STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966804	R 02/02/2018
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 three (Staff A, B, and D) of five employee records reviewed.

Findings included:

A review of employee records conducted on showed that Staff A was hired on , Staff B was hired on , and Staff D was hired on .

A review of the facility's Employee Roster conducted on showed that Staff A, B, and D were not entered.

The Administrator was interviewed at 2:33pm on concerning the lack of entries for staff in the Employee Roster. The Administrator reviewed the Employee Roster and acknowledged that the three employees were not entered.

Unclassified

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0000 - Initial Comments

Assisted Living Facility

A revisit to an complaint survey, (CCR# 2017010789), was conducted at Ledge Manor on in conjunction with complaint investigations, (CCR# 2017013954 & CCR# 20170142412), and biennial re-licensure. Ledge Manor had deficiencies at the time of the visit.

(License # 11289)

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 two (Resident #18 and #20) of four residents sampled.

Findings included:

A review of Resident #18's record was conducted on . The resident's record showed a history of 2 dated and . There was no documentation in the record that Resident #18's health care provider was notified of the .

The review of Resident #18's record showed an AHCA 1823 Form 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 Resident #20's record was conducted on . The resident's record showed a history of 17 from through . There was one incidence, dated , in which Resident #20's health care provider was notified of the .

The review of Resident #20's record showed an AHCA 1823 Form that indicated 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 .

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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. Further review of procedures show that a charge nurse, after each and any incident involving a resident being lowered to the floor, is to complete a " risk evaluation packet" and include it with accident/incident report.

The Administrator was interviewed at 1:55pm on concerning the lack of documentation of notifying Resident #18's and Resident #20's health care provider and inconsistent notification of the resident's responsible party. The Administrator acknowledged the lack of required notifications. The Administrator stated she was unaware of the " Risk Evaluation Packet".

Class III

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

Based on observation, interview, and record review, the facility failed to ensure that trained staff read the medication label in the presence of the resident and failed to ensure staff observed residents taking their medication for one (Resident #10) of four residents sampled for assistance with self-administration of medication.

Findings included:

During an interview with resident #10 on at 9:45am Staff "A" gave Resident #10 a soufflé cup that contained several pills. Staff "A" did not tell the resident what she was taking or observe the resident take the medication; she just told Resident #10 "this is your medication" and walked away.

A review of the medication observation record with Staff "A" revealed Resident #10 was given her 8:00am medication after 9:45am. Staff "A" stated that Resident #10 came late for breakfast and that was why she did not receive her medication on time. Staff "A" stated she is not allowed to give medication in the dining she waited until the resident was finished and leaving. Staff "A" stated she could see the resident and watched resident #10 take her pills from the medication cart.

Resident #10 received and 50 mcq tablet. A review of Resident #10"s orders revealed that the order stated to give one tablet every morning on an empty stomach. Residnet #10 was given medication after breakfast on a full stomach.

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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 two of nine residents sampled (Resident #6 and #17).

Findings included:

A review of MORs on revealed omission of med tech initials for 8:00 AM medication pass for Residents #6 and #17 for the date of .

During an interview with Staff A on at 8:10am concerning documentation on MORs, they stated that the staff passing medications on simply missed those residents and all other residens were initialed.

During an interview with the Administrator on at 9:10am, regarding lack of documentation on the MORs, they stated that the staff was supposed to document in the MORs prior to handing medications to residents. The Administrator reported there was no longer a Director of Nursing to conduct weekly and monthly MORs reviews.

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 two (Resident #4 and Resident #20) of five residents' .

Findings included:

During a tour of the facility beginning at 7:27 AM on , (in the facility's memory care unit) was observed. As a test, the call bell cord located near Resident #4's bed was pulled and it did not appear to be working. Staff E was interviewed at 7:47 AM on concerning whether they were notified of the need for assistance in . Staff E stated that there was no signal to them from the call bell and there was no read out on an electronic board located near the dining area. Staff E was also

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alerted to a can of aerosol sitting on a table by the door (photographic evidence obtained). Staff E stated that staff must have left it there. At this point Staff J, a member of the housekeeping staff, was called in to the discuss the safety hazard of the aerosol . Staff J observed the can of aerosol sitting on the table near the door and acknowledged that it shouldn't be there.

The Maintenance Director was interviewed at 7:51 AM on concerning the pull cord in . The Maintenance Director observed the pull cord, acknowledged that it wasn't working.

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 discharges.

Findings included:

A review of the facility's admission and discharge log conducted on revealed that two of the entries, Resident #12 and Resident #23, had "expired". Admission and discharge log did not show dates in discharge category for these residents.

The Administrator was interviewed at 11:46am on concerning the lack of discharge dates documented on the admission and discharge log. The Administrator reviewed the admission and discharge log and acknowledged the omission of discharge dates.

Class III