| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11967611** | **03/12/2019** |
| NAME OF PROVIDER OR SUPPLIER<br>**FARRINGTON HOUSE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**1970 FARRINGTON DRIVE**<br>**MERRITT ISLAND, FL 32952** | |

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

**0000 - Initial Comments**

The re-licensure survey with Extended Congregate Care (ECC) was conducted on . Farrington House Assisted Living Facility, license #11613, had deficiencies at the time of the survey.

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

Based on record reviews and interview, the facility failed to ensure an 1823 health assessment form was completed for 1 of 2 sampled residents (#5).

Findings:

Resident #5's record revealed a facility admission date of . A current 1823, dated , did not contain the resident's and and page 5 was incomplete. The record did not contain documentation to indicate the facility contacted a health care provider to obtain the omitted information.

At 12:50 p.m. the administrator confirmed the findings.

Photographic evidence obtained.

Class III

**0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC**

Based on observations, record reviews, and interview, the facility failed to follow a health care provider's order for 2 of 2 sampled residents (#1 and #5).

Findings:

1. Resident #5's record revealed a facility admission date of . A current 1823, dated , indicated that she required assistance with self-administered medications and her prescribed diet was puree. Her diagnoses included .

Observations made during the lunch meal at 12:15 p.m. revealed resident #5 was served a regular consistency meal.

At 12:29 p.m. the administrator confirmed the findings, said she did not know the diet ordered was

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SUMMARY STATEMENT OF DEFICIENCIES
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puree, and said the resident had never been served a pureed meal since her admission.

On , a provider ordered Roxanol 20 mg/ml prefilled syringe, give 0.25 ml by or every four hours around the clock however, it was scheduled on her Medication Observation Record (MOR) to be given at 6 a.m., 10 a.m., 2 p.m., 6 p.m., and 10 p.m. A dose was not scheduled to be given at 2 a.m., which would have covered every four hours around the clock.

At 12:50 p.m. the administrator confirmed the findings.

2. Resident #1's record revealed a facility admission date of . A current 1823 health assessment form, dated , indicated that she required assistance with self-administered medications. Her diagnoses included .

On , a health care provider ordered 50 mg tablet, give 1 tablet by at bedtime however, it was scheduled on her MOR to be given daily at 8 a.m.

Additionally, both her and were ordered to be given at bedtime and were scheduled to be given at 8 p.m.

At 1:29 p.m. the administrator confirmed the findings.

Photographic evidence obtained.

Class III

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

Based on observations, record reviews and interview, the facility failed to ensure the unlicensed caregiver (E) who assisted a resident (#1) with self-administered medications followed the correct procedures.

Findings:

Observations made during a medication pass for resident #1 on at 9:15 a.m. revealed the resident was sitting at the dining room table. Unlicensed caregiver E removed a basket of medication packages from a locked kitchen cabinet and took them, along with the Medication Observation Record (MOR,) to the resident. She said the name of each medication aloud, popped each one into her gloved

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, then she placed the med into a cup. At the conclusion of popping out each medication, she poured them all onto a napkin and prompted the resident to take them. The resident took them without assistance. The caregiver observed her take the meds then she signed the MOR.

Caregiver E did not read the prescription label aloud, as required.

On at 9:30 a.m. the caregiver confirmed the findings.

Class III

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

Based on personnel record reviews and interview, the facility failed to ensure the personnel record for 1 of 6 sampled staff (administrator) contained documented evidence of a negative ( ) exam on an annual basis.

Findings:

The administrator was hired on . Her personnel record contained documentation of a negative exam, dated . The record did not contain documented evidence of a negative exam for 2019.

On at 2:32 p.m. the administrator said she did not have a exam since .

Class III

**0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS**

Based on observations, personnel record reviews, and interview, the facility failed to ensure 1 of 4 unlicensed staff (E) who assisted with self-administered medications completed the initial training.

Findings:

Observations made on at 9:15 a.m. revealed unlicensed caregiver E assisted resident #1 with medications.

Caregiver E was hired on . Her record did not contain documented evidence to indicate she received the initial 4-hour training on assistance with self-administration of medication in an assisted

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living facility, as required.

At 3:10 p.m. the administrator confirmed the findings.

Class III

**0085 - Training - Nutrition & Food Service - 58A-5.0191(7) FAC**

Based on personnel record reviews and interview, the facility failed to ensure the person designated as responsible for the facility's food service and day-to-day supervision of food service staff (administrator) obtained a minimum of 2 hours continuing education annually in topics pertinent to nutrition and food service in an assisted living facility.

Findings:

On at 2:30 p.m. the administrator identified herself as the person responsible for the facility's food service. Her personnel record contained a certificate of training, dated , for 2 hours of training on nutrition and food service. The record did not contain documented evidence to indicate she received the required training in 2019.

At 2:40 p.m. the administrator confirmed the finding and said she did not have the training in 2019.

Class III

**0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC**

Based on personnel record reviews and interview, the facility failed to ensure certificates of training contained the required information for 1 of 5 sampled staff (F).

Findings:

Caregiver F was hired on . Her certificate of training for nutrition and safe food handling did not contain the provider of the training's name and dated signature, as required.

At 2:45 a.m. the administrator confirmed the finding.

Class

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SUMMARY STATEMENT OF DEFICIENCIES
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**0160 - Records - Facility - 58A-5.024(1) FAC**

Based on facility record reviews and interview, the facility failed to maintain an up-to-date admission and discharge log listing the names of all residents.

Findings:

The facility's resident census was 5.

On . . . at 9:30 a.m. a request was made to review the facility's admission and discharge log. The log listed only four current residents.

The administrator confirmed the finding and said resident #5 was not listed because she forgot to add her.

Class

**0162 - Records - Resident - 58A-5.024(3) FAC**

Based on record reviews and interview, the facility failed to obtain a written informed consent for 1 of 2 sampled residents (#5) or the resident's surrogate, guardian, or attorney-in-fact allowing unlicensed staff to provide assistance with self-administration of medication.

Findings:

The facility's unlicensed staff assisted with self-administration of medications.

Resident #5's current 1823 health assessment form, dated . . , indicated that she required assistance with self-administered medications.

Her record nor her contract contained a written informed consent allowing the unlicensed staff to assist with medications, as required.

At 12:50 p.m. the administrator confirmed the findings.

Class

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**0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS**

Based on record reviews and interview, the facility failed to ensure 2 of 2 sampled residency agreements (#1 and #5) contained all of the required information.

Findings:

Resident #1's residency agreement was dated .

Resident #5's residency agreement was dated .

Neither agreement contained a provision that if after a contract is terminated, the facility intends to make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond.

At 12:50 p.m. the administrator confirmed the findings.

Class

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

Based on personnel record reviews and interview, the facility failed to ensure the personnel record for 1 of 5 sampled staff (F) contained an Attestation of Compliance with Background Screening Requirements.

Findings:

Caregiver F was hired on . Her personnel record did not contain an attestation of compliance with background screening requirements, as required.

At 2:58 p.m. the administrator confirmed the finding.

Unclassified