STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911336	**11/26/2018**
NAME OF PROVIDER OR SUPPLIER **KIMBERLY PLACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **26315 NORTHERN CROSS ROAD** **PUNTA GORDA, FL 33983**	

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

0000 - Initial Comments

An unannounced relicensure survey was conducted on at Kimberly Place, an assisted living facility (license #7594) in Punta Gorda, Florida.

The following is description of the deficiencies.

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

Based on record review and staff interview, the facility failed to ensure residents admitted to the facility were examined by a health care provider and deemed appropriate for admission to an assisted living facility. Failed to review the health assessment form for accuracy for 2 (Residents #2 and #8) of 2 records reviewed.

The findings included:

Resident #2's file contained a Health Assessment Form 1823 (1823). The 1823 was not dated. The 1823 did not indicate what type of assistance was needed for medications.

Resident #8's file contained an 1823 dated . The 1823 indicated Resident #8 needed 24 hour nursing or , , care and that Resident #8 poses a danger to self or others.

On at 1:30 p.m., the Administrator said she had not noticed Resident #2's 1823 did not contain a date or what type of assistance was needed for medications. The Administrator also admitted an assisted living facility can not provide 24 hour nursing or , , care.

Class III

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

Based on staff interview and record review, the facility failed to ensure a staff member licensed to administer medications was available to administer medications in accordance with a health care provider's order for 3 (Resident #4, #7 and #8) receiving .

The findings included:

On at 10:14 a.m., Staff A said the facility had residents who receive . Staff A said she

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checks their and gives them their injection. Staff A said Residents #4, #7, and #8 received throughout the day. Staff A said she actually injects the shot into the patient herself. Staff A said she is trained as a medication technician.

On at 1:02 p.m., Staff B said there were residents receiving at the facility. When Staff B was asked if she actually gives the shot she stated, "I will assist them, well technically maybe, yes I may have given the shot." Staff B said she is trained as a medication technician.

A review of the Medication Observation Records for Residents #4, #7, and #8 show administrations signed for by Staff A and Staff B. On at 11:35 a.m., Staff A admits the signatures are hers and Staff B's.

On at 1:30 p.m., the Administrator admitted at times the staff gives the shot directly and explained at times the residents have difficulty administering the shot to themselves. The Administrator admitted she knew this was not in the scope of practice for a medication tech and would contact the doctor to have nursing visits established.

Class III

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

Based on observation, record review, and staff interview, the facility failed to ensure any change in directions for use of a medication must be accompanied by a written medication order signed by the residents health care provider and place an alert label directing staff to examine the revised directions for use in the Medication Observation Record (MOR) for 1 (Resident #2) of 2 medication observations.

The findings included:

On at 11:06 a.m., Staff A was observed assisting Resident #2 with medications. The medication label and MOR read: 25 mg 1 tablet by every 8 hours for . The MOR indicated administration times at 7 a.m., 3 p.m., and 7 p.m. Staff A said she had given this med at 7 a.m., and was giving this again at 11 a.m., as the order was supposed to be changed to with meals.

Review of Resident #2's chart revealed no order changing the administration instructions.

On at 1:30 p.m., the Administrator agreed the MOR and medication labels did not reflect a change in order, nor was there an order for the time change.

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Class III

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

Based on record review and staff interview, the facility failed to ensure all facility employees complete an education course on ( ) within 30 days of employment for 2 (Staff A and B) of 3 employee files reviewed.

The findings included:

Staff A was hired as a caregiver on . Staff A's employee file revealed no documentation of completion of an education course.

Staff B was hired as a caregiver on . Staff B's employee file revealed no documentation of completion of an education course.

On at 1:30 p.m.,m, the Administrator said she hadn't realized they didn't have the training and will ensure they do.

Class III

0092 - Food Service - General Responsibilities - 58A-5.020(1) FAC

Based on observation and staff interview, the facility failed to ensure staff performed duties related to assistance with feeding and dining in a safe and sanitary manner for 1 (Staff A) of 2 staff observed.

The findings included:

On at 11 a.m., Staff A was observed wearing gloves in the dining room. With these gloved Staff A was observed to touch a resident and touch her cell phone. With the same gloved Staff A was observed getting a container of thickener, opening it and placing her inside the container to scoop out a portion and placing the thickener in Resident #2's water glass. At no time did Staff A change her gloves. She then went in the kitchen and removed gloves.

On at 11:14 a.m., Staff A was observed assisting Resident #2 with feeding. Staff A's were gloved. Staff A was observed preparing Resident #2's sandwich at the table. Staff A was observed placing her gloved thumb directly on the lettuce she was putting on Resident #2's sandwich. Staff A was

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observed picking up the sandwich with same gloved and bringing it to Resident #2's . During this time, Staff A was observed touching her thighs, touching her chair, scratching her , adjusting her shirt and touching Resident #2's cell phones on the table and then return to picking up the sandwich with same gloved to feed Resident #2. At no time did Staff A remove or change her gloves.

On at 1:30 p.m., the Administrator said she had also observed Staff A touching the phones and would follow up on this.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation and staff interview, the facility failed to maintain 48 hours of onsite fuel to operate the generator in an emergency situation as required by state regulation for a facility with licensed capacity of 16 beds or less.

The findings included:

The facility maintains a portable generator onsite for power during an emergency. No fuel was available onsite to operate the generator.

On at 1:30 p.m., the Administrator said there are two gas stations nearby and they had planned on using these for fuel when needed. The Administrator reviewed the regulations and agreed they specify that a facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite.

Class III