STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968323	**08/16/2018**
NAME OF PROVIDER OR SUPPLIER **ESTATE AT HYDE PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **2301 W PALM DR** **TAMPA, FL 33629**	

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

0000 - Initial Comments

Assisted Living Facility

On , 2018, a biennial re-licensure survey in conjunction with a complaint survey (CCR 2018009956) was conducted at Estate of Hyde Park (The). Deficient practice was identified related to the biennial re-licensure survey.

(License #12223)

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

Based on observations and interviews, the facility failed to maintain medications for residents, who require assistance with medication self-administration or medication administration, in a centrally stored locked cart or storage receptacle, at all times, and failed to keep medications properly closed and concealed for 2 of 5 residents observed (#11 and #12).

Findings Included:

At 6:25am on , on the 2nd floor of the facility, located just outside of a Medication an open hallway, a medication cart was observed to be unlocked without an employee, nurse or medication technician (Med Tech) utilizing the cart. Later, at 6:30am, in another location on the 2nd floor, a medication treatment cart containing many creams and inhaler treatments prescribed for individual residents, was observed to be left unlocked in the hallway without anyone around.

Staff A was observed giving Resident #11 medications at 6:30am on . Staff A, a licensed practical nurse (LPN) identified Resident #11 in the resident's . Upon reviewing Resident #11's electronic medication administration record (MAR), Staff A noted that the resident's , 75mcg tablet was due. Staff A opened the medication cart, which was already unlocked, and took a small cup from the top drawer containing pudding with a little white pill pre-poured on top of the pudding. The cup had only a written on it, which matched Resident #11's . Staff A explained that this was the resident's , 75mcg tablet and proceeded to administer the medication to the resident with a spoon. Staff A stated the medication packaging with the prescription label for Resident #11's medication were not located on the medication cart that was in use at the time.

Staff A was observed giving Resident #12 medications at 6:40am on . Staff A identified Resident

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#12 in the resident's . Upon reviewing Resident #12's electronic medication administration record (MAR), Staff A noted that the resident's 50 mcg tablet was due. Staff A opened the medication cart and took a small cup from the top drawer containing a little white pill. The cup had only a on it, but not Resident #12's . Staff A explained that this was the Resident #12's 50 mcg tablet and proceeded to assist the resident with the medication. Staff A stated the medication packaging with the prescription label for Resident #12's medication were not located on the medication cart that was in use at the time.

In an interview with Staff A at 7:00am on , the LPN stated that because it is difficult to push 2 medication carts around at the same time, staff is in the habit of pre-pouring some of the residents' medications and storing them in the top drawer of another cart in small cups with the written on them. Staff A stated that the medication and treatment carts are normally locked when not in use.

An interview was conducted with the Health and Wellness Director at 9:30am on , who stated that the facility has expectations which require all staff, who utilize the medication carts and medication treatment carts within the facility, to keep those carts locked at all times unless they are currently using the carts to pull medications or treatments. Also, the facility does not allow the pre-pouring of medications and storing opened and unlabeled medications on medication carts. Medications are to be taken directly from the prescription labeled packaging and the labels read immediately prior to giving them to the residents to prevent medication errors.

Class III

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

Based on record review and interview, the facility failed to provide documentation that, staff submitted a written statement form a health care provider, within 30 days after beginning employment, documenting the individual does not have any signs or symptoms of communicable (Communicable Statement) for one (Staff D) of four employee records sampled.

Findings included:

A review of employee records conducted on showed that Staff D had a date of hire of . A review of Staff D's record showed no documentation of a Communicable Statement.

An interview was conducted with the Business Office Manager at 2:45 PM on concerning a

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Communicable Statement for Staff D. The Business Office Manager reviewed Staff D's record and stated that they did not see it.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC

Based on record review and interview, the facility failed to provide proof of in-service training, within 30 days of employment, in the subject of emergency procedures including the chain of command and staff roles related to emergency evacuation (Emergency Preparedness Training) for three (Staff B, Staff C, and Staff D) of four employee records sampled and failed to provide proof of training on safe food handling practices (Safe Food Handling Training) for two (Staff B and Staff D) of four employee records sampled.

Findings included:

A review of employee records conducted on showed that Staff B had a date of hire of , Staff C had a date of hire of , and Staff D was hired on . A review of the three employee records showed no proof of Emergency Preparedness Training. A review of the facility's direct care staffing schedule showed Staff B, C, and D listed.

A review of employee records for Staff B and Staff D also showed no proof of one hour of Safe Food Handling Training.

A series of interviews were conducted with the Business Office Manager beginning at 2:35 PM on concerning the lack of proof of required training for Staff B, Staff C, and Staff D. The Business Office Manager reviewed the employees' records and acknowledged that proof of required training was not present.

Class III