STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953611	**10/02/2017**
NAME OF PROVIDER OR SUPPLIER **BARRINGTON (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **901 SEMINOLE BOULEVARD** **LARGO, FL 33770**	

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

0000 - Initial Comments

Assisted Living Facility

Two complaint investigations, (CCR# 2017007210 and CCR# 2017008907), were conducted at Barrington (The), Assisted Living Facility, on . Barrington (The) had a deficiency at the time of the investigation.

(License # 7232)

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observations, interviews and records review, the facility failed to follow their own policy related to their call light system response and did not respond appropriately to residents requiring assistance for 7 of 10 residents observed (#4, #5, #6, #7, #8, #9 and #10).

Findings included:

During a test of the facility call lights system and response time check at the facility on , the following issues were observed:
At 9:45am, Resident #5's call light pull chain was pulled, as well as the resident's neck worn pendant call button was pushed there was no response from staff for 20 minutes. Surveyor waited to see that no staff ever answered the call button and then moved on to a different .
At 10:10am, Resident #6's call light pull chain was pulled and there was no response from staff for 20 minutes. Surveyor waited to see that no staff ever answered the call button and then moved on to a different .
At 10:45am, Resident #7's call light pull chain was pulled and there was no response from staff for 20 minutes. Surveyor waited to see that no staff ever answered the call button and then moved on to a different .
At 11:15am, Resident #8's call light pull chain was pulled and there was no response from staff for 15 minutes. Surveyor waited to see that no staff ever answered the call button and then moved on to a different .
At 11:50am, Resident #4's call light pull chain was pulled and there was no response from staff for 15 minutes. Surveyor waited to see that no staff ever answered the call button and then moved on to a

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different .
At 12:45pm, Resident #9's call light pull chain was pulled and there was no response from staff for 18 minutes. Surveyor waited to see that no staff ever answered the call button and then moved on to a different .
At 1:05pm, Resident #10's call light pull chain was pulled and there was no response from staff 15 minutes. Surveyor waited to see that no staff ever answered the call button and then moved on.
In an interview with Resident #4's family member on at 2:20pm, the family member stated that they have concerns that the facility's medical alert system is insufficient. Resident #4 has resided in the facility for more than one year and the neck pendant medical alert system has never functioned properly. The call button near the bed seems to have the same problem. The family member stated this has been brought to the attention of the facility, however, so far the problems persist.
The facility's policy and procedure on emergency pull was reviewed at 2:00pm on . The facility's policy is to respond "immediately" to resident pull cord alarms. It was observed that the facility failed to follow its own policy and procedure to respond immediately to resident pull cord alarms.
In an interview with the Administrator at 1:30pm on , the Administrator stated that the facility was having problems with the alert/call light system. The Administrator added that they were working on a solution to this problem because it needed to be corrected.

Class III