STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967471	**08/03/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYDE PARK ASSISTED LIVING FACILITY	**3011 WEST DE LEON STREET TAMPA, FL 33609**

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

0000 - Initial Comments

Assisted Living Facility

On , 2018 a complaint (CCR# 2018007379) survey was conducted at Hyde Park Assisted Living Facility, Deficient practice was identified at the time of the visit.

(license #11504)

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and interview, the facility failed to honor the residents' rights to live in a safe and decent living environment free from hazards such as fire violations and inappropriately stored tanks. Additionally, they failed to safe guard protected health information for 64 residents who currently reside at the facility.

Findings Included:

During a tour of the facility conducted on between the hours of 11:45 AM and 12:29 PM the following observations were made:

In , two urinals and a cup were observed sitting on the floor beside Resident #2's bed filled with , is a shared . Resident #2's bed sheets were observed to be stained. Resident #2 was observed lying in bed smoking a cigarette.

During an interview with Resident # 2, they stated, "I smoke in my , everyone smokes in their ."

During an interview with Staff K, they stated, "The residents smoke in their . They do but I don't."

Staff I was observed walking in the foyer of with a cigarette in their mouth.

During an interview with Staff I they stated, "I just walked in to unlock the door and I was going back out."

During an observation of B, accompanied by Staff A, a smell of marijuana was detected. Clips

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of smoking papers and a pipe with smoking residue was observed on the nightstand of Resident #15. The was covered in feces. Three used and uncovered razors were stored in the sill. B is a semi-private two residents currently residing. Cigarette butts were observed on the .

The facility's smoking policy was reviewed. It read, "Smoking is never permitted in resident . Smoking is only allowed in designated areas."

During an observation of A, an tank was observed in the resident's living space and one in his closet, neither of which were stored appropriately. The closet door was missing and sitting in the foyer outside the resident's .

During an observation of the physician's exam the second floor, the door was propped open with an tank allowing access into the . Resident's protected health information was observed in an unsecured drawer and in an unlocked trunk on the counter. An open sharps bin with used needles inside was sitting in the floor.

Staff B toured the facility with the Surveyor confirming the resident rights concerns.

Class III

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

Based on observation and interview the facility failed to ensure medications were stored in a locked storage cart at all times.

Findings included:

On at 9:05 AM the medication cart was observed in the dining area unlocked and unattended with an open medication observation log laying on the top of it.

On at 8:45 AM Staff F stated, "yes, it is open."

Class III

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0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation and record review the facility failed to follow physician's orders to assist with the self-administration of medication no sooner than one hour before medication is scheduled and no later than one hour after.

Findings Included:

On , 2018 at 9:09 am, a medication observation was conducted with Staff G who was assisting with the self-administration of medication for Resident #10.

During a review of Resident 10's medication observation record, it revealed the medication they received at 9:09 am was scheduled for 8:00 am, which exceeded the one-hour time frame.

On , 2018 at 9:13 am, a medication observation was conducted with Staff F who was assisting with the self-administration of medication for Resident #6.

During a review of Resident #6's medication observation record, it revealed the medication they received at 9:13 am was scheduled for 8:00 am, which exceeded the one-hour time frame.

During an interview with Staff A on at approximately 2:00 PM they stated they would retrain the staff on the required time frames for assistance with medications.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview the facility failed to provide a safe living environment, free from hazards and ensuring that all existing structural systems are maintained in good working order for 64 residents currently residing in the facility.

Findings included:

A tour of the facility was conducted on during the hours of 11:45 AM and 12:29 PM, the following observations were made:

B had a hole in the wall above the exposed wires. Above Resident #2's bed

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was an open, unsecured fuse box. In B the closet door was off the track, sitting in the floor. Above the entrance door was an air vent with a black substance on it, and water dripping from the vent in the floor.

In the main hallway outside of the Administrative offices, a broken wall outlet plate with exposed electrical components was observed.

At 12:29 PM on the surveyor toured the facility with Staff B. Staff B confirmed the physical plant issues.

During an observation of B the air vent was covered in a black mold-like substance.

During an observation of A the floor was covered in dirt and water spills. The was covered with a black plastic bag with tape around it preventing use by Resident # 1. The ceiling tiles were not in place exposing wires. The air vent was not secured to the ceiling.

During an observation of the foyer leading into the smoke detector was beeping.

During an observation of A the tiles were not in place. The air vent was covered in a black mold-like substance.

During an interview with Staff A, they confirmed the physical plant issues.

Class III