STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953611	**08/30/2018**
NAME OF PROVIDER OR SUPPLIER **BARRINGTON (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **901 SEMINOLE BOULEVARD** **LARGO, FL 33770**	

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

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

Based on record review and interview, the Facility failed to maintain an up-to-date Background Screening Clearinghouse Employee Roster (BSCER) for one employee (the Administrator) of four sampled employees.

Findings Included:

During pre-survey activity, review of the employee roster conducted on , revealed that the Administrator was not listed on the BSCER.

During an interview with the Administrator, conducted on at 04:20pm, the Administrator acknowledged and confirmed that the BSCER did not include the Administrator. The Administrator stated that, "I will have that checked and have my name added."

At the time of finalization of the survey conducted on , the Administrator was still not added to the BSCER.

Unclassified

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0000 - Initial Comments

Assisted Living Facility

A Complaint Survey (CCR#: 2018010616) was conducted at The Barrington Assisted Living Facility on . The Barrington Assisted Living Facility had deficient practice identified at the time of the survey.

(License#: 7232)

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to obtain completed Agency for Healthcare Administration Form 1823 (AHCA 1823), which included all required information to assist in determining the appropriateness of residents admitted to the facility for four Residents (#1, # 11, #12, and #13) of four sampled residents.

Findings Included:

A record review for Resident #1, conducted on , revealed that Resident #1 AHCA 1823 dated did not stipulate that needs can or cannot by met in an Assisted Living Facility. This faxed page was cut of and that section was not readable. Page five of Resident #1 AHCA 1823 not filled in by the Facility or signed by Resident #1 (or Responsible Party) for services required by Resident #1. Resident #1 had diagnoses and history of , , , , joint pain, , stiffness, and . Resident #1 required supervision with transferring and assistance with bathing, dressing, , and medication. Resident #1 admitted to the Facility on .

A record review for Resident #11, conducted on , revealed that Resident #11 AHCA 1823 dated did not have page five filled in by the Facility or signed by Resident # 11 (or Responsible Party) for services required by Resident #11. Resident #11 had to and . Resident #11 had diagnoses and history of , previously right hip, , low levels, , , , , and . Resident # 11 required supervision with ambulation and assistance with bathing, dressing, and medication. Resident # 11 admitted to the Facility on .

A record review for Resident #12, conducted on , revealed that Resident #12 AHCA 1823 dated was not on the required 2017 form and page five not filled in by the Facility or signed by

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Resident #12 (or Responsible Party) for services required by Resident #12. Resident #12 had to Sulfa, , and Dye. Resident #12 had diagnoses and history of left sided and general , and . Resident #12 required supervision with dressing and assistance with ambulation, bathing, and transferring. Resident #12 admitted to the Facility on .

An observation of Resident #13, conducted on at 10:30am, revealed that Resident #13 was walking with a walker in the first floor hallway. Resident #13 had a fading to the right eye and a bandage to the left top of the residents head just above region.

A record review for Resident #13, conducted on , revealed that Resident #13 AHCA 1823 was not dated and page five not filled in by the Facility or signed by Resident #13 (or Responsible Party) for services required by Resident #13. Resident #13 had diagnoses and history of Parkinson's , hard of hearing, memory loss, and precautions. Resident #13 required supervision with ambulation, bathing, dressing, and eating. The Activity of Daily Living for toileting and transfers was not noted on Resident #13 AHCA 1823. Resident #13 re-admitted to the Facility on .

During an interview with the Administrator, conducted on at 04:20pm, the Administrator acknowledged and confirmed that Residents #1, #11, #12, and #13 AHCA 1823 were missing required data.
Class III

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

Based on observation and interview, the Facility failed to ensure unlicensed staff read medication labels aloud to three Residents (#5, #7, and #8) of three sampled residents who need assistance with self-administration of medication.

Finings Included:

During an observation of the medication pass with Resident #7, conducted on at 11:44am, Staff A did not read the medication label aloud to Resident #7 for the prescribed 5mg tablet. Resident #7 required assistance with self-administration of medication.

During an observation of the medication pass with Resident #8, conducted on at 11:50am, Staff A did not read the medication labels aloud to Resident #8 for the prescribed medications 25mg and 0.5mg tablets. Resident #8 required assistance with

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self-administration of medication.

During an observation of the medication pass with Resident #5, conducted on at 11:50am, Staff A did not read the medication label aloud to Resident #8 for the prescribed medication Sucralafate 1-gram tablet. Resident #5 required assistance with self-administration of medication.

During an interview with the Administrator, conducted on at 03:54pm, the Administrator indicated that the Facility was unaware of the requirement to read medication labels aloud.

Class III

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

Based on record review and interview, the Facility failed to update Medication Observation Records (MORs) immediately each time a medication (med) was offered or administered to ten Residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, and #12) of twelve sampled residents who need assistance with self-administration of medication or medication administration.

Findings Included:

A review of Resident #1 MORs, conducted on , revealed that there were meds not documented as given to Resident #1. There were no orders to hold these meds in Resident #1's record. There was not a documented reason to hold these meds documented on the back of Resident #1's MORs. The following meds not documented as given to Resident #1:
- D-3 1000 unit tablets not documented on at 08:00am
- with tablets not documented through . There was no time indicated on Resident #1's MORs for when this med was due.
- Cellurise Ophthamic Solution 1% (eye drops) not documented on at 12:00pm, 04:00pm, and 08:00pm

A review of Resident #2 MORs, conducted on , revealed that Resident #2 prescribed med Muro 12%-5%, , Solution (eye drops) not documented as given on at 08:00pm. There was not a documented reason to hold this med on the back of Resident #2's MORs. There was not an order to hold this med in Resident #2 record.

A review of Resident #3 MORs, conducted on , revealed that Resident #3 prescribed med , 300mg capsules not documented as given on at 02:00pm. There was not a

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documented reason to hold this med on the back of Resident #3's MORs. There was not an order to hold this med in Resident #2 record.

A review of Resident #4 MORs, conducted on , revealed that there were meds not documented as given to Resident #4. There were no orders to hold these meds in Resident #4 record. There were no reasons to hold these meds on the back of Resident #4 MORs. The following medications not documented as given to Resident #4:
- Solution (eye drops) not documented as given on and at 05:00pm and 08:00pm
- 1mg tablets not documented as given on at 05:00pm
- Carbodope/ , 25-100mg tablets not documented as given on , , and at 02:00pm

A review of Resident #5 MORs, conducted on , revealed that there were meds not documented as given to Resident #5. There were no orders to hold these meds in Resident #5's record. There was not a documented reason to hold these meds documented on the back of Resident #5's MORs. The following meds not documented as given to Resident #5:
- 25mg tablets not documented as given on at 09:00pm
- 5mg tablets not documented as given on at 09:00pm
- 20mg tablets not documented as given on at 09:00pm

A review of Resident #6 MORs, conducted on , revealed that there were meds not documented as given to Resident #6. There were no orders to hold these meds in Resident #6's record. There was not a documented reason to hold these meds documented on the back of Resident #6's MORs. The following meds not documented as given to Resident #6:
- 5mg tablets not documented as given on at 05:00pm
- tablets not documented as given on at 05:00pm
- 10mg tablets not documented as given on at 05:00pm

A review of Resident #7 MORs, conducted on , revealed that there were meds not documented as given to Resident #7. There were no orders to hold these meds in Resident #7's record. There was not a documented reason to hold these meds documented on the back of Resident #7's MORs. The following meds not documented as given to Resident #7:
- NP 30mg tablets not documented as given on , , and at 06:00am
- 5mg tablets not documented as given on and at 02:00pm

A review of Resident #8 MORs, conducted on , revealed that there were meds not documented

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as given to Resident #8. There were no orders to hold these meds in Resident #8's record. There was not a documented reason to hold these meds documented on the back of Resident #8's MORs. The following meds not documented as given to Resident #8:
- ER 50mg tablets not documented as given on at 08:00pm
- 25mg tablets not documented as given on at 12:00pm

A review of Resident #9 MORs, conducted on , revealed that there were meds not documented as given to Resident #9. There were no orders to hold these meds in Resident #9's record. There was not a documented reason to hold these meds documented on the back of Resident #9's MORs. The following meds not documented as given to Resident #9:
- Solution 0.2% (eye drops) not documented as given on , , and at 02:00pm
- 10mg tablets not documented as given on and at 08:00pm
- Solution 0.005% (eye drops) not documented as given on at 08:00am

A review of Resident #12 MORs, conducted on , revealed that there were meds not documented as given to Resident #12. There were no orders to hold these meds in Resident #12's record. There was not a documented reason to hold these meds documented on the back of Resident #12's MORs. The following meds not documented as given to Resident #12:
- D 1000 unit capsules not documented as given on at 08:00am
- 2.5mg tablets not documented as given on , , , & at 09:00pm
- Alaprazolam 0.5mg tablets not documented as given on at 08:00pm

A review of the Facility's Medication Assistance Policy and Procedure, conducted on , revealed that Procedure #2 stated, "each dose administered is properly recorded in the MOR as indicated by the Med Tech (Medication Technician) initials in appropriate ."

During an interview with the Administrator, conducted on , the Administrator stated that, "I just wrote a bunch of Staff up for not signing the MORs."
In a later interview with the Administrator at 04:20pm, the Administrator acknowledged and confirmed the missing documentation from the aforementioned residents and their medication records.

Class III

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

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Based on observation, interview, and record review, the Facility failed to keep centrally stored medications (meds) in a locked cabinet, locked cart, or other locked storage receptacle at all times.

Findings Included:

An observation of the medication pass with Staff A, conducted on , revealed that the Facility did not keep centrally stored meds in a locked cabinet, locked cart, or other locked storage receptacle at all times. After Staff A gave Resident #7 medications, Staff A proceeded down the hall with the medication cart to Resident #8's . Resident #8's out of Staff A's sight of the medication . Staff A left the medication open and unlocked. There were four large unlocked totes full of meds in the medication . There was no other staff present in or around the med .

During an interview with Staff B, conducted on at , Staff B verified that the med was unlocked and open upon Staff B's return to the med .

During an interview with the Administrator, conducted on , the Administrator stated that, "the med should always be locked when no one is in there."

During a review of the Facility's Medication Storage Policy and Procedure, conducted on , revealed that, "all meds shall be stored securely and safely in a designated area in accordance with State Regulations.

Class III

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

Based on observation, interview, and record review, the Facility failed to follow prescription medication orders and obtain a Physician's order for a change in directions of use for the medication for one Resident (#5) of three sampled residents who need assistance with self-administration of medication.

Findings Included:

During an observation of the medication pass with Resident #5, conducted on at 11:54am, Staff A gave Resident #5 the prescribed medication Sucralafate 1-gram tablet. The directions for use for Resident #5's Sucralafate stated to take every day before meals.

An interview with Resident #5, conducted on at 11:54am, revealed that Resident #5 had

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already eaten lunch when Staff A gave Resident #5 the prescribed Sucralafate medication. Resident #5 stated that lunch "was very good."

A review of the Facility's Medication Assistance Policy and Procedure, conducted on , revealed that, "all orders are obtained from a licensed Physician before administering medication."
Class III

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

Based on record review and interview the facility failed to provide direct care staff with the required three-hours of in-service training within thirty-days of hire for Activities of Daily Living and Behavioral Needs Training (ADL & BN) for three employees (Staff A, B, and C) of four sampled employees.

Findings Included:

An employee record review for Staff A conducted on revealed that Staff A received one-hour of ADL & BN training on . Staff A had a hire date of .

An employee record review for Staff B conducted on revealed that Staff B received one-hour of ADL & BN training on . Staff B had a hire date of .

An employee record review for Staff C conducted on revealed that Staff C received one-hour of ADL & BN training on . Staff C had a hire date of .

In a staff interview with the Administrator conducted on at 05:00pm, the Administrator acknowledged and confirmed that the ADL & BN training did not include the required three-hour training for Staff A, B, and C.

Class III