STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968869	**10/26/2017**
NAME OF PROVIDER OR SUPPLIER **REGENCY PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **15000 HWY 441** **EUSTIS, FL 32726**	

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

0000 - Initial Comments

On , 2017 through , 2017 a biennial relicensure survey with Extended Congregate Care monitoring was conducted at Regency Park Assisted Living Center. Deficient practice was identified at the time of the survey.

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 safe control practice for 2 of 4 residents observed (Resident #9, #6).

Findings:

#1 During an observation on at 10:00 a.m., Staff B provided personal care to Resident #9. Staff B was observed to enter resident's knocking, and apply gloves. Staff B informed Resident #9 she was there to wash his face and change him. Staff B obtained the necessary supplies to complete the task and began with washing the resident's face. Staff B then performed oral hygiene on Resident #9, using a mouth swab. After completing oral hygiene, Staff B placed the used mouth swab on the overbed table. Staff B then proceeded to perform incontinence care on the Resident #9. Staff B removed soiled adult diaper and dropped the adult diaper on floor next to resident's bed. Staff B cleansed Resident #9 with a disposable wipe and dropped the used wipe on the floor following care. While performing care, Staff B was observed touching her own face three times with gloved hands that remained unchanged following peri-care. After completing peri-care, Staff B was observed to touch the Resident #9's head and face with her unchanged glove.

In an interview at 10:15 a.m. with Staff B, she stated she did not knock on the door before entering the Resident 9's . Staff B stated she did place the brief and wipes on the floor and the used mouth swab on the overbed table. Staff B stated she did touch her face and the resident's face with her unchanged gloved hand.

#2 During an observation on at 9:30 a.m., Staff D and Staff E provided personal care to Resident #6. Both staff put on gloves and assisted Resident #6 out of his wheelchair and into the bed. Resident #6 required changing of an adult brief that was soiled. Staff D did the cleaning to Resident #6 while Staff E assisted in positioning. Resident care was completed, Staff E removed his gloves, washed his hands with soap and water, and exited the . Staff D, after completing care did not remove gloves and proceeded to adjust the resident's bed and turn on the TV, both remotes were handled with the dirty gloved hand of Staff D. Staff D removed her gloves, disposed of gloves in trash. Staff D removed trash liner from Resident #6's washed her hands with soap and water.

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In an interview on at 10:00 a.m., Staff D acknowledge improper control practice by not removing gloves after providing peri-care stating "I agree I didn't remove my gloves after doing peri-care to Resident #6.

Class III

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

Based on observation and interview, the facility failed to maintain medication observation record(MOR) that was updated each time the medication was administered for 2 of 5 residents (#1 & #9) observed.

Findings:

#1 On at 9:25 a.m., Staff F was observed to sanitize her hands, retrieve medication packet from drawer in locked medication cart within the hallway on the third floor, verify medication packet with MOR. Staff F documented on the MOR prior to administration of medication and assembled medication cup, medication packet and a glass of water. Resident #1 was located and identified within the dining the third floor and given the medication in the medication cup and told "This is your morning pills". Staff F observed Resident #1 take the medication and disposed of used cup and returned to medication cart in hallway.

#2 On at 9:30 a.m., Staff F was observed to sanitize her hands, retrieve medication packet for Resident #9 from drawer in locked medication cart. Staff F verified medication packet with Resident #9's MOR. Staff F documented on the MOR prior to administration of medication and assembled medication cup, yogurt, spoon, and water. Staff F knocked on Resident 9's door and entered the , identified the resident by name and informed him she had his morning pill. Staff F placed medication into yogurt and feed yogurt to Resident #9. Staff F observed Resident #9 consume all the yogurt.

In an interview with Staff F at 9:45 a.m., she stated she had documented administration of medication prior to residents actually taking the medication. Staff F confirmed proper practice is to document medication administration after the resident takes the medication.

Class II

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to ensure staff have an annual statement from a

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health care provider stating the individual does not constitute a risk of communicating for 1 of 3 staff reviewed (Staff C).

Findings:

In an employee record review on at 12:30 p.m., a chest X-ray results were identified for Staff C dated . No annual statement from a healthcare provider stating Staff C did not constitute a risk of communicating was found.

In an interview with the administrator on at 10:30 a.m., she stated she was unable to located an annual statement from a healthcare provider stating Staff C did not constitute a risk of communicating .

Class III