

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967699	(X3) DATE SURVEY COMPLETED C 11/05/2018
NAME OF PROVIDER OR SUPPLIER GRANDE, LLC (THE)	STREET ADDRESS, CITY, STATE, ZIP CODE 725 DESOTO AVENUE BROOKSVILLE, FL 34601	

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

0000 - Initial Comments

On , an unannounced complaint investigation survey (CCR #2018016132 and CCR #2018016382) was conducted at The Grande Assisted Living Facility (License #11732). Deficient practice was identified at the time of the survey.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28() FS 429.27

Based on observation, interview and record review, the facility failed to honor resident rights, specifically access to adequate and appropriate health care consistent with established and recognized standards within the community related to control for 2 of 12 sampled residents (Resident #2 and Resident #3).

Findings:

1. On at 7:50 AM, Staff A, RCA (Resident Care Assistant) was observed to assist Resident #2 with ADL (Activities of Daily Living) care. Staff A was observed to assist Resident #2 to pull up her pants. Staff A was observed to leave the room and enter the dining room. As Staff A passed the nursing station, she stopped and put keys away. In the dining room, Staff A touched Resident #4 and Resident #3's wheelchairs. Staff A then picked up Resident #3's coffee cup, dumped it out and got more coffee from the coffee pot. Staff A then applied gloves and began to get breakfast plates out of the cart. At no time was she observed to wash her .

On at 1:33 PM, an interview was conducted with Staff A. She confirmed that she did not wash her during the observation of care with Resident #2 at 7:50 AM this morning. She stated she watched a video on washing when she started working here and had not had any other training. She stated the training taught her when she should wash her .

2. On at 9:45 AM, Staff A, RCA (Resident Care Assistant) was observed providing assistance to Resident #3 with toileting. She told the resident she was pulling her pants up. Then she told the resident to turn and sit in her wheelchair. Staff A came out of the bathroom with a pair of pants and placed them on the floor (hamper in laundry room). She went into the bathroom and pushed Resident #3 in her wheelchair out of the bathroom. At no time did the water run in the sink. The resident was not assisted to wash her . Staff A did not wash her , pushed the resident in her wheelchair to the dining room, and picked up a clean cup from the table and offered a cup of coffee to the resident. The coffee was poured by a co-worker, then the cup was handed to Staff A, who passed the cup to the resident. Staff A left the dining room. Staff A was followed into another resident's

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

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FORM APPROVED

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room to provide care. On at 9:55 AM, an interview was conducted with Staff A, who was asked when she washed her last, she stated when she came from break. She confirmed she did not wash her following care with Resident #3. She confirmed that she assisted Resident #3 to go to the restroom, then to dining room and gave resident a cup of coffee, then went to another resident's room to provide care without washing her between residents or tasks. A review of the facility policy entitled Control, Revised , reads under the section "Washing Guidelines": "Staff should use effective washing immediately and thoroughly in the following situations : after any contact with or other potentially or materials, after contact with items that may have been contaminated by or other , after removing personal protective equipment (gloves), before assisting a resident with a task that may involve contact with or (care), and before handling items in the food preparation and handling area." Class III		