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	AL11910002	**05/28/2019**
NAME OF PROVIDER OR SUPPLIER **AGUILA ADULT CARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **503 N. MATANZAS** **TAMPA, FL 33609**	

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

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, the Facility failed to maintain an up-to-date Background Screening (BGS) Employee Roster for one former employee (Staff D) of two sampled Former employees.

Findings Included:

A record review for Staff D, conducted on , revealed Staff D had a date of hire of and a termination date of .

A review of the Facility's BGS Employee Roster, conducted on , revealed that Staff D did not have a date of termination added to the Facility's BGS Employee Roster.

During an interview with Administrator, conducted on , the Administrator agreed that there was no termination date for Staff D on the Facility's BGS Employee Roster.
Unclassified

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 ensure that an Attestation of Compliance was signed and included in employee records for four employees (Administrator and Staff A, B, and C) of four sampled employee records.

Findings Included:

An employee record review for Staff A, conducted on , revealed that Staff' A's record did not include a signed Attestation of Compliance accompanying the employee's background screening (BGS) eligibility dated . Staff A's date of hire was on .

An employee record review for Staff B, conducted on , revealed that Staff B's record did not include a signed Attestation of Compliance accompanying the employee's BGS eligibility dated . Staff B's date of hire was on .

An employee record review for Staff C, conducted on , revealed that Staff C's record did not include a signed Attestation of Compliance accompanying the employee's BGS eligibility dated . Staff C's date of hire was on .

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An employee record review for the Administrator, conducted on . . . . . , revealed that the Administrator's record did not include a signed Attestation of Compliance accompanying the employee's BGS eligibility dated . . . . . . The Administrator's date of hire was on . . . . . .

During an interview with the Administrator, conducted on . . . . . at 12:50pm, the Administrator confirmed that the Administrator and Staff A, B, and C's employee records did not include a signed Attestation of Compliance.
Unclassified

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0000 - Initial Comments

Assisted Living

A Complaint Investigation (Complaint Number: 2019003543) was conducted at Aguila Adult Care Center 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 proper assistance with self-administration of medications according to the required steps in 429.256 Florida Statutes. In addition, the Facility failed to assist with medications according to safe practice in control for three Residents (#2, #3, and #4) of three sampled residents.

Findings Included:

During an observation of the medication pass with the Administrator for Resident #2, conducted on at 06:55am, the Administrator did not wash or sanitize before or after assisting Resident #2 with medications.

During an observation of the medication pass with the Administrator for Resident #4, conducted on at 07:05am, the Administrator did not wash or sanitize before, during, or after assisting Resident #4 with medications. When the Administrator assisted Resident #4 with the resident's prescribed , 50mcg, the Administrator picked the pill up out to the bottle cap with own and handed the pill to the resident. When the Administrator assisted Resident #4 with the resident's prescribed 100mg, the Administrator picked up the pill with own and place the pill in the bottle. When the Administrator assisted Resident #4 with the prescribed , , 1%, 0. .5%, and , 1%, the Administrator did not wear glove and the Administrator did not wash in between , . The Administrator did not wait a recommended five minutes between different types of , , and instead administered the , one right after the other.

During an observation of the medication pass with the Administrator for Resident #3, conducted on at 07:10am, the Administrator did not wash or sanitize before or after assisting Resident #3 with medications. When the Administrator assisted Resident #3 with the resident's prescribed medications , 400mg and D-3 25mcg (1000 IU), the Administrator picked the pill up out of the bottle caps (separately) with own and handed to the pills to Resident #3 to take. When

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the Administrator assisted Resident #3 with the resident's prescribed medication, the Administrator dropped the pill on the floor and picked it up with bear and after disposing of the pill in the trash receptacle, the Administrator continued with the medication pass without washing or sanitizing .

A review of .org, conducted on , revealed that when administering "more than one drop or more than one type of , wait five minutes before putting the next drop in. This will keep the first drop from being washed out by the second" .

A record review for the Administrator, conducted on , revealed that the Administrator had a two-hour updated Medication Technician Training dated . The Administrator did not have a six-hour Medication Technician Training as required.

During an interview with the Administrator, conducted on , the Administrator agreed that the Administrator did not wash or sanitize at all during the medication pass and did not wear gloves while instilling , for Resident #4. The Administrator agreed that the Administrator touched medications with contaminated and gave the pills to the resident to take and place one pill in the bottle. The Administrator agreed that the Administrator did not wait five minutes between different types of , , .
Class III

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

Based on record review and interview, the Facility failed to maintain Medication Observation Records with any known for two Residents (#5 and #7) of two sampled residents.

Findings Included:

Based on a review of the Medication Observation Records, conducted on , revealed that there were no in-house residents that had their known noted on any Medication Observation Record.

A record review for Resident #5, conducted on , revealed that Resident #5's Health Assessment Form dated stated that the resident was to .

A record review for Resident #7, conducted on , revealed that Resident #7's Health Assessment Form dated stated that the resident was to .

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During an interview with the Administrator, conducted on at 12:50pm, the Administrator agreed that there were no Medication Observation Records, which included resident .
Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the Facility failed to dispose of contaminated medications in a safe manner.

Findings Included:

During an observation of the medication pass with the Administrator for Resident #3, conducted on at 07:10am, the Administrator dropped Resident #3's prescribed on the floor. The Administrator picked the pill up off of the floor and disposed of it in the regular trash receptacle.

During an interview with the Administrator, conducted on at 12:50pm, the Administrator stated that the pill was placed "in the regular trash receptacle'. The Administrator was unable to provide a policy and procedure for medication disposal.
Class III

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

Based on observation, record review, and interview, the Facility failed to follow Health Care Provider's medication orders and failed to obtain a clarification of medication orders for three Residents (#3, #4, and #5) of four sampled residents that required assistance with self-administration of medications.

Findings Included:

During an interview with the Administrator, conducted on at 06:20am, the Administrator stated that Resident #5 was an dependent and that the resident's "family comes in to give [it] in the evening".

A record review for Resident #5, conducted on , revealed that Resident #5 had Regular per ordered. There was no frequency noted on the order describing how often this should be performed.

During an observation of the medication pass with the Administrator for Resident #4, conducted on at 07:05am, the Administrator did not provide Resident #4 with the resident's prescribed

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medication 100mg one-half tablets because the tablet was not scored. The Administrator gave Resident #4 two tablets of 500mg and the directions of used stated "take one tablet every day".

During an observation of the medication pass with the Administrator for Resident #3, conducted on at 07:10am, the Administrator gave Resident #3's the resident's prescribed medication 100mg. The directions of use for Resident #3's stated "take one capsule at bedtime". Resident #3's Medication Observation Records had the resident's scheduled at 08:00pm.

During an interview with the Administrator, conducted on at 06:20am, the Administrator stated that Resident #5 was an dependent and that the resident's "family comes in to give [it] in the evening". At 07:05am, the Administrator stated that staff "just giving it" to Resident #4. At 12:50pm, the Administrator stated that the Administrator went and gave Resident #4 the resident's prescribed medication. When asked if the Administrator gave a whole pill to the resident, the Administrator stated "no, I scored it [and] they just been giving here the whole pill I guess". The Administrator agreed that Resident #5's directions for used did not include how often. The Administrator agreed that Resident #3's was due at bedtime.
Class III

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

Based on record review and interview, the Facility failed to obtain evidence of a negative examination from a health care provider was documented on an annual basis for two employees (Administrator and Staff A) of four sampled staff.

Findings Included:

A record review for the Administrator, conducted on , revealed that the Administrator's record did not include annual evidence that the Administrator was free from signs and symptoms of from a Health Care Provider.

A record review for Staff A, conducted on , revealed that Staff A's record did not include annual evidence that Staff A was free from signs and symptoms of from a Health Care Provider

During an interview with the Administrator, conducted on at 12:50pm, the Administrator confirmed that neither the Administrator nor Staff A's employee record contained evidence that the Administrator and Staff A were free from signs and symptoms of from a Health Care

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Provider.
Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on a observation, record review and interview, the Facility failed to maintain written work schedules and staff time sheets for the most current six months as required by Rule 58A-5.019, Florida Administrative Code. Additionally, the Facility failed to comply with staff training requirements for one employee (Staff B) of three sampled employees.

Findings Included:

During observations, conducted throughout survey on [redacted], Staff B observed assisting residents and performing work duties and at no time observed in any kind of training class.

A record review for Staff B, conducted on [redacted], Staff B did not have the required Pre-service In-service Training, Resident Rights and Recognizing [redacted], Neglect, and [redacted] Training in the staff's employee record.

During a request of the Administrator for the most current six months of staff work schedules and staff time sheets, conducted on [redacted] at 06:12am, the Administrator stated that, "we don't keep the schedule" and "I don't keep them (referring to staff times sheets)". A staffing schedule from [redacted] through [redacted] only, provided and no time cards provided. During a later request for the missing training certificates from Staff B's record, the Administrator handed over the certificates with a completion date of [redacted] (the day of survey).

During an interview with the Administrator, conducted on [redacted] at 12:50pm, the Administrator stated that, "no staff schedules than the current schedule and time cards are not kept".
Class III

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

Based on record review and interview, the Facility failed to maintain Hospice admission document and failed to obtain a new -to- Health Assessments documented on the Agency for Health Care Administration's Form 1823 (1823) when three Residents (#6, #9, and #10) of three sampled residents that had a significant change in condition necessitating their admissions into Hospice services.

Findings Included:

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A record review for Resident #6, conducted on , revealed that Resident #6 was admitted into Hospice services on . Resident #6 had an 1823 dated , which did not include the required nursing services of Hospice on page one. Resident #6 was admitted into the Facility on .

A record review for Resident #9, conducted on , revealed that Resident #9 was admitted into Hospice services but had no admission paperwork from Hospice and was unable to determine exact Hospice admission date. Resident #9 had an 1823 dated , which did not include the required nursing services of Hospice on page one. Resident #9 was admitted into the Facility on .

A record review for Resident #10, conducted on , revealed that Resident #10 was admitted into Hospice services but had no admission paperwork from Hospice and was unable to determine exact Hospice admission date. Resident #10 had an 1823 dated , which did not include the required nursing services of Hospice on page one. Resident #9 was admitted into the Facility on .

During an interview with the Administrator, conducted on at 12:50pm, the Administrator stated that "I did not know that we were supposed to get a new 1823 when a resident is placed on Hospice".
Class III