STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968356	**07/19/2018**
NAME OF PROVIDER OR SUPPLIER **CARING FOR YOU ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **2212 E MCBERRY ST** **TAMPA, FL 33610**	

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

0000 - Initial Comments

Assisted Living Facility

A biennial licensure survey was conducted, in conjunction with complaint (CCR2018009808) survey, on at Caring for You Assisted Living Facility (License #12245), an assisted living facility in Tampa, Florida. There were deficiencies identified at the time of visit.

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on observation, interview and record review, the facility failed to provide the minimum requirement of scheduled activities to the residents.

Findings included:

Facility tour conducted on at 10:03 a.m., revealed that the activities schedule posted was for 2018.

Review of the Facility's activity schedule revealed various times for daily scheduled activities that included 08:00 a.m., 09:00 a.m., 10:00 a.m., and 02:00 p.m., or 08:15 a.m., 08:30 a.m., 10:00 a.m., and 02:00 p.m.

The only form of entertainment or activity observed during survey, on , was the television playing in the living /common area of the Facility.

During exit conference with the Administrator and the New Owner, on at approximately 05:20 p.m., they confirmed that no activities were offered to the residents during the survey.

Class III

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

Based on observation, interview, and record review, the facility failed to provide assistance with self-administered medications in accordance with procedures described in Section 429.256, F.S.; specifically, Staff A did not provide medication dosage within one-hour of the prescribed time for one (Resident #2) of four sampled residents for medication review.

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Findings included:

Review of Resident #2's Medication Observation Record (MOR) for , 2017, on at 02:10 p.m., revealed that Resident #2 had a prescribed medication dosage scheduled for 01:00 p.m. During interview with Staff B, who was present for MOR review, she stated that Resident #2 did not have medication at 01:00 p.m., Staff reviewed the MOR and stated that she gave the identified medication at 07:00 p.m. daily
. Staff B confirmed that the MOR indicated that medication was scheduled at 01:00 p.m., and not 07:00 p.m.

Class III

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

Based on observation, interview, and record review, the facility failed to ensure that only licensed staff administered medications to one (Resident #5) identified resident requiring administration of medications of four selected for medication review.

Findings included:

During observation and attempted interaction with Resident #5, with Staff B, on , at 3:25 p.m., Resident #5 did not display the awareness or physical capabilities to communicate or follow instructions that included, moving arms and hands or opening eyes. Staff B stated at the same date and time that Resident #5 required total care.

Review of Resident #5's Medication Observation Record (MOR) for , 2018, revealed that Staff B documented medications as given to Resident #5 by initialing.

During interview with Staff B, on at 03:53 p.m., Staff B confirmed her initials on the MOR, and stated, "We crush the medication and put it applesauce. We put the medication in their mouth and feed it to them. We do that 3 times a day". Staff B indicated that she believed that once an unlicensed staff completed the Assistance with Self-Administration of Medication training, the unlicensed staff was authorized to give the medications in that manner.

During exit conference with the Administrator and the New Owner, on at approximately 05:20 p.m., the Administrator confirmed Staff B was not licensed to administer medications. The

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Administrator stated that she was not aware that unlicensed staff were not allowed to spoon feed crushed medications (with applesauce) to residents.

Class III

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

Based on observation, record review and interview, the facility failed to document the accurate time on the Medication Observation Records (MORs) for medication provided for one (Resident #1) of four sampled residents for medication review.

Findings included:

Review of Resident #1's Medication Observation Record (MOR) for , 2017, on , revealed that Resident #1 had a prescribed medication dosage scheduled for 02:00 p.m.

During observation of assistance with medication self-administration with Staff B, on at 2:21 p.m., Staff B staff B provided Resident #1 with the oral dosage, and documented on the Medication provided to Resident #1 on the 07:00 p.m. .

During interview with Staff B, on at 02:21 p.m., she reviewed the MOR for Resident #1, and stated, "Oops I initialed the wrong time; it was supposed to be 2:00 p.m."

Class III

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

Based on observation and interview, the facility failed to ensure that centrally stored medications were locked at all times for medications stored for five residents (#1, #2, #3, #4 and #5) of five residents who received assistance with medication-self administration.

Findings included:

During observation of assistance with medication self-administration with Staff B, on at 12:00 p.m., Staff B removed the medication package from the medication cart, then left the medication storage , and left the cart unlocked, to assist Resident #1 with medications. Staff B retuned to the medication cart at 12:18 p.m., returned Resident #1's medication in the medication cart, and left the medication cart and door to the .

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During interview with Staff B, on , at 12:28 p.m., she confirmed that the door to the , and the medication cart were left unlocked. Staff B stated, "I opened it for 12:00pm medication that is my fault."

Class III

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

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

Findings included:

Review of Staffing schedule for staffing hour , on , revealed that Staff C was listed on the schedule for the entire month of , 2018.

During interview with the Administrator, on , at 01:18 a.m., Administrator confirmed that Staff C no long worked at the facility, as of . The Administrator stated that she covered the shifts listed as Staff C, and confirmed that it was not reflected on the staffing schedule.

Class III

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

Based on interview and record review, the facility failed to maintain personnel records, which contained at a minimum a copy of the employment application, with references furnished, documentation of completed training, documentation verifying freedom from signs or symptoms of a communicable , and documentation of Background screening for one (Staff A) employee, and failed to ensure that employees had evidence of a negative examination completed annually for three (Administrator, Staff A and Staff B) of three employees selected for record review.

Finding included:

Record review, conducted on , revealed no evidence of employment/personnel documentation for the Staff A, who was listed on the schedule as an active direct care staff.

Record review revealed that the last documented examination for the Administrator was

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dated , and for Staff B dated .

During interview with the Administrator on at 01:18 p.m., she stated that personnel record for Staff A was not at the Facility, and confirmed that Staff A was an active direct care staff who has worked at the Facility since .

During interview with the Administrator on at 03:07 p.m., she searched records and confirmed that there were no more current examinations for the Staff B and the Administrator.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to maintain on premise or produce any records, other than an assessment (AHCA Form 1823) for two residents (#4 and #5) of three residents selected for record review.

Findings included:

In response for record request for Resident #4 and Resident #5, on , at 11:40 a.m., that New Owner searched and stated that the Administrator was picking up records from her home.

On 11:46 a.m., the Administrator returned with resident records.

During interview with the Administrator, conducted on , at 03:25 p.m., she stated that she forgot to grab resident records for Resident #4 and Resident #5 from her home. The Administrator presented the most recent health assessment for Resident #4, and confirmed that was the only record onsite for the resident other than the Medication Observation Record.

Class III