STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953381	**03/01/2019**
NAME OF PROVIDER OR SUPPLIER **ARLINGTON GARDENS, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **7550 60TH WAY NORTH** **PINELLAS PARK, FL 33781**	

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

0000 - Initial Comments

Assisted Living Facility

A Complaint Survey (CCR#: 2019002680 and 2019002667) was conducted at Arlington Gardens Assisted Living Facility on . Arlington Gardens Assisted Living Facility had deficient practice identified at the time of the survey.

(License#: 5299)

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review and interview, the Facility failed to ensure the appropriateness of residency for one Resident (#12) of one residents sampled who did not meet admissions criteria.

Findings Included:

During an interview with the Facility Manager, conducted on at 10:15am, the Facility Manager stated that the Facility only employed unlicensed Medication Technicians to assist residents with self-administration of medication.

A record review for Resident #12, conducted on , revealed that Resident #12's Health Assessment Form dated stated that the the resident required medication administration. Resident #12's Medication Observation Records had medications given to the resident signed by unlicensed Medication Technicians.

During an interview with the Administrator, conducted on at 03:35pm, the Administrator acknowledged and confirmed that Resident #12 was inappropriate for admissions in to the Facility, as the resident did not meet admissions criteria according to Resident #12's Health Assessment Form and need for medication administration. The Facility did not employ or contract with a licensed Nurse to provide medication administration to Resident #12.

Class III

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

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Based on observation and interview, the Facility failed to provide medication assistance according to the requirements of statute and rule to four Residents (#1, #2, #3, and #4) of four sampled resident that required assistance with self-administration of medications.

Findings Included:

A medication pass observation with Staff A for Residents #1, #2, #3, and #4, conducted on , revealed the following:
At 11:50am, Staff A gave Resident #1 the medication , 1mg and Tears without comparing the medication labels to the resident Medication Observation Records (MORs).
- At 12:00pm, Staff A pulled Resident #2's medication card out of the medication drawer and popped pills in to a plastic medication cup and placed the medication card in the medication drawer and handed the medication to the resident. Staff A did not open the medication card to ensure that it was the correct medication card for the correct resident. Staff A did not compare the medication label to Resident #2's MORs. Staff A did not open the medication card up to ensure that the correct pills at the correct time were given to Resident #2.
- At 12:05pm, Staff A pulled Resident #3's medication card out of the medication drawer and popped pills in to a plastic medication cup and placed the medication card in the medication drawer and handed the medication to the resident. Staff A did not open the medication card to ensure that it was the correct medication card for the correct resident. Staff A did not compare the medication label to Resident #3's MORs. Staff A did not open the medication card up to ensure that the correct pills at the correct time were given to Resident #3.
- At 12:10pm, Staff A pulled Resident 4's medication card out of the medication drawer and popped pills in to a plastic medication cup and placed the medication card in the medication drawer and handed the medication to the resident. Staff A did not open the medication card to ensure that it was the correct medication card for the correct resident. Staff A did not compare the medication label to Resident #4's MORs. Staff did not open the medication card up to ensure that the correct pills at the correct time were given to Resident #4.

During an interview with Staff A, conducted on at 12:15pm, Staff A stated that the staff does not open the medication cards up because the staff knows "what the meds are" and "I've been doing it a long time".

During an interview Facility Manager, conducted on at 03:35pm, the Facility Manager stated that the Facility's expectation for Medication Technicians was to "to read and look at medication labels and read the labels to the resident and to wash their before and after medication pass and sanitize their between residents". The Facility Manager stated that it was "inappropriate to not

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open the medication card all the way".

Class III

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

Based on observation, record review, and interview, the Facility failed to provide prescribed medications as ordered to three Residents (#1, #5, and, #9) of five sampled residents that required assistance with self-administration of medication.

Findings Included:

During an observation of the medication pass with Staff A for Resident #1, conducted on , revealed that the Facility did not provide the resident with the prescribed medication , 1mg as ordered by the resident's Health Care Provider (HCP). Resident #1's was prescribed to take one tablet twice every day as needed for , or agitation. Resident #1's Count Sheet for had this medication signed as given to the resident three times at 12:16pm, 04:21pm, and 08:44pm.

A record review for Resident #1, conducted on , revealed that Resident #1's Health Assessment Form stated that the resident required assistance with self-administration of medications. There were no orders from Resident #1's HCP for the Facility to give an additional dose of , to the resident. There were no documented notifications to Resident #1's HCP or Responsible Party that the resident received additional , on .

A record review for Resident #5, conducted on , revealed that Resident #5's Health Assessment Form dated stated that the resident required assistance with self-administration of medications. Resident #5's , MORs had prescribed medications circled as not given to the resident on and due to "out of Facility". There were no orders by Resident #5's HCP to hold Resident #5's medications on and . There were no documented notifications to Resident #5's HCP or Responsible Party that the resident did not received prescribed medications on and .

A record review for Resident #9, conducted on , revealed that Resident #9's undated Health Assessment Form stated that the resident required assistance with self-administration of medication. Resident #9's , Medication Observation Records (MORs) had medications circled as not given to the resident on at 08:42pm due to "not at Facility yet". There were no orders by a HCP

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to hold Resident #9's medications on . There were no documented notifications to Resident #9's HCP or Responsible Party that the resident did not receive prescribed medications on .

A review of the Facility's Resident Sign-in and Sign-out Log, conducted on , revealed that Resident #5 did not sign-out when the resident left the Facility on and (See Photographic Evidence5).

A review of the Facility's Sign-in and Sign-out Policy and Procedure, conducted on , revealed that the Facility required residents to sign-in and sign-out when leaving the Facility "to assure resident's safety [and that] the resident will not miss their medications".

During an interview with the Facility Manager, conducted on at 03:35pm, the Facility verified that Resident #5 did not sign-in and out of the Facility appropriately. The Facility Manager stated that Resident #5 went out of the Facility "every day to go shopping or to lunch or where ever". The Facility Manager acknowledged and confirmed that Resident #1 was given an additional dose of on . The Facility Manager acknowledged and confirmed that Resident #9 was not given medication on the day of arrival .

Class III

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on record review and interview, the facility failed to maintain the compliance attestation for 4 (Staff A, Staff C, Staff D and Staff E) of 4 employee records reviewed.

Findings Included:

Employee record review conducted on revealed Staff A with a date of hire of and there was no compliance attestation in the employee record.

Employee record review conducted on revealed Staff C with a date of hire of and there was no compliance attestation in the employee record.

Employee record review conducted on revealed Staff D with a date of hire of and there was no compliance attestation in the employee record.

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Employee record review conducted on [redacted] revealed Staff E with a date of hire of 11/6/2018 and there was no compliance attestation in the employee record.

Interview conducted on at 2:02[m with the Facility Manager confirmed there were no compliance attestation in Staff A, Staff C, Staff D or Staff E employee records.

Unclassified