STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922141	07/08/2013
NAME OF PROVIDER OR SUPPLIER **Renaissance Retirement Center, Llc**	STREET ADDRESS, CITY, STATE, ZIP CODE **300 West Airport Blvd. Sanford, FL 32771**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - 0163 - 429.49 Fs - Records - Resident, Penalties For Alteration S-S= G

Specific Tag Findings:

0000-Initial Comments
conducted Assisted Living Facility complaint inspection CCR#2013003758.

Renaissance Retirement Center had deficiencies found at the time of the visit.

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observations and interview the facility failed to ensure when unlicensed staff provided assistance with the self-administration of medications, the staff followed the appropriate procedure at all times and did not take 1. Medication, in its dispensed, properly labeled container, from where it was stored and bring it to the resident. 2. In the presence of the resident, read the label, open the container, remove a prescribed amount of medication from the container, and close the container and observe the resident take the medications for 1 of 3 sampled residents (#2).

Findings:

Observation and interview while on tour with the nurse consultant of resident #2 on at approximately 10 AM who stated he had 2 souffle cups of medications that the unlicensed staff gave him last Thursday, and Friday, Observation revealed, one medication cup contained 3 pills and the second medication cup contained 4 pills. He stated, "Can you tell what is wrong with this?" He was asked what was wrong. He stated, "One cup has 3 pills and the other cup has 4 pills in it. There is a pill missing from one of the cups. "The resident did not recognize some of the medications and did not take the medications, as he did not feel they were the right medications. He did not tell the staff member that he did not take the PM medications and still had them in his that time.

The unlicensed staff did not take the medication, from where it was stored and bring it to the resident. In the presence of the resident, read the label, open the container, remove a prescribed amount of medication from the container and place the medication in a cup and observe the resident take the medication.

Resident record review for #1 revealed an Assisted Living Facility health assessment form (1823) dated that stated dependent sleep The resident needed assistance with self-administration of medications.

Review of the 2013 MOR revealed #2 received the following medications and they were charted as given, initials were in the box:

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600 + D daily in the PM charted on 7/4 and
(for lipids) 40 milligrams PM every other day on
supplement) 250 mg 2 tabs in PM on 7/4 and

Interview with the nurse consultant on at approximately 10 AM who was not aware the resident did not take his evening medications and had them in his and

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on record review and interview the facility failed to ensure for 1 of 3 sampled residents (#1) were kept in a locked storage area at all times to prevent theft.

Findings:

Resident record review for #1 revealed an Assisted Living Facility health assessment form (1823) dated that stated diagnoses of , , and The resident was on hospice and received assistance with self-administration of medications.

Review of physician orders dated revealed for pain) give one three times a day and one extra every 4 hours as needed twice a day, give 160 tablets.

Review of the 15 day Adverse Incident Report for resident #1 revealed on 60 tablets of for pain) were missing. Three cards of medications, each containing 60 tablets was left unattended on the Wellness Director's desk for about an hour. Upon returning to the office, one card with 60 pills was missing.

Review of Narrative Police Report from Sanford Police Department, signed by officer 2018. The case number 20130001636 dated , stated at approximately 9 AM, I left my office to go to the morning meeting. My office door was closed but the door was not locked. I had left 3 cards of on my desk upside down. Upon returning to my office at around 10 AM I noticed that there were only 2 cards of the left. All the staff was questioned and searched with permission. No evidence was found. Executive Director (Ruth Ann Ristow) called the police department.

Review of the policy and procedure for Medication Program stated all controlled substances will be stored using a double-lock system.

Corrective action taken:The locks were changed on the Wellness Director s office.
Random drug test for Assisted Living staff led to an employee resigning position related to testing positive for the same medication in her system.

Review of the facility's internal investigation revealed on , there was a situation in the community involving a resident's medication missing. As a result of this, an adverse incident report was completed, the police were notified and a police report was filed the same day.

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The following next day, staff was sent out for drug testing, Staff A was told that she was being sent out for drug screening by the Wellness Director, Human Resources and Executive Director. At that, time Staff A stated that she took the medication and that she would test positive for , the missing medication.

Staff A was requested to resign from her position. ED allowed employee to write resignation but informed/requested that she still go or the drug screening.

Staff A went for screening at Care Spot on . Herast day of employment was ending her shift at 1:15 PM.

Review of Staff A ' s time card report revealed her last day of employment was at 1:15 PM.

On the results came back as positive for Marijuana.

Interview with the ED and the nurse consultant on at approximately 12:30 PM who stated a staff member was terminated after drug testing related to the missing . The staff admitted to taking the medication. She also stated the previous ED was terminated due to lack of oversight, and commitment to the community on .

Class III

0162-Records - Resident 58A-5.024(3) FAC
Based on observation, record review and interview the facility failed to ensure health care provider's orders for residents to self-administer medications were obtained for 2 of 3 sampled residents (#1 & 2).

Findings:

1. Resident record review for #2 revealed an Assisted Living Facility health assessment form (1823) dated that stated dependent , sleep . The resident needed assistance with self-administration of medications.

Observation and interview with the resident on at approximately 10 AM who stated he self-administered his pens.

Record review revealed there was no physician order to self-administer .

Interview with the Wellness Director on at approximately 4 PM who stated the resident did not have an order to self-administer .

2. Resident record review for #1 revealed an Assisted Living Facility health assessment form (1823) dated that stated diagnoses of , and . The resident was on hospice and received assistance with self-administration of medications.

Review of physician orders dated stated family to administer 5-500, and (for eyes) 0.005%.

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Review of the MOR revealed 5-500 mg one 3 times a day and one extra every 4 hours as needed twice a day and 0.05 % put one drop into affected eyes twice a day. The MOR stated the medication was given by the family.

Interview and observation of resident #1 on at approximately 2 PM revealed the resident was frail, was ambulating in his I stated his family member filled his pill box for him for once week with his pain meds and he took them 3 times a day. The resident was observed taking a pill out of the pill box to take and writing it on his calendar. Record review revealed the resident did not have an order to self-administer the or He stated the family member did not come daily to give him his medications.

Interview with the Wellness Director on at approximately 4 PM who stated the family did not administer the residents above medications daily and he did not have an order to self- administer the medications.
Class III

0163-Records - Resident, Penalties for Alteration 429.49 FS
Based on record review and interview the facility failed to ensure staff did not falsify Medication Observation Records (MORs) for 1 of 3 sampled residents (#2).

Findings:

Resident record review for #2 revealed an Assisted Living Facility health assessment form (1823) dated that stated dependent sleep The resident needed assistance with self-administration of medications.

Observation while on tour with the nurse consultant and interview with resident #2 on at approximately 10 AM who stated he had 2 souffle cups of medications that the med tech gave him last Thursday, and Friday, Observation revealed, one medication cup contained 3 pills and the second medication cup contained 4 pills. He stated, "Can you tell what is wrong with this?" He was asked what was wrong. He stated, "One cup has 3 pills and the other cup has 4 pills in it. There is a pill missing from one of the cups." The resident did not recognize some of the medications and did not take the medications as he did not feel they were the right medications. He did not tell the staff member that he did not take the PM medications and still had them in his

Review of the 2013 MOR revealed resident #2 had the following medications that were charted as given, initials were in the box:
600 + D (supplement) daily in the PM charted on 7/4 and
(for lipids) 40 milligrams PM every other day on
supplement) 250 mg 2 tabs in PM on 7/4 and

The MOR was falsified to state resident #2 took his PM medications on 7/4 and ; when the unlicensed staff left the medications in the resident's

Interview with the nurse consultant on at approximately 10 AM who was not aware the resident did not take his evening medications and had them in his 7/4 and and they were charted as given.

Class II

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Renaissance Retirement Center, LLC
300 West Airport Blvd.
Sanford, FL 32771

Dear Administrator:

Re: CCR #2013003758

This letter reports the findings of a state licensure survey that was conducted on . 2013 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after . **2013,** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

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