STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965402	**09/20/2018**
NAME OF PROVIDER OR SUPPLIER **ATRIA PORT ORANGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1675 DUNLAWTON AVENUE** **PORT ORANGE, FL 32127**	

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

0000 - Initial Comments

On [redacted] a change of ownership (CHOW) survey, in conjunction with a limited nursing services (LNS) monitoring, was conducted at Atria Port Orange (License Number: 9792). Deficient practice was identified during the survey.

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

Based on observations, resident record review, and staff interview, the facility failed to provide assistance with the self-administration of medications in accordance with procedures described in section 429.256, F.S. for 3 of 3 sampled residents observed for medication assistance (Residents # 11, #12 and #13).

The findings included:

An observation and interview was conducted with Employee G at 1:10 pm on [redacted]. She stated she was a Medication Technician, not a nurse. Employee G was at the medication cart in the first floor lobby. She opened the medication observation record (MOR) for Resident # 11 and reviewed it before retrieving and dispensing the following medications into a small cup: 2 Nu-mag ([redacted]) 71.5 milligram (mg) tablets, 1 [redacted] 150 mg, and 1 [redacted] 100 mg tablet. Employee G poured a cup of water, and went to Resident #11's [redacted]. Resident #11 took her pills and swallowed them with the cup of water independently. Employee G did not read the labels in the presence of Resident # 11, or tell her what she was taking.

Record review for Resident #11 revealed an AHCA form 1823, Resident Health Assessment, completed by the Advanced Registered Nurse Practitioner (ARNP) on [redacted]. Section 2B indicated she required assistance with the self-administration of medications. Photographic evidence was obtained.

Employee G returned to the medication cart at 1:16 pm on [redacted]. She reviewed the MOR for Resident #12, retrieved the medication containers, and dispensed the following into a small cup: 2 [redacted] 500 mg tablets and 1 [redacted] 60 mg tablet. She sanitized her hands, poured a glass of water, and went to Resident #12's [redacted]. Without reading the label in the presence of the resident, or telling her what she would receive, Employee G handed Resident #12 the medicine cup and water. Resident #12 took the medications independently.

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Review of Resident #12's AHCA form 1823 dated revealed the examining Physician's Assistant noted she required assistance with the self-administration of medications. Photographic evidence was obtained.

Employee G was observed at 1:23 pm on , preparing medications for Resident #13. After washing her hands, she reviewed the MOR and dispensed the following medications into a cup, signing the MOR after each medication: 1 500 mg and 1 , , capsule. Employee G took the pills and some water to the resident's . Resident #13 took her pills independently once handed to her. Employee G did not tell the resident what she was taking, or read the label in the presence of the resident.

A review of Resident #13's AHCA form 1823 completed by the ARNP found she required assistance with the self-administration of medications. Photographic evidence was obtained.

An interview was conducted with Employee G at 1:40 pm on . She confirmed she neglected to read the labels, or tell Residents #11, #12 and #13 what they were receiving. She acknowledged the requirement to do so when providing assistance with medications.

Class III

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

Based on employee record reviews and staff interview the facility failed to provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training, for three (3) of four employee records reviewed (Employee's B, C, and D). The facility also failed to ensure that one (1) of four employees reviewed (Employee B) received all of the required in-service trainings.

The findings include:

1. An employee record review was conducted for Employee B, Resident Aide, and revealed a hire date of , 2018. A further review of the record revealed she had not received core training or the 2 hour preservice orientation that is required prior to being assigned on the floor for resident care.

An employee record review was conducted for Employee C, Resident Aide, and revealed a hire date of , 2018. A further review of the record revealed she had not received core training or the 2 hour preservice orientation that is required prior to being assigned on the floor for resident care.

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An employee record review was conducted for Employee D, Resident Aide, and revealed a hire date of , 2018. A further review of the record revealed he had not received core training or the 2 hour preservice orientation that is required prior to being assigned on the floor for resident care.

On at 1:17 PM an interview was conducted with the Administrator. He was not aware of the requirement of the 2 hour preservice orientation and was provided a copy of the regulation.

2. An employee record review was conducted for Employee B, Resident Aide, and revealed a hire date of , 2018. A further review revealed that she had not received required training in elopement response.

On at 2:10 PM an interview was conducted with the Administrator and he confirmed that Employee B did not have her elopement response training.

Class III

0082 - Training - / - 58A-5.0191(4) FAC

Based on employee record reviews and staff interviews the facility failed to ensure that one (1) of four (4) employee's reviewed recieved training in ( ) within 30 days of hire (Employee B).

The findings include:

An employee record review was conducted for Employee B, and revealed a hire date of , 2018. A further review revealed that she had not received required training in .

On at 2:10 PM an interview was conducted with the Administrator and he confirmed that Employee B did not have her training as required.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

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Based on employee record reviews and staff interviews the facility failed to ensure that two (2) of four (4) employee's reviewed had a freedom from communicable statement on file (Employee's A and B).

The findings include:

An employee record review was conducted for Employee A, Resident Aide, and revealed a hire date of , , 2018. The file did not contain a statement indicating Employee A has no signs/symptoms of communicable .

An employee record review was conducted for Employee B, Resident Aide, and revealed a hire date of , 2018. The file did not contain a statement indicating Employee A has no signs/symptoms of communicable .

On at 12:48 PM an interview was conducted with the Community Business Director. She confirmed that it was not available in their files.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on facility record review and staff interview, the facility failed to submit a Comprehensive Emergency Management Plan (CEMP) for approval following the change in ownership of the facility.

The findings include:

On at 11:15 AM the Administrator provided the CEMP letter. Upon review of the letter it was for the prior company, with the approval date of .

The provisional license for the facility had an effective date of .

On at 4:08 PM the Administrator confirmed that they had not filed a new CEMP since they had changed ownership.

Class III