STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910121	**10/05/2017**
NAME OF PROVIDER OR SUPPLIER **ROCKY CREEK VILLAGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **8606 BOULDER COURT** **TAMPA, FL 33615**	

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

0000 - Initial Comments

Assisted Living Facility

Two unannounced complaint surveys, (CCR# 2017007859 & CCR# 2017009324), were conducted at Rocky Creek Village, an assisted living facility, located in Tampa, Florida. There were deficiencies identified at the time of the visit.

(License # 5227)

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

Based on interview and record review, the facility failed to ensure that the resident's written record was updated to reflect a significant change or other change that resulted in the method of medication administration for one (Resident #12) of two sampled residents receiving assistance with medication.

Findings included:

While conducting observation of assistance with self-administration of medication with the Staff B, conducted on at 10:50 a.m., and Staff C on at 04:03 p.m., both employees, unlicensed staff, were observed administering a total of 6 medication tablets with a spoon.

During interview with Staff B, on at 10:54 a.m., she stated that Resident #12 cannot move her hands, and she cannot feed herself or take the medications. Staff B stated that, "we always have to give the medication with a spoon."

During interview with the Director of Nursing (DON) on at 11:15 a.m., he stated that Resident #12 was able to assist with the self-administration of medication. He stated that the Medication technicians have not notified him that they have been administering the medication for Resident #12, and that they are supposed to notify a nurse of Resident #12's lack of contribution to receiving assistance with self-administration of medication. DON confirmed there were no orders or anything that indicated that Resident #12 requires medication administration.

On at 04:27 p.m., Staff C stated that she always spoon-fed Resident #12 her medicine since

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her employment at the facility.
Record review for Resident #12, including most recent health assessment dated . . . . . indicated that Resident #12 needs assistance with self-administration of medication. Resident assessment did not indicate that resident is unable to move her arms and hands to self-administer medication with assistance, or that resident needs medication administration

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.Specifically, unlicensed staff (B and C) administered oral medication for one resident (#12), and failed to inform residents of medications provided for two (#12 and #13) of five resident selected for record review. Staff B failed to verify one resident (#12) swallowed the prescribed medications provided, and did not read the applicable medication labels, and removed the medications from primary packaging in the presence of the residents for two of five resident selected for record review.

Findings included:

During an observation of assistance with self-administration of medication with the Staff B, an unlicensed medication technician (Med Tech), conducted on at 10:50 a.m., Staff B did not inform Resident #12 of medication provided. Staff B was observed administering one tablet orally for Resident #12, by scooping the table and applesauce, and administering it for the Resident #12 with a spoon. The resident's hands did not make contact with the medication, or the cup of water given after oral dosage. Staff C did not document medication as given in the Medication Observation Record (MOR).

During interview with Staff B, on . . . . . at 10:54 a.m., she confirmed that she did not inform Resident #12 of the medications provided, and stated that Resident #12 cannot move her hands, and she cannot feed herself or take the medications. Staff B stated that, "we always have to give the medication with a spoon."

During an observation of assistance with self-administration of medication with the Staff C, an unlicensed Med Tech, conducted on . . . . . at 04:03 p.m., Staff C was observed, in the hallway,

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removing Resident #13's medication (three tablets) from primary packaging and placing them in a disposable cup, while the resident was in her . Staff C handed the medications to the resident without informing Resident #13 of the medication given. Staff C did not document medication as given in the MOR.

During continued observation of assistance with self-administration of medication with the Staff C, conducted on at 04:27 p.m., Staff C, observed in the hallway, removed five tablets from the primary packaging and crushed some of the medications, while Resident #2 was in her . Staff C used a spoon to administer the five tables with applesauce. Staff did not inform Resident #12 of medications provided. Staff C stated that she always spoon-fed Resident #12 her medicine.

At 04:27 p.m., Resident #12 stated that she could not swallow the medication, twice. Staff C did not respond and moved to the next the hallway without ensuring that resident swallowed the medication. At 0433 p.m., Resident #12 stated that she could not swallow the medication and showed a round, white, slightly dissolved tablet, in her mouth.

On at 04:35 p.m., Staff C stated that, "we're supposed to make sure the resident swallowed." Staff C went back to , and Resident #12 showed staff the tablet in her mouth, and stated again that she could not swallow it, and spat it out. Staff C did not document medication as given in the MOR.

During interview with Staff C conducted on at 04:45 p.m., she stated that she provides medication to all residents that are assigned to her and the document in the MOR for all residents. Staff was not aware that she is supposed to sign the MOR each time a medication was provided to each resident.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based in interview and record review, the facility (Staff C) inaccurately documented medication as given to resident while the facility was out of the medication for two (#1 and #2) residents of five residents selected for medication review; and failed to update the Medication Observation Record (MOR) each time medication was provided to the residents.

Findings included:

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On at 10:35 a.m. Resident #2 stated that the facility was out of one of his prescribed medications for about a week and staff have not informed him how or why they ran out or why they did not order the medication.

Review of the facility's Control Count Sheet for Resident #2's medication and the MOR for Resident #2 revealed that Staff C documented that Resident #2 ran out of the medication, prescribed for one table by mouth twice a day, on . There was no documentation indicating that a nurse or the pharmacy was notified. Record review also revealed that Staff documented the medication as given on , , , , , , , , , and .

During interview with the Director of Nursing (DON), on at 11:15 a.m., he confirmed that the medication was out on , he was not informed until . The DON was not able to furnish any documented refill request for Resident #2's medication. DON also confirmed that Staff C documented medication as given, although the facility did not have the medication at the facility.

Record review conducted on revealed that Resident #1 was out of prescribed medication, scheduled for one tablet by mouth twice daily (8a.m. and 5p.m.), was documented at not available in the morning on , , 19th and 20th on 2017 at 08:00 a.m., but documented as given in the evening of those dates by Staff C.

During interview with Staff A, licensed practical nurse (LPN), on at 01:556 p.m., she confirmed that Resident #1 was out the prescribed medication from to . Staff A, LPN confirmed that Staff C documented dosages as given, and she did not know why the medication was documented as given.

During interview with Staff C conducted on at 04:45 p.m., she stated that she provides medication to all residents that are assigned to her and documents in the MOR for all residents. Staff was not aware that she is supposed to sign the MOR each time a medication was provided to each resident. Staff acknowledged that is likely the reason she documented medication as given although residents (#1 and #2) were out.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

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Based on record review and interview, the facility failed to ensure that prescriptions for residents who receive assistance with self-administration of medication, or medication administration were filled or refilled in a timely manner for one (Resident #2) of five residents selected for medication review.

Findings included:

On at 10:35 a.m. Resident #2 stated that the facility was out of one of his prescribed medications for about a week and staff have not informed him how or why they ran out or why they did not order the medication.

Review of the facility's Control Count Sheet for Resident's medication and the Medication Observation Record (MOR) for Resident #2 revealed that Staff C documented that Resident #2 ran out of the medication, prescribed for one table by mouth twice a day, on . Record review revealed no indication of medication order for refill.

During interview with the Director of Nursing (DON), on at 11:15 a.m., he confirmed that medication was out on , he was not informed until . The DON was not able to furnish any documented refill request for resident's medication and confirmed that the facility did not have the prescribed medication for Resident #2.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on interview and record review, the facility failed to furnish proof of training completion relating to assistance with self-administration of medication for one (Staff C) employee of three employees selected for record review, who provide assistance with self-administration of medication.

Findings included:

Employee record review, conducted on , revealed no documentation indicating that Staff C, an unlicensed staff who was observed assistance with self-administration of medication and administering oral medication for residents, completed any training for assistance with

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self-administration of medication.

On , approximately at 05:15 p.m., the Administrator and DON confirmed they were unable to locate any proof of training related to assistance with self-administration of medication for Staff C.

Class III