STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965303	R 04/24/2019
NAME OF PROVIDER OR SUPPLIER **ALBINA MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **820 15 TH STREET N.** **SAINT PETERSBURG, FL 33705**	

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

0000 - Initial Comments

Assisted Living

A revisit to a Complaint Survey (CCR#: 2019001935) was conducted at Albina Manor Assisted Living Facility on . Deficiencies were identified at the time of survey.

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

Based on observation and interview, the Facility failed to ensure assistance with self-administration of medications was provided according to the required steps in 429.256 Florida Statutes for two Residents (#1 and #5) of two sampled residents. In addition, the Facility failed to assist with medications following safe practice in control for two Residents (#1 and #5) of two sampled residents.

Findings Included:

During an observation of the medication (med) pass with Staff A for Resident #1, conducted on at 11:56am, Staff A was observed popping Resident #1's pills out of the resident's pill pack, crushing the resident's meds, and mixing the resident's meds in applesauce while at the med cart. Resident #1 was sitting approximately behind Staff A. Staff A walked over to Resident#1 with the med/applesauce mixture and stated "here" while gathering the med/applesauce mixture onto a spoon and then inserting the mixture into Resident #1's . Staff A did not identify Resident #1. Staff A did not read Resident #1's med labels to the resident.

Staff A did not sanitize or wash their before prepping meds for Resident #5. At 12:17pm, Staff was observed at the med cart popping Resident #5's pills out of the resident's pill packs in to a plastic med cup. Staff A turned toward Resident #5 and handed the resident the med cup of pills. Staff A did not identify Resident #5. Staff A did not read Resident #5's med labels to the resident. Staff A walked away from Resident #5 before the resident took the meds. Staff A did not sanitize or wash the staff's before prepping the next resident's meds. Staff A did not speak to or interact with Resident #5.

During an interview with Staff A, conducted on at 12:30pm, Staff A stated that, "no, I am not a nurse, I am a Med Tech (Medication Technician)".

During an interview with the Designee in charge, conducted on at 02:00pm, the Designee in charge confirmed that Staff A should have identified each resident during the med pass. The Designee in charge agreed that the description provided of Staff A giving Resident #1 the medication in

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applesauce"sounds like med administration".

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, record review, and interview, the Facility failed to maintain Medication Observation Records (MORs) that contained all required data and failed to update the MORs each time medication was offered to four Residents (#2, #3, #4, and #6) of four sampled residents that required assistance with self-administration of medications.

Finding Included:

During an observation of Staff A, conducted on at 11:56am, Staff A was observed going through each resident's MORs signing page after page. When questioned, Staff A stated that she was signing residents' eight am meds (medications) [and] "I didn't have time to sign them [as] I was the only one here and didn't have time".

A review of Resident #2's , MORs, conducted on , revealed that Resident #2's MORs did not include the resident's Health Care Provider's name and telephone number as required. There was no documentation that Resident #2 received the resident's prescribed medication C 500mg on at 08:00am.

A review of Resident #3's , MORs, conducted on , revealed that Resident #3's MORs did not include the resident's Health Care Provider's name and telephone number as required. There was no documentation that Resident #2 received the resident's prescribed medications:
- 40mg tablets was not documented as given on at 08:00pm
- 5mg was not documented as given on at 8pm
- 300mg was not documented as given on at 05:00pm and 08:00pm

A review of Resident #4's , MORs, conducted on , revealed that Resident #4's MORs did not include the resident's Health Care Provider's name and telephone number as required. There was no documentation that Resident #4 received the resident's prescribed medication 3mg on and at 08:00pm.

A review of Resident #6's , MORs, conducted on , revealed that Resident #6's MORs did not include the resident's Health Care Provider's name and telephone number and as

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required.

During an interview with the Designee in charge, conducted on at 02:00pm, the Designee in charge confirmed that Residents #2, #3, #4, and #6's MORs did not include the residents' Health Care Provider's name and telephone number as required. The Designee in charge confirmed that Resident #6's MORs did not include the resident's as required. The Designee confirmed that Residents #2, #3, and #4's MORs were not immediately updated each time a medication was offered to the residents.

Class III