STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966804	**11/15/2017**
NAME OF PROVIDER OR SUPPLIER **LEDGE MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **12006 MCINTOSH ROAD THONOTOSASSA, FL 33592**	

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

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, the facility failed to maintain the employment status of employees, within the employee roster listed in the AHCA background screening clearinghouse (Employee Roster), within 10 business days of initial employment, for two (Administrator and Staff G) of five employee records reviewed.

Findings included:

A review of employee records conducted on 11/ showed that the Administrator was hired on and Staff G was hired on .

A review of the facility's Employee Roster conducted on showed that the Administrator and Staff G were not entered.

The Administrator was interviewed at 3:21 PM on concerning the lack of entries for the Administrator and Staff G in the Employee Roster. The Administrator reviewed the Employee Roster and acknowledged that the two employees were not entered.

Unclassified

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0000 - Initial Comments

Assisted Living Facility

Two complaint investigations, (CCR# 2017010616 and CCR# 2017010789), were conducted at Ledge Manor on . Ledge Manor, Assisted Living Facility, had deficiencies at the time of the visit.

(License # 11289)

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure that residents' medical examination forms (AHCA Form 1823) were fully completed, including a date of medical examination, for one (Resident #1) of six residents' records sampled.

Findings included:

A review of Resident #1's record on , who was admitted to the facility on , showed that the resident's current AHCA Form 1823 had no date stating when the examination was conducted.

The Administrator was interviewed at 3:25 PM on concerning the lack of a date on Resident #1's AHCA Form 1823 and acknowledged that the form was not dated.

Class III

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

Based on record review and interview, the facility failed to provide personal supervision as appropriate for each resident and ensure that residents' health care providers and family members were contacted for incidents and changes in condition that required medical attention for one (Resident #1) of six residents sampled.

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Findings included:

A review of Resident #1's record was conducted on . The resident's record showed a history of 11 from through . There was no documentation in the record that Resident #1's health care provider was notified of the , including a incident dated when the resident was sent to the hospital. The record also showed that the resident's responsible party was not notified of incidents that occurred on and .

The review of Resident #1's record showed an AHCA 1823 Form (not dated) that indicated that the resident was a risk and required precautions. The review of the resident's record showed no documentation of what interventions the facility put in place to help reduce the frequency of .

A review of the facility's " Prevention and Management Procedure" dated showed that procedures to help prevent falling included immediate interventions after a such as asking what the resident was attempting to do, notify the physician and emergency contact.

The Administrator and Resident Care Director were interviewed at 3:33 PM on concerning the lack of documentation of notifying Resident #1's health care provider and inconsistent notification of the resident's responsible party. The Administrator and Resident Care Director acknowledged the lack of required notifications. The Resident Care Director also stated that they were not aware of any current interventions to help reduce the frequency of for Resident #1.

Class III

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

Based on record review and interview, the facility failed to ensure that Medical Observation Records (MORs) were accurate and free from omissions and errors for five of six residents sampled (Resident #1, #4, #5, # 6, and #8).

Findings included:

A review of MORs on revealed omission of med tech initials for 8:00 AM medication pass for Residents #1, #4, #5, and #6.

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During an interview with Staff D on 11/ at 10:42 AM concerning documentation on MORs, they stated that they sometimes get busy and sidetracked helping other residents.

A review of the MORs on 11/ also revealed omission of med tech initials and documentation of medication refusal for Resident #8. Resident #8 was to receive 5-325, one tablet by mouth every four hours. Based on review of the MORs, the resident did not receive the 8 AM and 12 PM doses on , , and . Resident #8 did not receive the 12 PM dose on and did not receive 4 AM and 8 AM doses on . There was no documentation in the MORs to determine if the resident refused the medication.

During an interview with the Director of Resident Care on at 11:35 AM, regarding lack of documentation on the MORs, they stated that the med tech was supposed to document refusals in the MORs and notify Staff A. The Director of Resident Care reported that Staff A was supposed to conduct weekly and monthly MORs reviews.

During an interview with Staff A on 11/ at 12:10 PM regarding a lack of documentation on the MORs for Resident #8, they reported that the previous director of resident care kept nursing notes on medication refusals and excess . Staff A stated that they did not know the whereabouts of the previous director's notes.

Class III

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

Based on record review and interview, the facility failed to ensure that prescriptions for residents documented on medication observation records (MORs) were accurate and free of errors for one of six residents sampled (Resident #10).

Findings included:

An observation of a medication pass on revealed that Resident #10 received the medication , 10mg tablet at 8:35 AM . A review of the MORs revealed that the resident was to be given the medication at 8:00 AM. A review of the Physician's Order and prescription label revealed that Resident #10 was scheduled to receive the medication at bedtime.

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An observation of the medication pass on revealed Resident #10 received medication 20mg tablet at 8:35 AM. A review of the MORs revealed that the resident was to be given one tablet by mouth daily. A review of the Physician's Order and prescription label revealed that they should have received one and a half tablet by mouth daily.

During an interview with the Director of Resident Care on at 11:35 AM regarding the difference in prescription documentation, they stated that they she did not know why there was a discrepancy.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to provide a safe living environment and ensure that all electrical systems were maintained in good working order for one (Resident #1) of three residents sampled.

Findings included:

An observation of Resident #1's 9:45 AM on showed no pull cord by the bed for the facility's call light system in order to alert direct care staff of the need for assistance. A review of Resident #1's AHCA Form 1823 showed that they required precautions.

Staff A was interviewed at 9:47 AM on concerning Resident #1's call light system by their bed. Staff A observed the area and stated that there was usually a pull cord with a small "teddy bear" attached at the end. When asked how Resident #1 would alert the staff of need for assistance, Staff A stated, "I'm in awe".

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the facility failed to maintain an up-to-date admission and discharge log listing the names of all residents with dates of admission.

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Findings included:

A review of the facility's admission and discharge log conducted on . . . . . revealed that none of the entries showed a date of admission for the facility's residents.

The Administrator was interviewed at 3:49 PM on concerning the lack of admission dates documented on the admission and discharge log. The Administrator reviewed the admission and discharge log and acknowledged the omission of admission dates.

Class III