STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968666	**01/09/2018**
NAME OF PROVIDER OR SUPPLIER **HOMEWOOD LODGE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **430 SE MILLS ST MAYO, FL 32066**	

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

0000 - Initial Comments

On , 8 and 9, 2018, an unannounced biennial survey was conducted at Homewood Lodge Assisted Living Facility (license # 12528), Mayo, FL. Deficient practice was identified at the time of survey.

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

Based on observation and interview, the facility failed to provide assistance with self-administration of medications for 3 of 3 residents observed (Resident #3, Resident #6 and Resident #8).

Findings:

At approximately 12:08 PM on , unlicensed staff C was observed to administer , /Levadopa Tablet and , 25 mg Tablet to resident #3 instead of assisting the resident with self-administration of medication. Staff C pre-poured the medications into a cup and took the medications to the resident's stated the name of the medications to the resident. The staff C failed to read the label in the presence of resident #3.

At approximately 12:15 PM on , unlicensed staff C was observed to administer , 0.5 mg Tablet to resident #8 instead of assisting the resident with self-administration of medication. Staff C pre-poured the medication into a cup and identified the resident and stated: "This is your ". The staff C failed to read the label in the presence of resident #8.

At approximately 12:20 PM on , unlicensed staff C was observed to administer , 1 mg Tablet to resident #6 instead of assisting the resident with self-administration of medication. Staff C identified the resident, poured the medication into a cup and stated: "This is your , ". The staff C failed to read the label in the presence of resident #6.

At approximately 12:25 PM on , an interview was conducted with staff C, who confirmed that she failed to read the label in the presence of resident #3, resident #6 and resident #8.

(Class III)