STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966973	**10/24/2017**
NAME OF PROVIDER OR SUPPLIER **AMOEDO'S ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3415 W IVY STREET** **TAMPA, FL 33607**	

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

0000 - Initial Comments

Assisted Living Facility

An abbreviated biennial survey was conducted on at Amoedo's ALF, Inc. (License #11149), an Assisted Living Facility located in Tampa, Florida. There were deficiencies identified during the survey.

License #11149

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 ensure good sanitary and control practices; specifically, Staff B making contact with two residents (#1 and #2) while holding an unbagged soiled brief.

Findings included:

On at 10:00 a.m., Staff B was observed pushing Resident #3 in a wheelchair while holding a soiled unbagged brief with her gloved hands. Immediately after; Staff B was observed touching and rubbing Resident #1's back with her right hand while holding the soiled brief with her left hand.
During interview with Staff B and the Administrator conducted on at 11:00 AM , both agreed that Staff B was supposed to bag and discarded the brief after helping change and toilet Resident #2, and Staff B was supposed to discard her gloves and washed her hands prior to making contact with any other residents.

Class III

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

Based on observation and interview, the facility failed to provide assistance with self-administered medications in accordance with procedures described in Section 429.256, F.S. Specifically, Staff B failed to remove medications from the original packaging in the presence of residents and inform residents of medications provided for three (#1, #2 and #6) of three observed residents; and administered oral medication for one resident (#6) of three observed residents.

Findings included:

During an observation of assistance with self-administration of medication with Staff B, conducted on

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at 11:51 a.m., Staff B did not inform Resident #12 of medication provided.

During an observation of assistance with self-administration of medication with Staff B, conducted on at 05:34 p.m., she removed four medications tablets from primary packaging and handled the tablets with her bare hands while crushing and placing them in a container of apple sauce. Staff B then found the resident, and used a spoon to feed the crushed medications and applesauce to Resident #6 without informing the resident of medication provided or allowing the resident to make an attempt of self-administering the oral dosages. When asked, Staff B state that the resident was able to self-administer medication and that she just always feeds the medications to Resident #6. Resident #6 was observed finishing the remaining applesauce confirming that Resident #6 was able to self-administer medication using the spoon.

During continued observation, on at 05:39 p.m., Staff B removed one medication tablets from primary packaging and handled the tablets with her bare hands while crushing and placing in a container of apples sauce. At 5:44 p.m., Staff B handed Resident #2 the container of applesauce and medication and stated, "Here is your medicine," without informing resident of what medication is being provided. Resident #2 self-administered the oral dosage.

During interview with Staff B and the Administrator, on at 05:47 p.m., Staff B confirmed that she handled the medications with bare hands, opened medication in the absence of resident, did not inform the resident of medication, and administered the medication for Resident #6 who was able to self-administer the dosages.

Class III