STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968651	R 02/22/2018
NAME OF PROVIDER OR SUPPLIER **CRANES VIEW LODGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1601 HOOKS ST** **CLERMONT, FL 34711**	

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

0000 - Initial Comments

On . . . . . an unannounced follow-up to Limited Nursing Services and Extended Congregate Care monitoring survey was conducted at Cranes View Lodge, license #12546. The facility was not in compliance at the time of the survey.

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

Based on observation, interview and policy and procedure review, the facility failed to ensure that unlicensed staff (Staff A) assisting with medication self-administration took medication in its original packing to the resident and read the medication label aloud for 1 of 2 medication observations.

Findings

On . . . . . at 8:53 AM, an observation was made of Staff A, an unlicensed Medication Technician (MT) assisting resident #1 with medication self-administration. The MT removed the residents medications from the medication cart, compared them to the Medication Observation Record (MOR), and found that the and in the medication packet were no longer on the MOR. The MT then removed the . . . . from the medication packet and placed it into a plastic medication cup. The MT removed a card containing , from the medication cart and placed the medication into the plastic medication cup. The MT prepared . . . by measuring out the . . . powder and mixing it with water. The MT took the medications into the residents . The MT handed the resident the plastic medication cup and told the resident, "Here is your . , . and your . . . ." The MT handed the resident the cup of water mixed with to swallow the pills with. The Med Tech failed to bring the medication in its original packaging into the residents . . . . . failed to read the medication label to the resident. The Med Tech failed to tell the resident that her water was mixed with . . . .

On . . . . . at 9:00 AM, an interview was condcuted with Staff A, a Medication Technician (MT). The MT confirmed that she had not brought the medication in its original packaging into the residents , and had not read the medication label aloud to the resident. The MT also confirmed that she had not told the resident that her water was mixed with , a medication.

A review was conducted of the facility Policy and Procedure titled, "Medication Management: Assistance with Self-Administration or Supervision of Medication by Unlicensed Personnel," effective date , 2016. The policy states, "Unlicensed assistance with self-administration includes the following tasks: Taking the medication (in its previously dispensed, properly labeled container) from

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where it is stored in preparation to assist with self-administration; In the presence of the resident, reading the label. telling the resident why the medication is prescribed (i.e. pill, , pill, etc.), opening the container, removing the prescribed amount (without touching the medication) and closing the container."

Class III