STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966202	**03/07/2018**
NAME OF PROVIDER OR SUPPLIER **MARI-MAR MANOR 2**	STREET ADDRESS, CITY, STATE, ZIP CODE **493 8th AVENUE NORTH SAINT PETERSBURG, FL 33709**	

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

0000 - Initial Comments

Assisted Living Facility

A biennial survey was conducted on , in conjunction with a revisit to a complaint (CCR#2017013097 & CCR#2017014427), and third revisit to a complaint (CCR#2017005457), at Mari-Mar Manor 2 (License #10437), an Assisted Living Facility located in Saint Petersburg, Florida. There were deficiencies identified during the survey.

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

Based on observation, interview and record review, the facility failed to review the Medication Observation Record (MOR), and provide medication dosage within one-hour of the prescribed time for two residents(#2 and #9); and failed to wash or sanitize hands while assisting with medication for one (Residents #8 and #9) of three residents observed for assistance with medication administration or self-administration.

Findings included:

During observation of assistance with medication self-administration on at 09:25 a.m., the Administrator was observed providing medication scheduled for 08:00 a.m. for Resident #2.

During observation of assistance with medication self-administration on at 10:00 a.m., the Administrator was observed providing medication to Resident #9 without washing or sanitizing her hands or reviewing or documenting in the MOR for medications provided to Resident #9. The Administrator provided Resident #9 with two medication dosages (and) that were scheduled for bedtime medication.
On , at 10:21a.m., the Administrator was observed providing medication to Resident #8 without washing or sanitizing her hands prior to handling the medication.
Record review for Resident #2 and Resident #9 revealed that medication dosages were scheduled for 08:00 a.m. Further review of the MOR for Resident #9 revealed that two medications (and) provided to Resident #9 at 10:00 a.m. were scheduled for bedtime.

On at 11:24 a.m., the Administrator confirmed that Resident #2 received his medication at 09:25 a.m., and Resident #9 received medication at 10:00 a.m., and confirmed it was more than one hour after it was scheduled. Administrator confirmed that she did not make any attempt to contact residents primary care provider about changing the medication times for Resident #2 and Resident #9.

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Administrator was informed and confirmed, after she reviewed the Medication labels and the MOR for Resident #9, that she provided Resident #9 with two medications (. . . , ... and . . . , . . .) that were scheduled for bedtime.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to ensure that the cart used for centrally stored medications were locked for six (Resident #2, #3, #5, #8 and #9) of six residents who received supervision or assistance with self-administration of medication.

Findings included:

On at 01:29 p.m., the facility's medication cart located in common area, next to dining table, was observed unlocked. Further review revealed that the medication cabinet contained medication belonging to current residents Resident #2, Resident #3, Resident #5, Resident #8, and Resident #9. During follow-up interview, the Administrator was informed of the unlocked medication cart, she confirmed that the cart was unlocked, and locked the medication cart.
On . . . . . at 02:30 p.m., Administrator left the medication unlock as she attended to matters with staff D in her office.
On . . . . . at 02:40 p.m., Administrator informed that medication cart was left unlocked and unattended. Administrator confirmed that she left the cart unlocked again and locked it.

On at 03:30p.m., the medication cart was observed unlocked with no staff present and residents moving freely around the area.
On at 03:48 p.m., the Administrator was informed that medication cart was left unlocked. She confirmed that she did it again and locked medication cart.

Class III

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

Based on record review and interview, the facility failed to provide evidence of a negative . . . . . examination ( ) documented on an annual basis for two (Administrator and staff B) of three employees selected for record review.

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Findings included:

A review of employee records conducted on . . . . . revealed no evidence of a negative examination for the Administrator and Staff B.

During an interview with Administrator conducted on . . . . . at 5:00 pm, the administrator confirmed that the facility did not maintain a personnel record for staff B, including evidence of freedom from .

During an interview with Administrator conducted on at 5:00 pm, the administrator acknowledge and confirmed that she does not have evidence of a negative . . . . . examination in her records.

Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on observation, interview and record review, the facility failed to ensure that one employee (Staff D), who lived and worked alone in the facility, completed First Aid and , , ( ) training.

Findings included:

During interview with Staff D on . . . . . at 10:33 a.m., he confirmed that his official date of hire was on . . . . . , and that he worked and lives at the Facility with a daily 3-hour relief by the Administrator for a total of 21-hour working day.

Record review revealed no documentation the served as proof of completion for First Aid or for Staff D at the facility.

During interview with the Administrator, on at 05:24 a.m., she confirmed that there was no documentation or proof of completion for or First Aid training for Staff D. The Administrator confirmed that Staff D assist residents with activities of daily living, and worked 21 hours a day, which included shifts by himself.

Class III

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0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on interview and record review, the facility failed to furnish proof of required training for one (Staff D) of one unlicensed staff who provided assistance with self-administered medications for the Month of for five (#2, #3, #4, #5, #8 and #9) of seven residents who resided at the facility.

Findings included:

Record review on revealed that Staff D documented on the Medication Observation Record (MOR) for Resident #2, Resident #3, Resident #4, Resident #5, Resident #8 and Resident #9 for the month of of 2018.

Record review revealed no evidence that Staff D completed the required training related to assisting with medication self-administration.

During interview with the Administrator, on at 05:24 a.m., she confirmed that there was no documentation or proof of completion for training related to assisting with medication self-administration for Staff D. The Administrator confirmed that Staff D assist residents with medication self-administration.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on interview and record review, the administrator of a facility failed to maintain personnel records for one employee (Staff B), who cooked for seven (#1, #2, #3, #5, #7, #8 and #9) of seven Residents, which contain at a minimum a copy of the employment application, with references furnished, documentation verifying freedom from signs or symptoms of a communicable and documentation of compliance with staff training.

Finding included:

During interview with Staff D on at 10:33 a.m., he confirmed that he worked the facility as a caregiver. Staff D also stated that Staff B cooks for the residents.
During interview with Resident #9 at 10:45 a.m., the resident identified Staff B as an employee who cooks for the residents.
During interview with Resident #1 at 11:06 a.m., the resident identified Staff B as an employee who

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assist him with his shoes and socks, and cooks for the residents.
During interview with Resident #8 at 11:20 a.m., the resident identified Staff B as an employee who cooks for the residents.
During interview with Resident #5 at 11:42 a.m., the resident identified Staff B as an employee who cooks for the residents.
Record review revealed no documentation for Staff B at the facility.

During interview with the Administrator, on [redacted] at 04:22 p.m, the Administrator confirmed that Staff B cooks for residents. The Administrator confirmed there were no records for Staff B at the facility.

Class III