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
	AL11965317	A. BUILDING: _____ B. WING _____	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYOU GARDENS	1585 CURLEW RD. DUNEDIN, FL 34698

(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 A complaint (complaint numbers 2021010671 and 2021011989) in conjunction with a generator monitoring survey was conducted at Bayou Gardens Dunedin Assisted Living Facility on . Deficiencies were identified at the time of survey.	A 000		
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 [illegible] 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 [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing	A 054		

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A 054	Continued From page 1 physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain daily Medication Observation Records (MORs) that were immediately updated each time a medication was offered to five Residents (# 3, #4, #5, #6, and #7) of 42 sampled residents. Findings included: A MOR review conducted on for Resident #3, revealed that there was no documentation on the following dates that medication had been given: and for an 8:00 PM dose of 20 milligrams. and for an 8:00 PM dose of 250 milligrams , and for an 8:00 PM dose of 100 milligrams and for an 8:00 PM dose of 3 milligrams A MOR review conducted on for Resident #4, revealed that there was no documentation on the following dates that medication had been given: and for an 8:00 PM dose of , 15 milligrams. for an 4:00 PM dose and and for an 8:00 PM dose of , 250 milligrams , and for an 8:00 PM dose of 20 milligrams an 3:00 PM dose of , 1 mg and and an 8:00 PM dose and for an 8:00 PM dose of	A 054		

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A 054	Continued From page 2 5 milligrams and for an 8:00 PM dose of Rosuvastatin 10 milligrams and for an 8:00 PM dose of 50 milligrams and for an 8:00 PM dose of 150 milligrams A MOR review conducted on for Resident #5, revealed that there was no documentation on the following dates that medication had been given: and for an 8:00 PM dose of 15 milligrams. and for an 8:00 PM dose of 10 milligrams. and for an 8:00 PM dose of 300 milligrams. and for an 8:00 PM dose of 150 milligrams. and for an 8:00 PM dose of 20 milligrams. A MOR review conducted on for Resident #6, revealed that there was no documentation on the following dates that medication had been given: an 4:00 PM dose of 10 mg and and an 8:00 PM dose an 4:00 PM dose of 0.5 mg and an 5:00 PM dose of 20-100 mcg/INH and and an 8:00 PM dose and for an 8:00 PM dose of tab 100 milligrams. and for an 8:00 PM dose of 10 milligrams. and for an 8:00 PM dose of 30 milligrams.	A 054		

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A 054	Continued From page 3 to 6:00 PM dose of / 10/325 milligrams, and an 12:00 am an 12:00 PM dose. and for an 8:00 PM dose of Promacta 50 milligrams. thru for an 8:00 PM dose of 5 milligrams. A MOR review conducted on for Resident #7, revealed that there was no documentation on the following dates that medication had been given: and for an 10:00 PM dose of 10 milligrams. and for an 8:00 PM dose of 300 milligrams. and for an 8:00 PM dose of 800 milligrams. and for an 8:00 PM dose of 300 milligrams. for an 8:00 PM dose of , 300 milligrams. thru for an 8:00 PM dose of 50 milligrams. Resident interviews conducted on with Resident's #3, #4, #5, #6, and #7 all confirmed that they receive their medications every day and on time. During an interview with the Administrator conducted on at 11:33 am she confirmed that the MOR's for Resident's #3, #4, #5, #6, and #7 had missing initials for the dates thru on the evening shift, the med tech did not document as given. Class III	A 054		