self-administration of medications followed the correct procedure.

Findings:

Observations during the medication pass on at 2 PM noted staff A washed her hands. She retrieved the Medication Observation Record (MOR) and a plastic container with all the medications for resident #5. She took out a box with a prescription label dated that indicated , eye drops instill one drop to each eye at bedtime. The staff said the resident was getting those drops now. Staff A was asked if she was sure, the label read at bedtime. She replied "Yes, she get this one now and this other one later". She had Muro- 128 eye drops, which Staff A said resident #5 got those drops at night. Staff A was asked if she was sure and she replied "Yes". She also took a bubble pack labeled , 5 mg one 3 times daily. She went to the resident's . She put one pill in a cup and took it to the resident. She told the resident "Here is your 2 PM medication" and handed the resident the pill. The resident then laid down and the staff instilled one drop to each eye of the , eye drops. She did not read the label to the resident.

Review of the , 2017 MOR revealed it listed , eye drops one drop to each eye at bedtime and Muro- 128 eye drops one drop to each eye at 8 AM, 2 PM and 8 PM (5 minutes before Muro- 128 eye drops).

In an interview with the owner on at 3:30 PM who said that staff A was very conscientious about the medications, maybe she was nervous.

Class III

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

Based on interviews and record review, the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation and allowed them administration for 1 of 2 sampled residents (1).

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SUMMARY STATEMENT OF DEFICIENCIES
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Findings:

Observations on at 9:30 AM noted staff A, was the sole caregiver. Staff A was observed on at 12:30 PM feeding resident #1. He was identified as being under the care of hospice.

Resident record review for resident #1 revealed a health assessment report from 1823 dated that indicated diagnoses of , and . He needed total care with all the activities of daily living, including eating and needed medication administration. He was under the care of hospice since .

Review of the , 2017 MOR revealed he needed medications administered at 8 AM, 6 PM and 8 PM. Further review revealed the initials where of the unlicensed staff, not the nurse.

Review of the , 2017 staff schedule dated 5/8/ to revealed that staff A worked 7 AM to 3 PM, staff B worked 3 PM -11 PM and staff C, an RN, worked 11 PM to 7 AM.

Personnel record review for staff A and B revealed they were not nurses therefore unable to administer medications.

In an interview with the administrator on at 3:30 PM revealed, she was not aware the health assessment report indicated medication administration.

Class III

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

Based on observations, record review and interview the facility failed to ensure that 1 of 2 sampled resident records (#1) contained all the required components.

Findings:

Resident record review for resident #1 revealed he was under the care of hospice since . The review revealed that a hospice interdisciplinary plan which specified the services provided by hospice and those provided by the facility and was developed and implemented by a licensed hospice in consultation with the facility, was not available for review.

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SUMMARY STATEMENT OF DEFICIENCIES
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During an interview with the administrator on . . . at 3:30 PM who stated, she was not aware of the interdisciplinary plan.

Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on record review and interview the facility failed to ensure 1 of 2 resident contracts contained all the required information (#1).

Findings:

Resident record review for resident #1 revealed the contract did not contain the following required information: A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule.

During an interview with the administrator on . . . at 3:30 PM who stated, the information was overlooked.

Class III