STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968137	07/02/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Ana Assisted Living Facility	**140 Oaxaca Lane Kissimmee, FL 34743**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
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

Specific Tag Findings:

0000-Initial Comments
an unannounced complaint inspection CCR#2013003992 was conducted.

Ana Assisted Living had deficiencies found during the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on resident record review and interview the facility failed to provide care and services to ensure 2 of 3 sampled residents (#2 and #3) received medications as ordered by the healthcare provider.

Findings:

Resident record review for resident #2, on said date at approximately 11:30 AM revealed a health assessment report dated with diagnoses of Parkinson's, high and required a walker. Assistance was needed with self-administration of medications. She was at times.

Facility note dated at 7:20 AM indicated the resident had a change in level of was and daughter was called, no reply. She was called again at 7:40 AM, the resident's was 911 was called at 7:50 AM. At 8:20 Dr. {name} called and told the administrator not to take resident to ER. A decision was made by daughter to transfer resident to a nursing home.

The administrator wrote in the note dated that she (daughter/doctor) brought in a half-bottle she had in her car a few months ago and those were being used first rather than the multi-dose bubble pack. The daughter also wanted a piece of a bed rail, the administrator offered to replace the piece but she stated it had been a gift, she did not know where it was purchased from.

Note dated indicated that the 911 operator instructed the administrator not to give anything by mouth (NPO) until medics arrived. Per note, the doctor/daughter came to the facility to visit a resident. She told the administrator that her mother had become sick because her medication was not given correctly and gave the administrator a copy of the hospital record. The doctor/daughter also stated there were extra medications had they been given correctly there should be no extra.

A letter dated from the administrator to the resident's daughter indicated she hoped she received the box of Patches. She was unable to locate a missing piece of the bed rail and comforter, which she would double check around the house for it.

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A letter dated indicated the residents belongings and medications were removed; her last physical day at the facility was

Letter dated indicated that a phone call was received from a social worker indicating the resident was moving out.

Hospital record dated indicated the resident would go to a nursing facility. Her final diagnoses and Parkinson's . The hospital course indicated she was brought in with c/o significant tremors and change in mental condition. "It was discovered that she has not been given her Parkinson's medicine as she was scheduled to go Home." Medications were resumed as she was supposed to be taking and her tremors have significantly improved " . She also had a and were given.

Admission and discharge log indicated date of discharge "Resident admitted to Florida Hospital on due to her health declining. The medics were called on She had a blank look and was only starring at the ceiling. Her ability to walk and speak was very weak".

The Medication Observation Records (MOR) dated from 2012 to 2013 listed 37.5-150 200 mg 1 tablet 6 times daily for Parkinson's; given at 7 AM, 10 AM, 1 PM, 4 PM, 7 PM and 9 PM.

Prescription dated indicated 37.5-150 200 mg 1 table 6 times daily for Parkinson's; given at 7 AM, 10 AM, 1 PM, 4 PM, 7 PM and 9 PM. 180 tablets dispensed and 5 refills. The medication was marked as ordered daily until when the resident was sent to the ER and did not get her medications that morning and did not return to the facility.

The administrator stated at approximately 12 PM that the reason for the extra medication was that when the resident moved in to the facility; she would get a 90 refill. Once she moved-in to the facility she changed to local pharmacy, which prepared multi-dose bubble packs and refilled on 30 days cycle. So when they switched over to the local pharmacy there were about a 10 days' worth supply of left over from the 90 day supply. Rather than returning the 10 day supply to the daughter, she used it and therefore she always had a surplus of about 10 days' worth.

Resident record review for resident #3 revealed a Florida Family Medicine visit note dated that indicated "stomach" and had an arrow that pointed to " d/c Meloxican consult" . Resident allowed to perform own sterile sugar test and listed a diagnosis of

Florida Family Medicine visit note dated indicated "start 81 mg qd (daily)".

Florida hospital ED (emergency department) report dated indicated resident was seen due to pain. Health assessment dated indicated diagnoses of and assistance was needed with medications.

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Continued review revealed:

The 2013 Medication Observation Record (MOR) did not list , although it was ordered by the physician on .

The 2013 MOR listed Meloxican 7.5 mg daily and was marked as given from 6/1 to , although it was discontinued by the physician on and did not list .

The 2013 MOR still listed Meloxican 7.5 mg daily and was given and did not list .

Observations of the resident's medications at approximately 11:30 AM noted the Meloxican with a label dated was still among the resident's current medications. The was not available.

At approximately 11:30 AM administrator stated that the was not started because the resident's grandson asked why did she need and he brought a cream " Varn-Fresh for healthy veins" since the resident complained of pain. Regarding Meloxican, she stated the order to discontinue was not forwarded to pharmacy.

Class II

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observations, record review and interview the facility failed to ensure 1of 3 sampled residents was treated with consideration and respect and with due recognition of personal dignity, individuality and the need for privacy and allowed care to be provided in a common area in the presence of other residents.

Findings:

At approximately 9:15 AM the resident came from his the dining area, stated he wanted to sit at the table, and asked if "She was here already".

Observations at 9:20 AM noted the nurse arrived at the facility. Resident #1 sat at the dining table, while the other residents sat in the common area directly across. She placed a stool and a towel over it. The resident elevated his left foot. He stated his toe hurt, all the time. She placed gauze on the table and put some Mupricion ointment on the gauze. She also had tape and . She took his . Four other residents sat in common area and could see the resident and the nurse providing care. The husband's owner came in, stopped to see the progress of the nail. The surveyor sat at the table as well. The administrator stated the nurse was from home health.

She (administrator) stated at approximately 12 PM she was aware the resident had that on his toe. She had preferred he had been sent to rehab for but the doctor said it was OK for him to be in the ALF as long as control was followed. She added the resident's clothes including the bed sheets and blankets were washed separately from the other residents. He had been using the , just him and she cleaned it after with lots of bleach. The first days he ate alone but became and cried, he wanted to be with

the others. He was on TMP one .

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observations, record review and interview the facility failed to ensure the staff who assisted with self-administration of medications brought the medication to the resident in its original dispensed container and read the label to the resident, for 1 of 3 sampled residents (#1).

Findings:

At approximately 10 AM the administrator was observed with a small cup that had the resident's name. She called resident #1 to the dining area, told him "This is your 10 o'clock , gave him juice, observed him take the medication. She then signed the MOR.

Health assessment dated listed diagnoses of Parkinson's . assistance was needed with medications. Prescription dated 25 mg -200 mg -100 1 tab, five times daily.

The administrator stated at approximately 1 PM, as we sat to discuss the observations of the medication pass, that she did not do the medications correct.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observations, record review and interview the facility failed to ensure over-the-counter medications (OTC) in the resident's was kept locked when the resident was absent, unless the medication was in a secure place within the in some other secure place which was out of sight of other residents, for 1 of 5 residents (#1) .

Findings:

Record review for resident #1 revealed a Health assessment dated listed diagnoses of Parkinson's assistance was needed with medications.

Facility note dated indicated the administrator met with the resident's legal guardian regarding the OTC (Over the Counter) he kept in his "She explained to me there are some OTC meds that residents are allowed to keep. She is willing to write a letter explaining it for the facility".

Regarding the OTC the administrator stated at approximately 12:15 PM the resident's granddaughter worked at another ALF and told her he could keep OTC in his The surveyor requested to see what medications they were and where they were kept.

Observations at approximately 12:15 PM noted the resident's unlocked, the door was ajar and the

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resident was out on a facility outing. The dresser had a lock on the top drawer and was unlocked. The key was on top of the dresser. The administrator opened the drawer and inside was 2 bottles of on top of a table a bag of Epson salt. On the bedside table there were 2 bottles of eye drops, one bottle of regular strength and a tube of ointment. She added the resident refused to lock his the drawer and he (resident) stated that if he needed to lock his would move out.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Ana Assisted Living Facility
140 Oaxaca Lane
Kissimmee, FL 34743

Dear Administrator:

Re: CCR #2013003992

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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