STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967925	**04/10/2018**
NAME OF PROVIDER OR SUPPLIER **ATRIA LADY LAKE**	STREET ADDRESS, CITY, STATE, ZIP CODE **930 HIGHWAY 466** **LADY LAKE, FL 32159**	

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

0000 - Initial Comments

A two day unannounced biennial licensure survey with Extended Congregate Care was conducted , 9-10, 2018 at Atria Senior Living (License #11908), Lady Lake, FL. Deficient practice was identified at the time of the survey.

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

0052

Based on observation, interview and record review, the facility failed to observe the resident take medications for 1 of 10 residents observed during interviews. (#4).

Findings:

During an interview/observation with Resident #4 on at 1:35PM, an observation revealed 2 clear medication cups on resident's chairside table: one contained 3 medications and the other cup had one large tablet split in half. Resident #4 confirmed the medications sitting in the cups on the chairside table were left this morning by Staff E, Resident Medication Technician. The Medication Technician responded after the call pendant was activated by Resident #4. (See photographic evidence).

During an interview on at 2:00 PM with Staff E, Medication Technician, Staff E confirmed she had left the medication cups with medication in them on the resident's chairside table this morning. Staff E confirmed medication is not supposed to be left at bedside and she should have observed the resident swallow the medications. The Resident services director was immediately notified of the incident.

During an interview on at 2:30 PM with Staff D, RN (Registered Nurse and Resident Services Director), she confirmed that the facility policy states the Medication Technician is to observe that the resident has swallowed their medication.

Record Review of Policy and Procedure titled Atria Department: Care & Enhanced Care. Policy No: MED-001. Subject: Assistance with Self-Administration of Medications. Procedures: Residents will be offered assistance with self-administration in the following manner: (bullet #9) Observe that the resident has swallowed their medications.

Class III

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

E210 - ECC - Training - 58A-5.0191(7) FAC

Based on record review and interview, the facility failed to ensure 1 of 4 (Staff A, Staff B, Staff C, & Staff D) sampled direct care staff, providing care to residents in an Extended Congregate Care (ECC) program, received at least 2 hours of in-service training (Staff D).

Findings:

The review of the Facility's ECC Policies and Procedures Manual identified Staff D, as the ECC Registered Nurse (RN). The review further revealed Staff D's hire date as . . . . . with no supporting documentation that Staff D received ECC training.

A Record Review of ECC policy states all direct care staff providing care to residents in an Extended Congregate Care Program must complete at least 2 hours of in-service training provided by the facility administrator or ECC supervisor, within 6 months of employment with the facility.

On . . at 11:00 AM an interview with Staff D, (RN, Resident Services Director). Staff D confirmed that she is currently the ECC Nurse, and confirmed there is no documentation to support she received the required ECC training.

Class III

On . at 10:34 AM an interview was conducted with Staff F, (Interim Administrator). Staff F confirmed there is no documentation to indicate Staff D (ECC RN/Resident Services Director) recieved ECC training.

Class III