STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932435	**10/03/2017**
NAME OF PROVIDER OR SUPPLIER **SHARICK'S DECK RETIREMENT RANCH**	STREET ADDRESS, CITY, STATE, ZIP CODE **4506 BRUTON ROAD** **PLANT CITY, FL 33565**	

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

0000 - Initial Comments

Assisted Living Facility

An unannounced complaint survey, (CCR# 2017008174), was conducted at Sharick's Deck Retirement Ranch on , an assisted living facility, located in Plant City, Florida. There were deficiencies identified during the survey.

(License # 5335)

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

Based on observation and interview, the facility failed to honor resident's rights to private communication by telephone without supervision by facility employees for 23 of 25 resident who uses the facility provided telephone.

Findings included:

During interview with Resident #8, on at 09:17 a.m., he stated that residents are able to use the phone after asking staff and staff are with the residents in the kitchen when using the telephone. During interview with Resident #2, on at 09:22 a.m., he stated that residents are supervised when in the kitchen or while used the phone which is located in the kitchen. Resident #2 stated that Residents are not allowed to use the telephone after nine o'clock at night.

During interview with Staff B on at 09:51a.m., She stated that the facility has two phones that the resident can use. "They cannot use the kitchen phone without us there, because they can't go in the kitchen without us there. The other phone, we have to unlock the that way they don't take anything. It is in the food storage ." Staff showed phone in food storage area and stated that someone has to be here so residents don't take anything.

Secondary telephone observed in food storage area that requires staff to unlock the door. Area was cluttered with food supplies with no cleared walking pathway (image taken). The wired telephone was located on top of a red fire control panel, across from water heater (image taken).
During interview with Staff C on at 01:32 p.m., he stated that the residents ask the staff to

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use the phone, and "we monitor them while they are in the kitchen." Staff C also confirmed that residents are not allowed in the kitchen at night after nine at night. Staff B and Staff C confirmed that only two residents have their own personal mobile phone.

During interview with the Administrator on at 02:03 p.m., he stated that the facility practice is to supervise residents while in the kitchen, and in food storage area. He was no aware that any residents had issues with phone privacy and they never mentioned that to him. Administrator confirmed with Staff B about the clutter in the food storage area.

Class III

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

Based on observation, interview, and record review, the facility failed to provide assistance with self-administered medications in accordance with procedures described in Section 429.256, F.S. Staff B did not wash or sanitized hands prior to providing medications to one (#3) of five observed residents. Staff B failed to inform residents of medications provided, and did not provide medications at the prescribed time for five (#3, #4, #5, #6 and #7) of five residents observed.

Findings included:

While conducting medication observation with Staff B on 10:50a.m., Staff B did not wash or sanitize her hands prior to assisting with self-administration of medication. Staff B also provided Resident #3 with his medications without informing the resident of medication provided that included three tablets and one capsule.

Review of the Medication Observation Record (MOR) revealed that the medications (three tablets and one capsule) given to Resident #3 were scheduled for 08:00a.m. Resident #3 received his medications at 10:50 AM.

During interview with Staff B on at 10:54a.m., she stated Resident #3 wakes up and take his medications when he wants, and that he takes his medicine late everyday. Staff B stated that facility has not notified the doctor of the resident's preference for later medication and confirmed that the MOR indicated that medications were to be given at 08:00 a.m. Staff B conformed that she did not wash or sanitize her hands prior to medications

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On [redacted] 01:02 p.m., Staff B stated that she was ready to start the noon medications. Staff looked at the big analog clock on the wall and stated it was 12:00p.m. Surveyor informed her that the clock actually read 01:04 p.m. Staff looked closer and confirmed that she misread the time and confirmed that she is starting medication pass after the one-hour grace period. The following was observed during the medication pass:
At 1:08 p.m. Staff B placed medications on Resident #4's hand and did not inform resident of medication being provided that included two tables and one capsule.
At 1:10 p.m. Staff B placed medication on Resident #5's hand and did not inform resident of medication being provided that included four tablets and one capsule.
At 1:12 p.m. Staff B placed medication on Resident #6's hand and did not inform resident of medication being provided that included one tablet and one capsule
1:16 p.m. Staff B placed medication on Resident #7's hand and did not inform resident of medication being provided that included three tablets.

Review or orders and MOR for Residents #3, #4, #5, #6 and #7 confirmed that observed medication were to be given at 12:00 p.m. daily.

During interview with Staff B, on [redacted] at 01:18 p.m., she confirmed that she did not inform the residents of the medications provided to them. She stated, "I thought they know what their medications are."

Class III