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
	AL11965368	A. BUILDING: _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AT OCOEE	80 NORTH CLARK RD OCOEE, FL 34761

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A 000	Initial Comments Complaint Investigation #202016168 and an . . . . Control monitoring were conducted on and . Madison At Ocoee had deficiencies at the time of the visit.	A 000		
A 025 SS=G	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 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 supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule	A 025		

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A 025	Continued From page 1 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 electronic medication observation record (MOR) review, record reviews and interview, the facility failed to provide care and services to meet the needs of 1 of 4 sampled residents by not removing from her in 7 days as ordered (#4), failed to provide medications as ordered for 2 of 4 sampled residents (#3 & 4), did not maintain a written record when 2 of 4 sampled residents were transported to the hospital (#1 & 2), and did not notify the health care provider when 1 of 4 sampled residents refused to take medications as ordered (#4). Findings:	A 025		

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A 025	Continued From page 2	A 025		

1. Resident #4's health assessment form 1823, dated , included diagnoses of and . The resident required assistance with bathing and grooming and her medications were to be administered by a nurse. Resident #4 resided in the secured memory care unit.

Resident #4's MORs for , and revealed the resident refused various medications daily. There were times documented that she would spit the medication out. There was no documentation to confirm that the health care provider was contacted when the resident refused to take her medications as required. The MOR reflected that the resident refused the 10 mg. 1 daily at 6 PM on , 13, 14, 19, 21, 22, 23 and 25/2020. There were circles with initials on and . The exceptions sheet on at 6:25 PM and at 5:14 PM read, "Physically unable to take - med unavailable." On certain days the resident refused to take the 10 mg., and there should have been medication available for her to take on and .
" is used along with a proper diet to help lower "bad" and fats (such as , triglycerides) and raise "good" ( ) in the ." (webmd.com).

On at 2:10 PM The DON reviewed the MOR and confirmed the findings. She said she did not have an explanation why 10 mg was not given. She said the health care provider was contact regarding the resident's refusal to take her medications but it was not documented as required.

Information was received by the agency that

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A 025	Continued From page 3 resident #4 had a at the facility and received on and they were not removed until , eighty one (81) days later when she arrived at her new facility. Resident #4's hospital discharge record revealed that on , the resident received a injury. The education instructions read, " and care/suture care, keep generally dry but wash with soap and water daily." Under Follow-up it read, "Return in 7 days for follow up for stitch/staple removal." It reflected that the resident was discharged to the facility and instructions were given to the DON. Review of additional information/notes received from the resident's current facility revealed that on , there were 5 staples present on admission which were removed that day. The notes reflected that the were discovered when the facility staff gave her a shower on . Resident #4's record revealed the following: at 7:35 AM - "Nurse was notified that resident had to the of her . When nurse attempted to assess her , resident was combative. Nurse was able to see about 1-inch gash to the of her . Unwitnessed . Unable to get vitals due to resident to resident being combative and refusing help or care. 911 called for transport to ER from evaluation." at 2:26 PM - "Returned from ER, no new orders; was clear. were placed in the of ." -"Resident pleasant most of the day; she took her medications to the of	A 025		

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A 025	Continued From page 4 the . . . appears intact. Unable to obtain vital signs due to resident refusing to have vitals taken." . . . . . - "During the 3 PM-11 PM shift, the resident's daughter came to take her to the hospital and the resident left in the care of her daughter. Staff also informed that the resident's medications were given to her daughter." The admission and discharge log noted the resident was discharged on . There was no order found for the care and removal of the . . . . . On at 3 PM, the DON said she was not aware that the were not removed. On at 11:50 AM, the DON called to report that she could not locate any evidence that the resident's were removed, or care provided. Resident #4 received . . . . due to a . at the facility on . The facility did not follow the hospital's discharge order to remove the in 7 days. There was no evidence that the facility provided care and . . . . with a home health agency to provide care to the resident's . . . . after the . . . . were applied. The were not removed until resident #4 arrived at the new facility on . . . . . , eighty one (81) days later. 2. Review of the facility's electronic MOR for resident #1 revealed that she did not receive medications on because she was sent to the hospital on . The facility's electronic notes revealed there was no	A 025		

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A 025	Continued From page 5 documentation to confirm why the resident required a higher level of care (hospitalization) and that the family and health care provider were notified. 3. Resident #2's electronic note dated reflected that the resident returned from the hospital on and he was alert and oriented to person, place and time. The note did not contain documentation to confirm why the resident required a higher level of care (hospitalization), and that the family and health care provider were notified. On at 1:40 PM, the Director of Nursing (DON) reviewed the MOR and notes for residents #1 and #2 and confirmed the findings. 4. Resident #3's health assessment form 1823, dated , included diagnosis of , , , , and . The resident was alert and oriented to person and place but disoriented to time due to . The resident needed to be fed, required assistance with all of activities of daily livings (ADLs), and required assistance with his medications. The resident's record revealed that he did not use the facility's preferred pharmacy; he used one of the local pharmacies. A letter from the resident's family member, dated , indicated that the family member delivered 120 tablets of 500 milligrams (mg.), 60-day supply, to the facility. " is an effective drug prescribed for the treatment of people diagnosed with type 2 that are not able to regulate their condition in any type of other method." (.com). The MOR reflected that 1 tablet of	A 025		

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A 025	Continued From page 6 was to be given twice a day, and was given at 8 AM and 7 PM. On at 8 AM, there was a circle with an initial around it on the MOR. The exception sheet contained the reasons why the medications were not given noted at 8:49 AM for the : "Physically unable to take-waiting for nephew to drop off script." The resident received his medication thereafter. A 60-day supply of was delivered to the facility on , and should have been available on . The MOR on at 8 AM and at 7 PM had initials with circles around them on the exception sheet for at 8:58 AM on and 7:43 PM on which read, "Physically unable to take." The MOR on at 7 PM relected 50 mg. twice daily and , 25 mg. ER (extended release) at bedtime. Initials with circles around them were on the MOR, and the exception sheet on for both medications at 8:30 PM read, "Physically unable to take." There was no explanation why resident #3 was physically unable to take his medications." is used to lower pressure inside the , (pressure) in people with certain types of " (drugs.com). " , ER is a -blocker that affects the and circulation (flow through and veins." (drugs.com). On at 1:40 PM, the DON reviewed the resident's record and MORs and confirmed resident #3 should have had enough to take on at 8 AM. She said she was not aware why the resident did not receive his medications as ordered on and .	A 025		

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A 025	Continued From page 7 Class II	A 025		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ˘ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by:	A 054		

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A 054	Continued From page 8 Based on record reviews and interview, the facility failed to ensure the Medication Observation Records (MORs) were updated for 2 of 4 sampled residents who required assistance with self-administered medications (#2 & 3). Findings: Resident #2 and #3's records revealed they required assistance with the self-administration of their medications. Review of their Electronic MORs for and revealed there were blank spaces and no explanation as to why the spaces were blank as follows: 1. Resident #2's MOR for noted , 25 milligrams (mg.) 1 tablet once daily. Call if , greater than . From through , the spaces were blank for the results of the resident's and . Staff initialed the medications as given on those days. 2. Resident #3's MOR for for Solution 0.15% 1 drop into both , three times daily and Dorzol/timol Solution 22. .8 1 drop into each , every 8 hours were blank at 8 PM on and at 2 PM on . Lumigan Solution 0.01% 1 drop into each , at bedtime was blank at 9 PM on , 500 mg. twice daily, 50 mg. twice a day, , 20 mg. at bedtime, , 25 mg ER (extended release) at bedtime were all blank on at 7 PM. 10 mg. at bedtime was blank on at 9 PM.	A 054		

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A 054	Continued From page 9 On ... . at 2 PM, the DON confirmed the findings. Class III	A 054		