STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968282	**11/03/2017**
NAME OF PROVIDER OR SUPPLIER **BRENTWOOD AT FORE RANCH**	STREET ADDRESS, CITY, STATE, ZIP CODE **4511 SW 48TH AVE** **OCALA, FL 34474**	

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

0000 - Initial Comments

A complaint investigation (CCR#2017008962, CCR2017009632) was conducted at Brentwood at Fore Ranch (License #12234) on . . . . Deficient practice was identified at the time of the investigation.

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 provide care in a safe manner for 1 of 3 residents observed.

Findings:

During an observation of assistance with medication administration on at 12:50 p.m., Staff A was observed to sanitized her hands, obtained medication from secure cart, gathered supplies and went to Resident #12's . Resident #12 was found to be in pain and refused to take the medication at this time. Staff A and Staff E pulled resident up in the bed and attempted to reposition resident without applying gloves. Staff A then exited the obtain pain medication for Resident #12 without sanitizing hands. Staff A retrieved medications from secured medication cart, verified medication with MOR and preceded back to Resident 12's . Staff A prepared the medication for administration in the syringe, verified dose with bottle and MOR, and injected the medication into the Resident 12's mouth and held the Resident 12's mouth with her unsanitized, ungloved hand and observed Resident #12 swallow the medication. Staff A then exited Resident 12's . . . , returned medication to secured cart, and document on MOR.

In an interview with the Staff A at 1:30 p.m., she confirmed she had not sanitized or washed her hands prior to administrating medication to Resident #12.

Class III

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

Based on observation and interview, the facility stored prescription medication that was not properly labeled for 1 of 3 residents observed.

Findings:

During an observation of assistance with medication administration on at 11:45 a.m., Staff A retrieved Resident #11's . . . pen from the top drawer of a secured medication cart. The pen had Resident #11's name printed on it with permanent marker. No medication label containing resident's

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SUMMARY STATEMENT OF DEFICIENCIES
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name, practitioner's name, date dispensed, or direction for use.

During an interview on at 1:15 p.m., the Health and Wellness director identified Resident #11's pen and confirmed the pen was not labeled and should be labeled.

Class III

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Findings:

During an observation of assistance with medication administration on at 12:50 p.m., Staff A was observed to sanitized her hands, obtained medication from secure cart, gathered supplies and went to Resident #12's . Resident #12 was found to be in pain and refused to take the medication at this time. Staff A and Staff E pulled resident up in the bed and attempted to reposition resident without applying gloves. Staff A then exited the obtain pain medication for Resident #12 without sanitizing hands. Staff A retrieved medications from secured medication cart, verified medication with MOR and preceded back to Resident 12's . Staff A prepared the medication for administration in the syringe, verified dose with bottle and MOR, and injected the medication into the Resident 12's mouth and held the Resident 12's mouth with her unsanitized, ungloved hand and observed Resident #12 swallow the medication. Staff A then exited Resident 12's . . . , returned medication to secured cart, and document on MOR.

In an interview with the Staff A at 1:30 p.m., she confirmed she had not sanitized or washed her hands prior to administrating medication to Resident #12.

Class III

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