STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966240	R 06/18/2018
NAME OF PROVIDER OR SUPPLIER **ABIGAIL (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **320 SOUTH DELAWARE** **TAMPA, FL 33606**	

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

0000 - Initial Comments

Assisted Living Facility

An revisit to a Change of Ownership survey was conducted on . . . . . at The Abigail (License #10498), an assisted living facility in Tampa, Florida. There were deficiencies identified at the time of visit.

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

Based on record review and interview, the facility failed to ensure that two (#7 and #8) of four sampled residents medical examination by a health care provider accurately reflected the level of assistance needed for medication.

Findings included:

Review of Resident #7's health assessment (AHCA Recommended Form 1823), dated . . . . . indicated that Resident #7 needed assistance with self-administration of medication.

Review of Resident #8's health assessment (AHCA Recommended Form 1823), dated indicated that Resident #8 needed assistance with self-administration of medication.

During observation of assistance with self-administration of medication, on at 12:57 p.m., Resident #7 was not able to self-administer medication with assistance. Staff A had to administer an oral dosage for Resident #7. During interview, Staff A confirmed that unlicensed staff also administer medications for Resident #8.

Interview with Hospice Nurse, on . . . . . , at 03:03 p.m., revealed that Resident #7 and Resident #8 required medication administration.

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 maintain or produce documentation of medical examinations by a healthcare provider after the resident experienced a significant change, and failed to

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ensure interdisciplinary care plans were developed for three (#7, #8 and #13) of three residents admitted to hospice.

Findings included:

Record review revealed that Resident #7 and Resident #8 were admitted to hospice on . . . . . .
Both Resident #7 and Resident #8's most recent documentation of medical examinations (AHCA Form 1823) were dated . . . . . and reflected that both residents require assistance with self-administration of medications.

Record review revealed that Resident #13 was admitted to hospice on .

Record review conducted on revealed no evidence of interdisciplinary care plans for Resident #7, Resident #8 or Resident #13.

During interview with Assistant Administrator and Staff A, who operated as Facility Manager, on at 04:15 p.m., they confirmed the facility did not have a documentation of medical examinations on AHCA Form 1823s post hospice admittance, and confirmed that hospice residents did not have interdisciplinary care plans.

During interview with the Hospice Clinical Manager, on at 04:17 p.m., she confirmed that the facility was not provided with an interdisciplinary care plan.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview, and record review, the facility failed to ensure only licensed nurses administered medications to residents; specifically, an unlicensed staff (Staff A) administered oral medication for one (#7) of three observed resident, and one (#8) identified resident who needs medication administration.

Findings included:

During an observation of assistance with self-administration of medication with Staff A, on . . . . . at 12:57 p.m., Staff A administered medication dosage with apple sauce by spoon feeding Resident #7 the medication dosage, with no assistance provided by Resident #7. Staff A confirmed that she was not

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licensed to administer medication, and that Resident #7 was not able to self-administer medication or use a spoon to feed self. Staff A, who also served as Facility Manager, confirmed that the hospice does some medication, and unlicensed staff administer medications to Resident #7 and Resident #8.

Review of the 2018 Medication Observation Record revealed that Staff A documented medications given to Resident #7 and Resident #8 who requires medication administration.

Interview with Hospice Nurse, on , at 03:03 p.m., revealed that Resident #7 and Resident #8 required medication administration. Hospice Nurse also confirmed that hospice nurses visit Residents #7 and #8 once a week and only administer the medications related to hospice.

Class III

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

Based on observation, interview, and record review, the facility had ongoing deficient practice related to the assistance with self-administration of medications.

Findings included:

During a survey conducted on the facility was cited with one Class III deficiency for Medication - Administration. During a revisit, conducted on , the facility was cited for Medication - Administration at an uncorrected Class III.

During an observation of assistance with self-administration of medication with Staff A, on at 12:57 p.m., Staff A administered medication dosage with apple sauce by spoon feeding Resident #7 the medication dosage, with no assistance provided by the Resident #7. Staff A confirmed that she was not licensed to administer medication, and that Resident #7 was not able to self-administer medication or use a spoon to feed self. Staff A, who also served as Facility Manager, confirmed that the hospice does some medication, and unlicensed staff administer medications to Resident #7 and Resident #8.

Based on uncorrected class III deficiencies concerning unlicensed staff administering oral dosages to residents, the facility shall be required to employ the consultation services of a licensed pharmacist or a registered nurse.

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The consultant shall at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required.

This serves as a written notification of the requirement for the above described consultation services.

Class III

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

Based on observation, interview, and record review, the facility failed ensure that oversight was provided by a manager with the same qualifications as an administrator, to include Core training, for the Administrator and Assistant Administrator, who supervised a total of three licensed facilities.

Findings included:

Offsite preparation, on , revealed that the Administrator and the Assistant Administrator were listed as operators of three total licensed facilities.

During interview with the Assistant Administrator, on at 02:12 p.m., she confirmed that she has not completed the required CORE exam, and confirmed that she was the Assistant Administrator for the Facility since 2015.

During interview with the Assistant Administrator, on at 02:20 p.m., she confirmed that the Administrator and Assistant Administrator continued to operate three licensed facility with no designated manager for each of the facilities. The Assistant Administrator confirmed that Staff A continued her role as the Facility's Manager, and confirmed that Staff A did not complete the Core training or exam.

Record review revealed documentation dated , that identified Staff A as Manger in absence of Administrator and Assistant Administrator. Record review for revealed no evidence that Staff A completed the Core training.

Class III

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

Based on record review and interview, the facility failed to ensure that all employees had evidence of a negative examination completed annually for one (Staff A,) of four employees selected for

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record review.

Findings included:

Record review revealed that the last documented ( ) examination for Staff A was .

During interview with the Assistant Administrator, on at 02:35 p.m., she stated that results dated did not expire until . Assistant administrator stated that Staff A visited her provided for / injection, but did not go back for result reading. She confirmed that there was no documentation of that visit.

Record review revealed that the expiration date was for the master batch lot expiration date, and not the timeframe which a reading was good for.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on record review and interview, the facility failed to maintain a written work schedule that accurately reflected the direct care staffing pattern.

Findings included:

Review of direct care staffing schedule revealed that the night shift was not included on the schedule for the shift. Facility did not have staffing schedule from previous weeks.

During interview with Staff A, who operates as Facility Manager, on at 11:14 a.m., Staff A stated the schedule is the same each week, so they don't have copies of previous weeks. Staff A confirmed that Staff C's last day worked was , and confirmed that the facility did not have a schedule that reflected the night shift or, dayshift worked by Staff C.

Class III