STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910002	**07/16/2018**
NAME OF PROVIDER OR SUPPLIER **AGUILA ADULT CARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **503 N. MATANZAS** **TAMPA, FL 33609**	

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

0000 - Initial Comments

Assisted Living Facility

An abbreviated biennial licensure survey was conducted on . . . . . at Aguila Adult Care Center (License #7228), an assisted living facility in Tampa, Florida. There were deficiencies identified at the time of visit.

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

Based on observation, interview, and record review, the facility failed to review and follow-up with providers to ensure that the resident health assessments were completed accurately for continued residency determination for three (#5, #6, and #7) of three residents who required medication administration.

Findings included:

Review of Resident #5's health assessment (AHCA Form 1823), dated , revealed that the assessment indicated that Resident #5 needed assistance with medication self-administration.

Review of Resident #6's health assessment (AHCA Form 1823), dated . . . . . revealed that Resident #6 needed assistance with medication self-administration

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

During interview with the responsible party for Resident #5, on . . . . . , at 11:46 a.m., the family member indicated that the facility staff administer medications for Resident #5. She is not capable of self administration with assistance.

During observation of assistance with medication administration with the Administrator on . . . . . at 2:15 p.m., the Administrator had to administer medications with no effort of self administration on the part of Resident #5 due to her lack of awareness

During interview with the responsible party for Resident #6, on . . . . . , the family indicated that Resident #6 needed medication administration.

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SUMMARY STATEMENT OF DEFICIENCIES
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Observation of Resident #7, on revealed that Resident #7 remained seated in a wheelchair with rolled washcloths in both hands. An attempted verbal interaction revealed that the resident was not aware enough to be interviewed, or to voluntarily move her arms and hands.

During an interview with the Administrator on at 2:17 p.m., the Administrator confirmed that Resident #5, Resident #6 and Resident #7 needed medication administration, and confirmed that the health assessments for Resident #5, #6 and #7 did not reflect that the residents required medication administration.

Class III

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

Based on observation, interview, and record review, the facility failed to ensure that licensed staff administered medications to 3 of 5 residents observed and/or reviewed for assistance with medication self-administration, (Resident #'s 5, 6 and 7)

Findings included:

During interview with the responsible party for Resident #5, on , at 11:46 a.m., the family member indicated that facility staff administer medications for Resident #5 by crushing medications, mixing with apple sauce and feeding it to the resident.

During observation of assistance with medication administration with the Administrator, on at 2:15 p.m., Resident #5 was not able to follow instructions, hold the eye drops container or move her arms up towards her head. The Administrator had to administer medication with no effort by Resident #5.

During interview with the responsible party for Resident #6, on , the family indicated that Resident #6 needed medication administration, and that the facility staff have to mix the medications with applesauce to feed to the resident.

Observation throughout the day of the survey of Resident #7, on revealed that the resident remained seated in a wheelchair with rolled washcloths in both hands. Attempted verbal interactions with the resident revealed that she was not aware enough to follow instructions, or to voluntarily move her arms and hands.

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

Review of Medication observation record (MORS) conducted on , revealed that for the month of , 2018, Facility employee A and B, and the Administrator, who documented as assisting with medication for Resident #5, Resident #6, and Resident #7 were not licensed to administer medications.

During an interview with the Administrator on at 2:17 p.m., the Administrator confirmed that Resident #5, Resident #6 and Resident #7 needed medication administration. The Administrator confirmed that the Facility did not have any licensed staff to administer medication three times a day for the residents who needed medication Administration.

Class III

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

Based on observation and interview, the facility failed to ensure that medication stored in a refrigerator located in the kitchen were maintained in a locked for two of three residents with medications that require refrigeration.(Resident#2, and #3)

Findings included:

On at approximately 02:18 p.m., the refrigeration unit located in the kitchen was observed with medications on the top shelf of the refrigerator door. A black box used for locking medications was observed in the shelf directly below it. The Administrator, who was present, stated that the refrigerated medications were removed from the lock-box earlier in the day, and confirmed that the medications should have been returned to the locked container.

Class III