STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966240	R 08/13/2018
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

A Second 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.

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 ensure the appropriateness of continued residency for three residents (Resident #7, Resident #8, and Resident #13) who were identified as needing medication administration, when the Facility did not have licensed staff to administer medications.

Findings included:

During an observation of a medication pass with Staff A, on at 08:15 a.m., Staff A administered medication dosages for Resident #7, Resident #8 and Resident #13.

Review of Resident #7's Agency for Health Care Administration Health Assessment Form 1823, dated , on , revealed that Resident #7 required medication administration.

Review of Resident #8's Agency for Health Care Administration Health Assessment Form 1823, dated , on , revealed that Resident #8 required medication administration.

Review of Resident #13's Agency for Health Care Administration Health Assessment Form 1823, dated , on , revealed that Resident #13 required medication administration.

Review of the plan of correction documents dated that were submitted to the Agency revealed that the Facility indicated they hired a licensed nurse to administer medications.

During interview with the Administrator, on at 10:20 a.m., she acknowledged that the Facility submitted a plan of correction to the Agency that indicated that the Facility hired a nurse to administer medications for residents who required medication administration. The Administrator confirmed that Facility did not hire a nurse, and unlicensed staff continued to administer medication for residents that needs medication administration.

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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 (13) of four resident observed for assistance with medication self-administration, and Staff A, unlicensed, administered oral medication dosages for three (Residetn #7, Resident #8, and Resident #13) of four resident observed for Assistance with medication self-administration.

Findings included:

During an observation of assistance with self-administration of medication with Staff A, on at 08:15 a.m., Staff A administered medication dosage with apple sauce by spoon feeding Resident #8 the medication dosage, with no assistance provided by Resident #8.

During an observation of assistance with self-administration of medication with Staff A, on at 08:27 a.m., Staff A administered medication dosage with apple sauce by spoon feeding Resident #13 the medication dosage, with no assistance provided by Resident #13. Review of the Medication observation Record (MOR) for 2018 revealed tablet was scheduled for 07:00 a.m.

During interview with Staff A, on at 08:33 a.m., Staff A confirmed that MOR indicated that was scheduled at 07:00 a.m. and medication was given to Resident #13 one hour and a half late.

During continued observation of assistance with self-administration of medication with Staff A, on at 08:41 a.m., Staff A administered medication dosage with apple sauce by spoon feeding Resident #7 the medication dosage, with no assistance provided by Resident #7.

Review of the 2018 Medication Observation Record (MOR) for Resident #7 revealed that prescribed dosages were not documented as given for eight in the morning and five in the evening for .

During interview with Staff A, on at 09:05 a.m., Staff A confirmed that Resident #7's dosage was not documented as given for . Staff A indicated that perhaps it was

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an oversight.

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 three (Resident #7, Resident #8 and Resident #13) of four observed for assistance with medication self-administration.

Findings included:

During interview with Staff A, who served as the Facility Manager, on . . . . . , at 08:07 a.m., she stated that the Facility did not have a nurse to administer medications to residents that require medication. Staff A stated that she and other unlicensed staff administered medications for residents who needed medication administration.

During an observation of the medication pass with Staff A, on at 08:15 a.m., Staff A administered medication dosages for Resident #7, Resident #8 and Resident #13.

Review of most recent health assessment, on . . . . . , revealed that Resident #7, Resident #8, and Resident #13 required medication administration.

Class III

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

Based on record review and interview, the facility failed to maintain accurate and up-to-date Medication Observation Records (MORs) that reflected each time medications were provided to residents for one (#7) of four residents sampled for MOR review.

Findings included:

Review of the 2018 MOR for Resident #7 revealed that prescribed , dosages were not documented as given for eight in the morning and five in the evening for . . . . . .

During interview with Staff A, on . . . . . at 09:05 a.m., Staff A confirmed that Resident #7's , dosage was not documented as given for . Staff A indicated that perhaps it was

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an oversight.

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 failed to employ the consultation services of a licensed pharmacist or a registered nurse, as required following ongoing deficient practice related to the assistance with self-administration of medications.

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.

During an observation of assistance with self-administration of medication with Staff A, on at 08:15 a.m., Staff A administered medication dosages for Resident #7, Resident #8 and Resident #13. In addition, the facility failed to ensure that Resident #13 received medication dosage within one-hour of the prescribed time, and failed to document whether or not medication dosages scheduled for eight in the morning and five in the evening on . . . . for Resident #7.

During interview with the Administrator, on at 10:20 a.m., she acknowledged that the Facility submitted a plan of correction to the Agency that indicated that the Facility hire a nurse to administer medications for residents who required medication administration. The Administrator confirmed that Facility did not hired a nurse, and unlicensed staff continued to administer medication for residents that needs medication administration. The Administrator stated, that the Facility hired someone from a third party company.

On . . . . . , at 11:42 a.m., the Assistant Administrator stated that the third party pharmacist provided training for all staff with assisting residents with medication self-administration of medications. The Assistant Administrator did not have any documented proof of onsite consultation.

During interview with the owner and pharmacist, of the third party pharmacy, on . . . . . at 11:47 a.m., the Pharmacist indicated that the Facility did not contact them about consulting for correction of ongoing deficiencies, and that was the first time he heard of it. The Pharmacist confirmed that the pharmacy did not provide consulting services.

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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.

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 the second 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 to ensure that oversight was provided by a manager Administrator with the same qualifications as an administrator, to include core training, for the Administrator and manager who supervised a total of three licensed facilities.

Findings included:

A revisit was conducted on for, , survey that revealed the Administrator and the Assistant Administrator were operators of three total licensed facilities.

During interview with the Administrator, on , at 10:20 a.m. the Administrator confirmed that she and the Assistant Administrator operated three assisted living facilities. The Administrator confirmed that neither, Staff A, the designated Facility Manager, nor the Assistant Administrator completed and passed the core exam.

During interview with the Assistant Administrator, on , at 12:07 p.m., the Assistant Administrator confirmed that neither the Assistant Administrator, nor the Manager for the Facility completed the Core proficiency exam, that they were not enrolled to take upcoming core proficiency exams. The Assistant Administrator stated that was the Assistant Administrator for the Facility since 2015.

Record review, on , revealed a designation of duty, dated , identifying delegation of position to the Facility Manager and the Assistant Administrator. Record review revealed no evidence

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that the designated Facility Manager (Staff A) completed the required assisted living facility core training, and no evidence that the Assistant Administrator successfully completed the required core competency examination. The Assistant Administrator completed the core training on , and the 12-hour Core update on but had no evidence of passing the core exam.

Class III