STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968783	08/15/2018
NAME OF PROVIDER OR SUPPLIER **ARBOR TERRACE AT CITRUS PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **13810 SHELDON RD** **TAMPA, FL 33626**	

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

0000 - Initial Comments

Assisted Living Facility

A complaint investigation, (CCR#2018009379 & CCR#2018009641), was conducted on [redacted] at Arbor Terrace at Citrus Park, an assisted living facility in Tampa, Florida. Deficient practice was identified at time of the visit.
License #12657

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on on observation, interview and record review, the Facility failed to ensure that unlicensed staff assisted with medications in accordance with procedures described in Section 429.256, F.S.; specifically, Staff A, unlicensed, removed medication from the original packaging without the resident present, did not inform the resident of medications given, provided medication dosage 2-hours prior to the prescribed time, and administered oral dosages for one (Resident #5) of one residents observed.

Findings included:

While initiating a staff interview on [redacted], at 11:06 a.m., Staff F was observed in the hallway with a single use disposable cup, with crushed medications in pudding. Staff F indicated that she removed the medication from the primary packaging, and crushed the medication in the lobby, near the nurses' station. Staff F walked to Resident #5's [redacted], and spoon fed oral medication dosages to Resident #5. Staff F did not have the Medication label to inform the Resident of medications provided.
On [redacted], at 11:06 a.m., Staff F confirmed that she was not licensed to administer medications.

Review of Medication observation record (MOR) for [redacted] 2018 and medication label revealed that both medications were scheduled for 01:00 p.m., one of the medication labels had instructions to provide medication with meal at 1:00 p.m.

During interview, and record review with the Resident Care Director, on [redacted], at 03:45 p.m., she confirmed that Staff F was not licensed to administer medication for residents. She indicated that she was not informed that Resident #5 needed medication administration after hospital discharge. She indicated that Staff F should have alerted a nurse for the medication administration. Review of documentation on Electronic MOR indicated that medications were given to Resident #5 at 12:49 p.m.

Class III

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

Based on observation, interview and record review, the Facility failed to ensure that only licensed nurses administered medications to one (Resident #5) of one sampled residents observed receiving medication administration.

Findings included:

On [redacted], at 11:06 a.m., Staff F, an unlicensed employee, was observed spoon feeding oral medication dosages to Resident #5 with pudding. Staff F did not have the Medication label to inform the Resident of medications provided.

Review of most recent health assessment, on [redacted], revealed that Resident #5 needed assistance with medication self-administration.

During interview, and record review with the Resident Care Director, on [redacted], at 03:45 p.m., she confirmed that Staff F was not licensed to administer medication for residents.

Class III

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

Based on record review and interview, the facility failed to furnish documented proof of completion for in-service/training related to recognizing and reporting resident [redacted], neglect, and [redacted] for three employees (Staff A, Staff C, and Staff G), reporting adverse incidents for two employees (Staff A and Staff C), and resident's rights for one (Staff A) for four employees selected for record review.

Findings included:

A record review for Staff A, on [redacted], revealed there was no evidence of completed training related to Resident rights, Incident Reporting, and Recognizing/Reporting [redacted], Neglect, and [redacted]. Record review also revealed that Staff A was hired on [redacted], and terminated on [redacted] for reasons that included "theft," and was [redacted] for taking residents' jewelry.

A record review for Staff C, on [redacted], revealed there was no evidence of completed training related to Incident Reporting, and Recognizing and reporting resident [redacted], neglect, and [redacted] for three employees. Record review also revealed that Staff C was hired on [redacted].

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A record review for Staff G, on [redacted], revealed there was no evidence of completed training related to Recognizing and reporting resident [redacted], neglect, and [redacted], for three employees. Record review also revealed that Staff C was hired on [redacted].

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review, the facility failed to complete an Adverse Incident Report with the Agency following a reported incident that resulted in investigation by local law enforcement, and [redacted] of an employee (Staff A) who stole jewelry from two (Resident #9 and Resident #10) of at least three identified residents.

Findings included:

Interview with responsible party for Resident #9, on [redacted] at 10:09 a.m., revealed that Resident #9's jewelry went missing two months prior to date of visit, in late [redacted], to early [redacted] of 2018. The Responsible party indicated that the Facility was informed. About two weeks after initial notice, the Memory Care Program Director, recommended that responsible party file a police report.

Interview with responsible party for Resident #10, on [redacted] at 01:06 p.m., revealed that Resident #10's jewelry went missing in [redacted], of 2018. Responsible Party notified local law enforcemnt in [redacted], of 2018 and an investigation was conducted.

Review of Facility's record to include Grievance forms, nurses notes, and Shift-to-Shift 24-hour communication logs revealed no documentation by the Facility for Resident #9, or Resident #10 related to expressed concerns of missing items since [redacted], of 2018. Last documented Grievance Form was from [redacted], of 2018.

Review of the local Sherriff's Office webpage revealed that Staff A was [redacted] on [redacted] for charges that included Grand Theft (third degree), [redacted] of an elderly person, dealing in stolen property, and Petit theft (first degree).

Review of Facility provided Termination Form dated [redacted] indicated that Staff A terminated for "No call, No show. Consistent tardi[ness] & call offs. Theft"

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During interview with the Administrator, and Memory Care Director, on . . . . . at 07:32 p.m., the Memory Care Director confirmed that Responsible Parties informed the Facility of missing jewelry on multiple occasions, which resulted in law enforcement investigation in , of 2018, and of 2018. The Administrator and the Memory Care Program Director stated that they believed that the Facility was only required to report an adverse incident report, when the Facility was the one who contacted law enforcement, and confirmed that the Facility had no documentation and no adverse incident reports related to Staff A's theft that occurred in the Facility.

Class III

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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview the facility failed to maintain an updated employee roster in the Agency background-screening clearinghouse for two (Administrator and Staff A) of four employees selected for review. Staff A was . . . . . on . . . . . for taking residents' property and selling it to a local pawn store.

Findings included:

Review of the AHCA Background Screening Clearinghouse Agency website reveled an absence of the Administrator's name, and Staff A's name on the roster for the provider.

During record review with the Business Office Manager, on . . . . . , at 05:54 a.m., she confirmed that Staff A worked at the Facility from . to termination date of . . . . The business office manager also confirmed that the Administrator was not included on the Facility Roster.

Unclassified

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on record review and interview the facility failed to ensure that one (Staff B) of four sampled employees renewed their required Level II background screening.

Findings included:

Review of the AHCA Background Screening Clearinghouse Agency website revealed that the Staff B's level II background screening was competed on . . . . . and a new screening was required.

Record review on . . . . . revealed that Staff B, hired on . . . . . worked as dietary staff, whose duties included assisting with meal preparation, meal set up, serving meals, and assisting resident with completing menus. Review of Employee Time Card confirmed that last day worked was . . . . . .

During record review with the Business office manager, on . . . . . at 04:24 p.m., she confirmed that Staff B was a current employee who was hired on . At 04:24 p.m., on . The Business office manager confirmed a new background screening was not completed for Staff B.

Unclassified

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