STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932571	R 04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEEL AT HOME, INC.	**129 WEST 131ST AVENUE** **TAMPA, FL 33612**

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

0000 - Initial Comments

Assisted Living Facility

A Revisit to 02/26/2018 Complaint Survey (CCR#: 2018001370 and 2018000665) in conjunction with a second Revisit to 01/04/2018 Complaint Survey (CCR#: 2018000013) conducted at Feel at Home Assisted Living Facility on 04/18/2018. Feel at Home Assisted Living Facility revealed deficient practice and uncorrected deficiencies at the time of survey.

(License#: 4653)

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

Based on observation, record review, and interview, the facility failed to provide assistance with self-administration of medication appropriately for one Resident (#1) of three sampled residents.

Findings Included:

During a medication review conducted on Wednesday, at 07:50am, before the surveyor had a chance to observe her, the Administrator removed the pill pack from the medication cart and proceeded to Resident #1 (identifying him as Resident #1), and gave the resident his pill. The Administrator was not observed to have compared the pill pack label with the medication observation record before taking the pill pack to Resident #1. Upon the Administrators return to the medication cart after giving Resident #1 his morning medication, she attempted to place the pill pack in the medication cart and the surveyor stopped her. Upon inspection of the pill pack by the surveyor it was discovered that the label on the pill pack revealed a medication belonging to another resident (Resident #3).

The Wednesday morning medications were missing from Resident #3's pill pack. An inspection of Resident #1's medications revealed that all Wednesday morning medications were still sealed within the pill pack.

The Administrator began to retrieve the next resident's medications from the medication cart drawer. The surveyor stopped the Administrator from continuing the medication pass and was directed to notify Resident #1's Primary Care Physician regarding the medication error that had just occurred. The Assistant Administrator took over responsibility for the medication pass.

Resident #1's Physician was contacted and indicated that the resident should be fine but to monitor him

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for 24 hours for any change in condition. The resident refused to go to the hospital.

During an interview with the Administrator conducted on Wednesday, at 12:55pm, she acknowledged and confirmed that based on this error and continued uncorrected medication deficiencies, that she needed assistance to oversee assistance with self administration of medications.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the facility failed to maintain daily medication observation records (MORs) with residents' known for three Residents (#2, #3, and #4) of three sampled residents with known .

Findings Included:

A MOR review for Resident #2 conducted on , revealed that the MOR did not list any . Resident #2's most current Agency for Healthcare Administration Form 1823 lists as an for Resident #2.

A MOR review for Resident #3 conducted on , revealed that the MOR did not list any . Resident #3's most current Agency for Healthcare Administration Form 1823 lists as an for Resident #3.

A MOR review for Resident #4 conducted on , revealed that the MOR did not list any . Resident #4's most current Agency for Healthcare Administration Form 1823 lists as an for Resident #4.

During an interview with the Administrator conducted on at 11:25am, the Administrator acknowledged and confirmed that the MORS for Residents #2, #3, and #4 did not list their known . The Administrator stated, "we will get that fixed."
Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on observation, record review, and interview, the facility failed to correct previously cited Class III medication deficiencies as required.

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Findings Included:

During the revisit survey the facility failed to correct two of three Class III medication deficiencies (A0052, A0054) cited on a complaint survey.

During an exit conference held with the Administrator on at 12:55pm, the Administrator acknowledged and confirmed the need for employing the services of consultant services of a licensed Pharmacist or licensed Registered Nurse.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observation, record review, and interview, the facility administrator failed to supervise the operation and maintenance of facility medications appropriately for four Residents (#1, #2, #3, and #4) of four sampled residents. This is an uncorrected deficiency

Findings Included:

Observation of medication pass at the facility conducted on beginning at 7:50 AM revealed that the facility does not compare medication labels with the Medication Observation Record (MORs) ensuring the delivery of the correct medication to the correct resident.

The facility does not maintain up-to-date resident's MORs that include information

During a medication review conducted on at 07:50 am, the Administrator did not compare Resident #1 medication pill pack with the medication observation record, which resulted in Resident #1 receiving the wrong medication. The Administrator needed prompting in order to notify Resident #1 Primary Care Physician.

During a medication observation record review conducted on , Residents #2, #3, and #4's were not listed.

In review of the Class III deficiencies cited during a Complaint Investigation conducted on 2 of the 3 Class III medication deficiencies were not corrected.

During an interview with the Administrator conducted on at 11:25am, the Administrator

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acknowledged giving the wrong medication to Resident #1 and confirmed that the MORS for Residents #2, #3, and #4 did not list their known [illegible]. The Administrator acknowledged and confirmed the need for employing the services of consultant services of a licensed Pharmacist or licensed Registered Nurse to oversee medications.

Class III