STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968586	**10/31/2018**
NAME OF PROVIDER OR SUPPLIER **HARBORCHASE OF VILLAGES CROSSING**	STREET ADDRESS, CITY, STATE, ZIP CODE **13517 NE 86TH CT** **LADY LAKE, FL 32159**	

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

0000 - Initial Comments

On , , an unannounced complaint investigation (CCR #2018015487) survey was conducted at Harborchase of Villages Crossing Assisted Living Facility (license #12467). Deficient practice was identified at the time of survey.

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

Based on record review and interview, the facility failed to ensure 3 of 3 sampled residents (Resident #1, Resident #2, and Resident #4) had a complete Resident Health Assessment (AHCA Form 1823).

Findings:

A record review of Health Assessment (AHCA Form 1823) was conducted for Resident #1, Resident #2, and Resident #4. Page 2 and page 3 under Activities of Daily Living and Self Care Task did not include the required information explaining the extent and type of supervision or assistance needed in the comments column. Page 5 was totally blank for Resident #1, #2, and #4 and did not include any information.

On at 4:00 PM, an interview was conducted with the Executive Director. She confirmed that the Health Assessments (AHCA Form 1823) were incomplete for Resident #1, #2 and #4

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS

Based on observation and interview, the facility failed to ensure 1 sampled resident (Resident #9) was treated with consideration and respect and with due recognition of personal dignity, individuality and the need for privacy.

Findings:

On at 12:00 PM, an observation was made of Resident #9 being wheeled out of his room near the dining room. A strong smell of permeated from his room. His tube was observed sticking out of his shorts between his with yellow and white sediment in the tubing and there was no cover on the bag hanging from the bottom of his wheelchair.

On at 12:20 PM, an interview was conducted with Staff H, LPN. She confirmed that the resident's bag should be covered, especially in a public area such as the dining room.

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On at 2:09 PM, an interview was conducted with the Executive Director. She confirmed that a resident's bag should be covered when in view of the public to provide personal dignity and patient privacy.

Class III

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

Based on observation, interview and record review, the facility failed to ensure 2 of 2 observed staff members (Satff A and Staff B) were qualified to perform their assigned duties consistent with their level of education, training, preparation and experience for 1 of 4 sampled residents (Resident #5).

Findings:

On at 09:50 AM, an observation was made of Resident #5 being provided care by Staff A and Staff B, Care Partners, in the resident's private bathroom. Both Staff A and B had gloves on when surveyor entered the room. Permission granted by the resident for observation. Staff B wiped female resident front to with multiple disposable wipes and dried the resident skin, pulled up the clean brief and the resident's pants. Staff B kept gloves on while touching the resident's clothing, opening the resident's medicine cabinet and touching hair brush, then touching the resident's wheelchair and the faucet handles and handing resident the soap. Staff B then removed gloves and did not wash her . Staff A assisted Staff B in toileting Resident #5 and after removing her gloves, she did not wash or sanitize her .

On at 09:58 AM, an interview was conducted with Staff A. She confirmed she did not remove her gloves after toileting and wiping Resident #9 and before touching the resident's clothes, wheelchair, personal items and faucet handles.

On at 2:09 PM, an interview was conducted with the Executive Director. She confirmed that after residents are assisted with toileting, staff should take off gloves and wash their before they touch anything.

Record review of the facility policy was conducted. The policy reads: "Resident Standards Manual: Guide to Use of Personal Protective Equipment: Disposable gloves/Directions for use: Possible contact with and body during resident care. Personal Protective Equipment: Decontamination and Disposing of PPE (Personal Protective Equipment): You must remove PPE when you complete the task requiring it when you leave the work area or if the PPE becomes contaminated. Other Protective

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Practices: You must also wash your immediately or as soon as possible after removing PPE."

Class III

E207 - ECC - Services - 58A-5.030(8) FAC

Based on record review and interview, the facility failed to ensure nursing staff providing ECC (Extended Congregate Care) services provided nursing service permitted within the scope of their license to Resident #9.

Findings:

A record review was conducted for Resident #9, who was on ECC (Extended Congregate Care) services starting from . Monthly ECC assessment was signed by Staff H, LPN (Licensed Practical Nurse).

On at 4:00 PM, an interview was conducted with the Director of Resident Services. She confirmed that Staff H, LPN had completed and signed the monthly nursing assessment dated required for Resident #9. She also confirmed that it was not in the scope of practice for an LPN to perform an assessment and that the ECC assessments were required to be performed by a Registered Nurse.

Class III