STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964374	C 03/03/2018
NAME OF PROVIDER OR SUPPLIER **HAMPTON ALF AT 24TH ROAD LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1500 S.E. 24TH ROAD** **OCALA, FL 34471**	

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

0000 - Initial Comments

An unannounced OFF HOURS complaint survey (CCR 2018002548) was conducted on , 2018 at Hampton Manor at 24th Road Assisted Living Facility (License #8927) in Ocala, FL. Hampton Manor at 24th Road Assisted Living Facility had deficiencies at the time of the survey.

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

Based on interview and record review, the facility failed to obtain a complete and accurate Resident Health Assessment for Assisted Living Facilities, AHCA Recommended Form 1823 for 2 (Resident #2 & 11) of 7 Resident Assessments reviewed.

Findings:
1. A review of the Resident Health Assessment for Assisted Living Facilities, AHCA Recommended Form 1823 for Resident #2 revealed on page 1 under 'Nursing / treatment / , , service requirements' it reads 'Medication Administration.' On page 4, Section 2 - B, item B reads 'Does the individual need help with taking his or her medications?' This section was blank.

On page 2, Section 1, Activities of Daily Living, Item A does not explain the extent of supervision for bathing, , and toileting.

On page 4, the Medical Certification Section is incomplete, missing the address of the examiner and the telephone number.

An interview was conducted with the Community Director on at 12:55 PM. She confirmed the information on the Resident Assessment on Page 1, 2 and 4 was not accurate or incomplete.

2. On at 8:50 AM the Staff A, a Medication Technician (MT) was observed to take all of the packs of medications out of the locked medication cart and popped out medication from each pack into a medication cup. The MT sat the medications in front of the resident. The resident took the medication cup and swallowed the medication with water.

A review of the Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823 for Resident #11 revealed on page 4,Section 2 - B, item B reads 'Does the individual need help with taking his or her medications?' This section reads: 'needs medication administration.'

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An interview was conducted with the Community Manager on at 9:10 AM. She confirmed Resident #11 needs assistance with self-administration, not medication administration. She confirmed the Resident Health Assessment, Form 1823 is inaccurate.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the facility failed to obtain a new Resident Health Assessment following a significant change for 2 (Resident #2 and #8) of 7 resident assessment reviewed.

Findings:

1. A review of the physicians order for Resident #2 dated reads: Hospice to evaluate and treat. A review of the Hospice Interdisciplinary Care Plan showed a start date (admission) of .

A review of the Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823 for Resident #2 dated revealed no documentation of the resident receiving hospice services.

An interview conducted with the Community Director on at 12:55 PM confirmed the Resident Health Assessment did not document Resident #2 receiving Hospice services.

2. A review of the physician's order for Resident #8 dated reads: Hospice to evaluate and treat. A review of the Hospice Interdisciplinary Care Plan showed a start date (admission) of .

A review of the Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823 for Resident #2 dated revealed no documentation of the resident receiving hospice services.

An interview conducted with the Community Director on at 4:10 PM confirmed the Resident Health Assessment did not document Resident #2 receiving Hospice services.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, interview and record review, the facility failed follow control standards to maintain a safe environment and prevent the spread of .

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Findings:

On starting at 8:07 AM, observation of medication review was conducted with Staff A, a Medication Technician (MT). Staff A was observed to prepare medications for Resident #4, take them to the resident, administer the medications and then return to her medication cart. Staff A was then observed to prepare medications for Resident #9, attempt to administer medication, medications were refused by resident and Staff A returned to her medication cart. Staff A was not observed to wash or sanitize her hands between residents. Staff A was then observed to put on gloves and put on a , medication on Resident #9. Staff A did not wash or sanitize her hands before glove use. Staff A was observed to prepare medications for Resident #10 and prepare medications for Resident # 11. Staff A was not observed to hand wash or sanitize between residents.

On at 8:50 AM, an interview was conducted with Staff A. She confirmed she did not wash or sanitize her hands between resident contacts. She also confirmed she did not wash or sanitize her hands before glove use.

A review of the policy entitled " Control Standards and Precautions for Assisted Living Facilities" reads: When to wash hands: before and after wearing gloves, before and after each patient contact.

Class III

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

Based on observation, interview and record review, the facility failed to provide assistance with self-administration of medications for 3 (Resident #4, #10 and # 11) of 4 residents during the medication review.

Findings:

1. A review of the Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823 for Resident #4 dated reads on page 4, Section 2-B.B, the resident needs assistance with self-administration of medications.

On at 8:16 AM, Staff A, a Resident Care Aide (RCA)/Medication Technician (MT) was observed to take all of the packs of medications from the locked medication cart, popped out each pill from each pack, crushed each pill using a pill crusher and placing them in individual medication cups. The MT was then observed to put applesauce in each medication cup. The MT took all the medication cups

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to Resident #4 at the dining and stated to the resident "here is your medicine." The MT was observed to take a spoon and spoon medication and applesauce into the resident's mouth. The MT stated to this writer, "this is how I usually do it."

On at 9:00 AM, an interview was conducted with the Community Director. She confirmed the MT should not have spooned the medications into the resident's mouth as that was medication administration, not assisting with self-administration. She further confirmed the MT should have showed the medications to the residents and read the labels to the resident when assisting with self-administration of medications.

2. On at 8:45 AM, the MT was observed to take all of the packs of medications out of the locked medication cart and popped out medications from each pack into a medication cup. The MT sat the medications in front of Resident #10. The resident took the medication cup and swallowed the medication with water.

A review of the Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823 for Resident #10 dated reads on page 4, Section 2-B.B, the resident needs assistance with self-administration of medications.

An interview was conducted with the MT on at 8:55 AM. She confirmed she did not show the medications to the residents and she did not read the label of the medications to the residents.

3. On at 8:50 AM the MT was observed to take all of the packs of medications out of the locked medication cart and popped out medication from each pack into a medication cup. The MT sat the medications in front of the Resident #11. The resident took the medication cup and swallowed the medication with water.

A review of the Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823 for Resident #11 dated reads on page 4, Section 2-B.B, the resident needs medication administration.

An interview was conducted with the MT on at 8:55 AM. She confirmed she did no show the medications to the residents and she did not read the label of the medications to the residents. She also confirmed she was not a nurse.

An interview was conducted with the Community Manager on at 9:10 AM. She confirmed Resident #11 needs assistance with self-administration, not medication administration. She confirmed

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the Form 1823 is inaccurate.

A review of the policy entitled Medication Standards, Staff Providing Assistance of Medications reads under procedure:
A trained designated staff person will assist the resident to self-administer medications in the following manner:
a. Medication shall be taken from where it is stored and brought to the resident.
b. In the presence of the resident, read the label, open the container, remove a prescribed amount of medication from the container and close the container.
c. Place oral dosage in the resident's hand or place the dosage in another container and help the resident by lifting the container to his or her mouth.
e. Returning the medication container to proper storage.

Class III

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

Based on observation, interview and record review, the facility failed to follow written physician's order for treatments and failed to obtain written physician's orders for a change in directions for use (crushed) for medications for 2 (Resident #3 and #4) of 5 residents reviewed for medications.

Findings:

1. A review of the Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823 for Resident #4 dated reads on page 4, Section 2-B.B, the resident needs assistance with self-administration of medications.

On at 8:16 AM, Staff A, a Resident Care Aide (RCA)/Medication Technician (MT) was observed to take all of the packs of medications from the locked medication cart, popped out each pill from each pack, crushed each pill using a pill crusher and placing them in individual medication cups. The MT was then observed to put applesauce in each medication cup. The MT took all the medication cups to Resident #4 at the dining and stated to the resident "here is your medicine." The MT was observed to take a spoon and spoon medication and applesauce into the resident's mouth.

A review of the clinical record for Resident #4 showed no physician order to crush medications.

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On at 4:30 PM, an interview was conducted with the Community Director. She confirmed there was no physician's order to crush medications for Resident #4.

2. On at 11:00 AM, an interview was conducted with the daughter of Resident #3. She stated Resident #3 had not received her treatment today.

A review of the Physician's Order dated for Resident #3 showed , , / via neb ( ) twice per day for .

A review of the Medication Observation Record for 2018 for Resident #3 showed the treatment was not given in the morning on , not given at all on and not given in the morning of .

On at 12:09 PM, an interview was conducted with the Community Manager. She confirmed the treatments had not been given the mornings of and . She further confirmed the treatments had not been given on .

Class III