Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969489	A. BUILDING: _____ B. WING _____	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASCAPE AT NAPLES LLC	3490 DR NAPLES, FL 34109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced change of ownership (CHOW), extended congregate care, emergency power plan monitoring, and health facility reporting system survey was conducted at Seascape at Naples, LLC on through . Deficiencies were identified at the time of survey. .	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal	A 025		

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A 025	Continued From page 1 supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review, and interviews, the facility failed to provide adequate supervision to prevent resident to resident altercation for 2 (Resident #12, #13) of 2 residents reviewed. Failure to properly supervise resulted in Resident #12 being bitten and thrown on the floor by Resident #13. Resulting in Resident #12 needing to be transferred and treated at an acute care facility due to the incident. The findings included:	A 025		

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A 025	Continued From page 2 Record review showed that on around 6:30 a.m. Resident #12 and #13 were walking in the common area. Resident #13 bit Resident #12 and threw her on the floor. Review of Video surveillance of the incident confirmed that both Resident #12 and # 13 were walking in the memory care unit's common area when Resident #13 suddenly bit Resident #12 and threw her on the floor. Resident #12 remained on the floor and Resident #13 walked away. Review of Resident #12's record revealed an admit date of . Further review revealed a Resident Health Assessment Form (1823) dated , indicating diagnoses of Frontal , , history of , predicable, ( ) , , , , and . Resident#12 was independent with activities of daily living. (ADLS). Review of Progress notes for Resident #12 found no evidence of aggressive behavior. Further review revealed progress noted dated: 7:38a.m. indicating; resident to resident altercation. . . Resident Report: "resident stated that the other resident approached her aggressively, bit her on her right arm and pushed her on the floor." Resident #12 was taken to the Emergency Department of a local Hospital after the incident and was treated for a human bite, open , administered a shot and prescribed medications. Review of Resident #13's record revealed an admit date of . Further review revealed an 1823 dated indicating diagnoses of , , , agitation,	A 025		

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A 025	Continued From page 3 aggression, , , , , and , , , or behavioral status indicated: agitation, impulsive and history of . Resident #13 was independent with eating, needed supervision with ambulation, assistance with bathing, , grooming, toileting, and transferring. Review of Progress notes for Resident #13 dated 7:48 p.m. read, "resident arrived at the facility, alert and , resident currently agitated and exit seeking, and is currently on ." Further review of progress notes dated 11:15 a.m. read: "Med tech was parked in front of # and knocked on the door to give the resident her medications. Resident #13 rushed up and was trying to get into #118, Resident #13 raised her motioning to hit the medication technician and also the Resident in # , and the med tech blocked her. The Resident in # said Resident #13 bangs on her door often and is looking for her husband in the room." . .Progress note dated 10;05 a.m. read: "ADON was notified that Resident #13 hit another resident and bit them. Residents were immediately separated." There was no interventions documented on record after the incident that took place on for Resident #13. On at 11:30 a.m. during an interview the Administrator said that on Resident #13 bit Resident #12 and pushed her down on the floor. Resident #12's son was notified immediately of the incident, and took his mother to the hospital where she was treated, administered a injection and prescribed medication as a preventative measure. The Administrator said Resident #13 was agitated and she communicated with the Residents	A 025		

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spouse regarding Resident #13's agitation, and the spouse refused medications for Resident #13 prior to the incident. The Administrator said only after the incident did Resident#13's spouse agree to medication treatment but refused private care for Resident #13. The Administrator said after the first incident they spoke to Resident #13's spouse, but he did not want his wife to be assessed by a psychiatrist. He eventually agreed and Resident #13 was seen by a , , nurse practitioner that ordered new medications for the resident on .
The Administrator said they do not have a set time, indicating how often staff needed to check on the residents in the memory unit. She said that the residents are to be kept in the main living area for better supervision, and the staff are expected to do rounds at least once per shift.

On at 7:25 a.m., during an interview Staff E said there was no prior history between Resident #12 and
#13. Staff E said they do not have a set time indicating the frequency by which they needed to check on the residents, but they made sure residents were in the main area for better supervision.

On at 8:20 a.m, During an interview, Resident #12 said she was walking in the common area and Resident
#13 suddenly bit her and pushed her to the floor. Resident #12 said she had never had any prior issues with Resident #13. The staff immediately took care of her and her son took her to the hospital. Resident #12 said she has not seen Resident #13 since then, she thinks she is gone.

On at 9:42 a.m., During an interview the Health and Wellness Director (HWD) said

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A 025	Continued From page 5 Resident #13 was recently admitted to the facility from her home and was agitated, but staff was able to redirect the resident. The HWD said there were no prior incidents between Resident #12 and #13. The HWD said there was no set time to indicate when staff needed to check on residents in the memory unit, but all residents were to be kept in the main area for better observation and staff are expected to check on the residents at least twice each shift. On at 11:00 a.m., During an interview the Assistant Health and Wellness Director (AHWD) said Resident #12 never had any aggressive episodes. The AHWD said Resident #13 was recently admitted to the facility from her home and was agitated, but staff was able to redirect the resident. The AHWD said there was no policy in place or time frame indicating the frequency of resident's supervision in the memory care unit. Class III .	A 025		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C.	A 030		

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(b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;

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A 030	Continued From page 7 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe,	A 030		

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impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care

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, , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, , and

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prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or

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A 030	Continued From page 11 dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review, observation and interviews the facility failed to provide a safe living environment free from and neglect for 1 (Resident #12) of 17 residents reviewed. Failure to provide a safe living environment resulted in resident to resident altercation with Resident #12 been bitten by Resident #13 and thrown on the floor. The findings included: Requested and obtained facility policy titled: Elder /Neglect. Issued . Revised . Definitions: Elder includes physical, emotional, or harm inflicted upon an older adult. financial , , or neglect of their welfare by people who are directly responsible for their care. , : the intentional use of force against a elderly person that results in physical , , injury or , . Record review showed that on around 6:30 a.m. Resident #12 and #13 were walking in the common area. Resident #13 bit Resident #12 and threw her on the floor. Review of Video surveillance of the incident	A 030		

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confirmed that both Resident #12 and # 13 were walking in the memory care unit's common area when Resident #13 suddenly bit Resident #12 and threw her on the floor. Resident #12 remained on the floor and Resident# 13 walked away.

Review of Resident # 12's record revealed an admit date of . Further review revealed a Resident Health Assessment Form (1823) Review dated , indicating diagnoses of Frontal , A fib, history of , predicable, ( ) , , , , and . Resident#12 was independent with the activities of daily living. (ADLS). Review of Progress notes for Resident #12 found no evidence of aggressive behavior. Resident #12 was taken to the Emergency Department of a local Hospital after the incident and was treated for a human bite, administered a shot and prescribed medications.

Review of Resident #13's record revealed an admit date of . Further review revealed an 1823 dated indicating diagnoses of , , , agitation, aggression, , , , , and , , or behavioral status indicated: agitation, impulsive and history of . Resident #13 was independent with eating, needed supervision with ambulation, assistance with bathing, , grooming, toileting, and transferring. Review of Progress notes for Resident #13 dated 7:48 p.m. read, "resident arrived at the facility, alert and , resident currently agitated and exit seeking, and is currently on ." Further review of progress notes dated 11:15 a.m. read: "Med tech was parked in front of room

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A	Continued From page 13 #118 and knocked on the door to give the resident her medications. Resident #13 rushed up and was trying to get into #118, Resident #13 raised her motioning to hit the medication technician and also the Resident in # , and the med tech blocked her. The Resident in # said Resident #13 bangs on her door often and is looking for her husband in the room." . .Progress note dated 10;05 a.m. read: "ADON was notified that Resident #13 hit another resident and bit them. Residents were immediately separated." There was no interventions documented on record after the incident that took place on for Resident #13. On at 11:30 a.m. during an interview the Administrator said that on Resident #13 bit Resident #12 and pushed her down on the floor. The Administrator said Resident #12 has been in the facility for some time and did not have aggressive episodes. Furthermore, per Administrator there was no prior incidents with the two residents. Resident #12's son was notified immediately of the incident, and took his mother to the hospital where she was treated, for human bite, open , administered a injection and prescribed medication as a preventative measure. The Administrator said Resident #13 was agitated, she communicated with the Residents spouse regarding Resident #13's agitation, and the spouse refused medications for Resident #13 prior to the incident. The Administrator said only after the incident did Resident #13's spouse agree to medication treatment but refused private care for Resident #13. The Administrator said after the first incident they spoke to Resident #13's spouse, but he did not want his wife to be assessed by a psychiatrist.	A 030		

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A 030	Continued From page 14 He eventually agreed and Resident #13 was seen by a , , nurse practitioner that ordered new medications for the resident on . The Administrator said they do not have a set time, indicating how often staff needed to check on the residents in the memory unit. She said that the residents are kept in the main living area for better supervision. The Administrator said that the staff are expected to do rounds at least once per shift. On at 7:25 a.m., during an interview Staff E said they do not have a set time indicating the frequency by which they needed to check on the residents, but they made sure residents were in the main area for better supervision. On at 8:20 a.m, During an interview, Resident #12 said she was walking in the common area and Resident #13 suddenly bit her and pushed her to the floor. Resident #12 said she had never had any prior issues with Resident #13. The staff immediately took care of her and her son took her to the hospital. Resident #12 said she has not seen Resident #13 since then, she thinks she is gone. On at 9:42 a.m., During an interview the Health and Wellness Director (HWD) said Resident #13 was recently admitted to the facility from her home and was agitated, but staff was able to redirect the resident. The HWD said there were no prior incidents between Resident #12 and #13. The HWD said there was no set time to indicate when staff needed to check on residents in the memory unit, but all residents were to be kept in the main area for better observation and staff are expected to check on the residents at least twice	A 030		

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A 030	Continued From page 15 each shift. On at 11:00 a.m., During an interview the Assistant Health and Wellness Director (AHWD) said Resident #12 never had any aggressive episodes. The AHWD said Resident #13 was recently admitted to the facility from her home and was agitated, but staff was able to redirect the resident. The AHWD said there was no policy in place or timeframe indicating the frequency of resident's supervision in the memory care unit. Class III .	A 030		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and	A 052		

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A 052	Continued From page 16 dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with	A 052		

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A 052	Continued From page 17	A 052		

prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.
(h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.
(5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003.

59A-36.008
(3) ASSISTANCE WITH SELF-ADMINISTRATION.
(a) Any unlicensed person providing assistance with self-administration of medication must be [redacted] or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule.
(b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed.
(c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused

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A 052	Continued From page 18	A 052		

doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.
(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,
2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.
(f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S.
(g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition.
(h) All trained staff must adhere to the facility's control policy and procedures when

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A 052	Continued From page 19 assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure staff who assist with self-administration of medications do so appropriately for 3 (Resident #13, Resident #16, Resident #17) of 3 residents observed for medications. The findings included: Distinctive Living Medication Administration Procedure issued :. . . 6. Nurse / Medication Aide performs hygiene On at 7:52 a.m., during observation of a medication pass, Medication Technician (MT) Staff D prepared , 5 mg (,), , 125 mg ( ), 100 mg (, ,), , 5 mg (, ,), and 20 mg (.) for Resident #16. No hygiene was performed. Staff D attempted to give Resident #16 the cup to take the medication but the resident was unable to. Staff D then took a spoon from the cart and scooped out each pill one at a time, and placed the spoon in the of Resident #16. Staff D then put the cup of water up to the Resident #16's , and directly fed her the water between each pill. Staff D failed to perform hygiene before, during, and after medication pass. On at 7:58 a.m., during observation of a medication pass, Staff D provided , 10 mg (,), , 81 mg ( )), , 40 mg ( ),	A 052		

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A 052	Continued From page 20 1 mg (supplement), Thera M tab (supplement), B-1 (supplement), 0.5% (,), and Olopatadine 0.2% (,) to Resident #17. MT Staff D failed to perform hygiene before, during, and after medication pass. On at 8:06 a.m., during observation of a medication pass, Staff D provided 10 mg ( ), 8 mg ( ), Nitrofurant Mono 100 mg ( ), 30 mg (,), 20 meq (supplement), , 25 mg (,), 20 mg (, ,), 100 mg ( ), and , 10 mg (,) to Resident #13. MT Staff D failed to perform hygiene before, during, and after medication pass. On at 8:15 a.m., during an interview, Medication Technician (MT) Staff D said she directly feeds the medications to Resident #16. Staff D said over the past few months Resident #16 has been less able to take the medications on her own, and she had told the nurse several times that there were issues with Resident #16 being able to take her medications. Staff D said she knew that she shouldn't be giving the medication directly, but if they don't, the med's just onto the floor. Staff D said she knows she needs to sanitize or wash her between residents. Staff D confirmed she did not perform hygiene during the medication pass. On at 11:36 a.m., during an interview, the Health and Wellness Director (HWD) said the expectation is that medication technicians follow the facility policy. The HWD acknowledged not performing sanitization was against policy, they can provide over assistance but	A 052		

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A 052	Continued From page 21 they cannot directly administer or put a spoon in the residents . The HWD and the Executive Director acknowledged that an unlicensed staff member placing a spoon directly into a resident's is administering medications and is against regulation. Class III .	A 052		