STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932598	**01/16/2018**
NAME OF PROVIDER OR SUPPLIER **RESIDENCE OF STUART, INC. (THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1048 N. FORK ROAD** **STUART, FL 34994**	

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

0000 - Initial Comments

A Relicensure survey was conducted on at Resident of Stuart, Inc., License #8163. The facility had deficiencies at the time of the visit.

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

Based on resident record review and staff interview, the facility failed to ensure the health assessment (AHCA Form 1823) was completed accurately and in its entirety for 1 of 2 residents whose records were reviewed (Resident #2). T

The findings included:

On , a review of Resident #2's current Health Assessment contained within his medical chart had the following issues:
1) Section 1, Part D was left blank as to whether Resident #2's needs could be met in an assisted living facility which in not a medical, nursing, or , facility. A notation is contained which stated, "Requires 24 hr supervision."
2) Section 2, Part A - Self-Care and General Oversight Assessment has no check marks in the appropriate columns with explanation as to the extent and type of assistance necessary for self-care tasks, only a note that "resident is unable to perform any of these tasks."
In Part B, there is no indication as to the extent required for general oversight needed regarding Reminders for Important Tasks.
3) Resident #2 is receiving "assistance" with medications, which is appropriate according to the Administrator on at 2:30 PM. However, the Resident's Health Assessment states he requires "medication administration."
4) The Health Assessment does not include the date the Health Care Provider completed the face-to-face examination.

On at 2:30 PM, the Administrator was shown Resident #2's Health Assessment (AHCA Form 1823), and she acknowledged the concerns noted above.

Class III

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

Based on observation, interview and record review, facility staff failed to:
1) follow proper protocol for assisting with self administered medications, and
2) follow universal hand hygiene precautions

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as outlined in the regulatory mandated annual training for assistance with self-administered medication (Staff A).

The findings included:

1. On at 10:10 AM, an observation was made of Staff A assisting Resident #2 with the Self-Administering of Medications.
a) Staff A washed her hands prior to removing Resident #2's medication from locked medication cart.
b) Staff A compared the Medication Observation Record (MOR) and label;
c) Staff A removed 2 of the medications from their labeled containers and placed them into a small med cup while standing at the medication cart located on the far side of the living . The resident was seated at one of the tables in the dining ; Resident could not view Staff prepare the medications.
d) The 3rd medication (, 100 mg) was taken out of the container and placed in a pill splitter with the staff's ungloved hand. Staff had to situate the pill in the splitter several times using her ungloved hand before finally halving the pill. Staff A took the pill out of the splitter with ungloved hand and placed it into small med cup.
e) Staff A handed resident the medications without reading the medication label to the resident;
f) Staff A observed the resident swallow the medications, and
g) Initialed the MOR immediately after the medication was given to resident.

2. On at 11:55 AM, the following observations were made while Staff A was assisting Resident #2 with his self-administered medications:
a) Staff A washed her hands prior to removing Resident #2's medication from locked med cart.
b) Staff A removed medication from labeled container and placed in small med cup.
c) Staff A handed resident the medications without reading the medication label to the resident;
d) Staff A observed the resident swallow the medications, and
e) Staff A initialed the MOR immediately after the medication was given to resident.

3. On at 12:00 PM the following observations were made while Staff A was assisting Resident #5 with his self-administered medications:
a) Staff A did NOT wash her hands after assisting Resident #2 and before beginning assistance to Resident #5.
b) Staff A removed Resident #5's medication card from the locked cart.
c) Staff A removed Resident #5's tablet from the medication card with ungloved hands, and placed pill in small med cup.
d) Staff A handed resident the medications without reading the medication label to the resident;
e) Staff A observed the resident swallow the medications, and

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f) Staff A initialed the MOR immediately after the medication was given to resident.

The Administrator acknowledged on at 2:40 that staff did not follow the proper protocol assisting with medications and for medication handling.

Class III

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

Based on observation, record review and staff interview, staff failed to follow physician orders for timing of medication for 1 of 2 residents observed for medication assistance (Resident 2).

The findings included:

1. On at 10:10 AM, an observation was made of Staff A assisting Resident #2 with the self-administering of , 100 mg, 1/2 tab.
A review of the physician order recorded on the MOR for this medication documents Resident #2 is to receive , 100 mg, 1/2 pill at 8 AM. This medication is to be taken 3 times per day (8 AM, 12 PM, and 6 PM).
Resident received the 8 AM dosage at 10:10 AM, 2 hours after the prescribed time.

2. On at 12:10 PM, Staff A provided the second dose of , , 100 mg to Resident #2.
There was only 2 hours between the 1st dose and the 2nd dose of , .

On at 12:05 PM, Staff A acknowledged the 1st dose of , was to be given at 8 AM.
Resident was given the medication at this time because that is when he got up for breakfast.

Review of the MOR shows no documentation that the medication was given 2 hours past prescribed time.

Class III

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

Based on employee record review and staff interview, the facility failed to ensure 2 of 2 staff submitted evidence of a negative ( ) examination on an annual basis (Staff A and Staff B).

The findings included:

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Staff A was hired on . A review of Staff A's employment record contained no negative documentation for 2016 or 2017. The last evidence obtained of a negative examination was dated .

Staff B was hired on . There was no documentation that this staff was free from any signs or symptoms of communicable including at the time of hire, and there was no evidence a negative examination conducted anytime in 2017.

The administrator could not produce any documentation showing negative status for Staff A and Staff B at the time of the survey. She stated on at 2:30 PM that Staff A and B had appointments set for the examinations to be conducted.

Class III

0082 - Training - / - 58A-5.0191(3) FAC

Based on employee record review and staff interview, the facility failed to ensure 1 of 2 staff completed a one-time education course on / (/) within 30 days of employment. (Staff A).

The findings included:

On , the employee record for Staff A, whose hire date is , did not contain a training certificate showing completion of state required education course on / within 30 days of hire. The Administrator was asked for evidence Staff A had completed the / training.

On at 2:45 PM, the administrator stated she could not find any documentation showing Staff A had completed the / education course.

Class

0167 - Resident Contracts - 58A-5.025 FAC

Based on record review and staff interview, the facility failure to have a signed and dated contract between the resident or resident's legal representative and the facility before or at the time of admission for 1 of 2 residents (#2).

The findings included:

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During contract review on for Resident #2, who was admitted to the facility on , it was observed that the contract did not contain date and signatures of the facility's administrator or Resident #2's legal representative on page 8 of the contract.

During interview with the Administrator on at 2:40 PM, she acknowledged the absence of required signatures and dates on the last page of the facility contract with the resident and their legal representative.

Class