STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932484	07/11/2017
NAME OF PROVIDER OR SUPPLIER **BAYOU GARDENS**	STREET ADDRESS, CITY, STATE, ZIP CODE **2275 NEBRASKA AVENUE** **PALM HARBOR, FL 34683**	

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

0000 - Initial Comments

Assisted Living Facility

Four complaint investigations, (CCR# 2017004107, CCR# 2017004330, CCR# 2017004721, and CCR# 2017005275) were conducted at Bayou Gardens on through . Bayou Gardens had deficiencies at the time of the investigation.

(License # 8104)

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

Based on observation, interview and records review, the facility failed to maintain a written record, updated as needed, of significant changes or other changes that resulted in the provision of additional services for 1 of 9 residents whose medical records were reviewed.

Findings included:

At 11:15am on , in the dining the facility, Resident #6 was observed attempting to sit down at a table with other residents for lunch. Staff F was heard telling Resident #6 not to sit down, that the resident had an open on the back of resident's right hand and it needed to be covered up and that the resident could not come into the dining "like that".

A review of Resident #6's medical records at 1:30pm on revealed that the resident had a borne communicable that could potentially other residents and staff members. The record review did not reveal any nurses notes, doctor's orders or any other indication that the resident needed or was receiving care for the open on the back of the right hand.

The next day, , at 11:00am, it was revealed in an observation and interview with Resident #6, that the resident had an open that covered the greater portion of the back of the right hand. The on Resident #6's hand was covered with a bandage and the Administrator, who was also present, asked the resident to remove the bandage. When the bandage was removed, the was observed to be no less than sized 6cm x 4cm and seeping a reddish clear liquid. The resident stated that the was due to a from hot coffee over a week ago. The resident stated that the was very

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and painful. The interview revealed that the Administrator did not know if anyone had notified a doctor about the and resident stated that a doctor had not been notified. The Administrator stated that the resident would need to go to a doctor that day for treatment.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and interview, the facility failed to ensure that a clean, safe, and decent living environment was maintained for 33 of 33 residents.

Findings included:

The by Resident #20 and Resident #21 was observed on at approximately 10:20 AM. Upon entering the residents' strong odor was detected. There were brown marks observed on the floor. The observation of the shower stall revealed feces on the drain and a few inches from the drain (photographic evidence obtained). An interview was conducted with Staff D at 10:21 AM on and they were asked to look in the shower stall and describe what they saw. Staff D observed the shower stall and stated that it was feces.
A tour of the second floor common area of the facility at 9:45am on was noted to have furniture in disrepair and covered by wrinkled and dingy sheets, a wadded up towel lying on a table, a used A/C filter covered with gray matter laying on the floor, and an open book lying on the floor (photographic evidence obtained).
At 9:50am on , in the first floor rear common area of the facility, a breathing treatment machine with plastic tubing and a strap-on , mask was observed sitting on a side table. Beneath the table of was a waste basket that was filled to the top with used crumbled up Kleenex. In an interview with the Administrator it was revealed that the breathing treatment machine and used Kleenex in the common area belonged to Resident #1, whose family was coming to take the resident to the hospital that day because they were afraid that the resident might have , . There were also used cups with the remains of beverages lying around the other tables (photographic evidence obtained).

At 11:15am on , in the dining the facility, Resident #6 was observed attempting to sit down at a table with other residents. Staff F was heard telling Resident #6 not to sit down, that the resident had an open on the back of resident's right hand and it needed to be covered up and that the resident could not come into the dining "like that". Records revealed that Resident #6 had

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a borne communicable that could potentially other residents and staff members.

At 12:00pm on , in the dining lunch, Staff A, a Med Tech, was observed handing out a kit to Resident #3, whom staff said administers the and glucose testing independently. The kit was encased in a plastic bag that appeared to have been worn out - the label with the resident's name was peeling off and the plastic was crinkled. Staff A did not wash or sanitize hand prior to handling the kit and handing it over to the resident. Resident #3 was observed conducting glucose testing and injection at the table, during lunch, with other residents in close proximity. Resident #3 did not sanitize hands or use wipes during the process. After the glucose testing was completed, Resident #3 was observed placing a bloody glucose test strip on the lunch table nearby other residents.

At 12:20pm, Resident #7 approached Staff A and requested an inhaled breathing treatment. Staff A opened the drawer of the medication cart and pulled out a machine for administering breathing treatments. The machine did not have any resident's name, or identifying marks on it, and it was kept open in the medication cart, without any protective plastic bag or other container that would reduce contamination. This machine was place on top of the medication cart and set up for Resident #7's use as the resident sat in a wheel chair in the dining lunch, receiving and inhaled breathing treatment in the midst of other residents.

During the lunchtime medication pass on , Staff A, a Med Tech was observed giving medications out to Resident #5 , #4 and # 7 between 12:10pm and 12:25pm. Staff A did not sanitize hands before or after resident care/med pass and was observed intermittently, during the medication pass, assisting residents with food dishes, cups, napkins and utensils.

Class III

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

Based on observation, interview and records review, the facility failed to observe residents taking medication and failed to verbally prompt residents to take medications as prescribed for 2 of 4 residents observed.

Findings included:

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At 12:00pm on , during a medication observation in the dining , during lunch, Staff A, a Med Tech, was observed giving medications to Resident #4. Resident #4 approached Staff A and requested medication for a stomach ailment that was prescribed to be given "as needed". Staff A failed to review Resident #4's medication observation records to verify the prescription and determine the last the last time the medication was given. Staff A took the medication out of the cart, read the label and popped the pill into small cup. After doing so, Staff A pulled up Resident #4's medication observation record. The doctor's order stated, "1 tablet every 6 hours as needed". Staff #A handed med cup to Resident #4, without explaining the medication to the resident, who walked back to sit down at a dining , and did not observe the resident swallow the pill.

At 12:20pm on , Resident #7 approached Staff A and requested an inhaled breathing treatment. Staff A did not look at Resident #7's medication observation record, but instead just opened the drawer of the medication cart and pulled out a machine for administering breathing treatments, pulled out a vial of the requested inhaled medication from the Resident #7's supply of inhaled medications and had the resident sit near the medication cart to receive the breathing treatment. Staff A assisted Resident #7 to pour the vial of medication into the machine, wipe the mouthpiece of the inhaler machine with an wipe and turn the machine on to begin inhaling the medication. Staff #A did not explain the medication to the resident, but was heard telling Resident #7 "you can have it every 4 hours". A review of Resident #7's medication observation record revealed a doctor's order for the inhaled breathing treatment to be given as needed, not to exceed 3 times per day.

Class III

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

Based on observation, interview and records review, the facility failed to maintain medication observations records for 2 of 4 residents observed.

Findings included:

At 12:00pm on , in the dining , lunch, Staff A, a Med Tech, was observed giving medications to Resident #4. Resident #4 approached Staff A and requested medication for a stomach ailment that was prescribed to be given "as needed". Staff A failed to review Resident #4's medication observation records to verify the prescription and determine the last the last time the medication was given. Staff A took the medication out of the cart, read the label and popped pill into small cup. After

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doing so, Staff A pulled up Resident #4's medication observation record. The doctor's order stated, "1 tablet every 6 hours as needed". Staff #A handed med cup to Resident #4, who walked back to sit down at a dining , and did not observe the resident swallow the pill. Staff #A did not document giving out the medication directly after medication was given.

At 12:20pm, Resident #7 approached Staff A and requested an inhaled breathing treatment. Staff A did not look at Resident #7's medications medication observation record, but instead just opened the drawer of the medication cart and pulled out a machine for administering breathing treatments, pulled out a vial of the requested inhaled medication from the Resident #7's supply of inhaled medications and had the resident sit near the medication cart to receive the breathing treatment. Staff #A was heard telling Resident #7 "you can have it every 4 hours". A review of Resident #7's medication observation record revealed a doctor's order for the inhaled breathing treatment to be given as needed, not to exceed 3 times per day. Staff A did not document that the medication was given to Resident #7. On , the next day after Resident #7's medication observation, the resident's MOR was reviewed and there was no documentation of the medication that was observed on at 12:20pm had been given.

A record review of Resident #7's 1823 assessment dated stated that the resident was diagnosed with and needed assistance with medication self-administration. In a phone call on , the Administrator stated that Staff A was not able to document the medication in the medication observation records for Resident #7 because the computer was programed for the resident to self-administer this medication. The Administrator could not explain the discrepancy of the 1823 assessment stating the resident needed assistance with self-administration and the electronic medication observation record being programed so that the facility could not keep track on when and how many times per day the resident was receiving the medication.

Class III

0123 - Fiscal - Resident Trust Funds - 429.27(3-4) FS; 58A-5.021(2) FAC

Based on interview and record review, the facility failed to ensure that complete and accurate records were kept for resident trust funds for four (Residents #21, #23, #28, and #29) of seven records reviewed.

Findings included:

A review of resident trust funds records was conducted on . A review of Resident # 21's record

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showed that it hadn't been updated since . A review of Resident #23's record showed that it hadn't been updated since . A review of Resident #28's record showed that it hadn't been updated since . A review of Resident #29's record showed that it hadn't been updated since .

An interview was conducted with the Administrator at 1:00 PM on concerning the lack of completeness and accuracy of resident trust fund records for Residents #21, #23, #28, and #29. The Administrator stated that there had been transactions since those dates listed and acknowledged that they were not recorded in the resident trust fund records.

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

Based on interview and record review, the facility failed to maintain the employment status of employees within the employee roster listed in the AHCA background screening clearinghouse (Employee Roster), within 10 business days of initial employment, for two (Staff B, and Staff C) of three employee records reviewed.

Findings included:

A review of facility records conducted on showed that Staff B was hired and Staff C was hired on . A review of facility records also showed that Staff B and Staff C provided direct care to the facility's residents.

A review of the Employee Roster conducted on showed that Staff B and Staff C were not entered as required.

An interview was conducted with the Administrator at 10:21 AM on concerning Staff B and Staff C not being listed in the Employee Roster. The Administrator acknowledged that they hadn't entered in the two employees' names in to the Employee Roster.

Unclassified