| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11967856 | 01/30/2014 |
| NAME OF PROVIDER OR SUPPLIER<br>**Desoto Palms Assisted Living Community** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**5601 N Honore Ave Sarasota, FL 34235** | |
| SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION) | | |

**List of Tags Cited:**
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= E
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= E
St - A - 0057 - 58a-5.0185(8) Fac - Medication - Over The Counter (otc) Products S-S= D

**Specific Tag Findings:**
These are the results of an unannounced Biennial survey conducted on . . . . through . at DeSoto Palms Assisted Living Community, an Assisted Living Facility (ALF).

The following is a description of non-compliance:

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on interviews and record review, the facility failed to ensure 1 (Resident #15) of 3 residents which were reviewed revealed their Health Assessment (1823) was not signed and dated by a licensed heath care provider.

The findings included.

On . review of Resident #15's medical records revealed she was admitted to the facility . A Heath Assessment (1823), a face-to-face medical examination completed by a licensed health provider, was found in Resident #15's medical records. The top left corner has a sticker which states 1823 reviewed on . and signed by the Director of Nursing (DON). The 1823 on page 4 was not signed or dated by a physician. It is also missing the medical license number, address, and phone number of whom had completed the 1823. A faxed copy of an 1823 page 4 was connected to the 1823. The faxed copy has a fax date of . . . . . and . . . . . but does not have the date the physician had completed the examination.

On . at 3:00 p. m. an interview with the DON confirmed she had reviewed the 1823 because her signature was on page 1 with her signature and a date of . . . . . She also confirmed page 4 of the 1823 was not filled out by a licensed health care provider including not having a signature, date is was completed, or a license number. She also confirmed the faxed 1823 did not have the date the health care provider conducted the exam. She stated she had filled completed the 1823 for the health care provider but they had not completed the medical certification section. She confirmed because the 1823's did not have the required information, she is unable to tell when the face-to-face examination was completed.

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on observation, record review and staff interview, the facility failed to accurately maintain a daily Medication Observation Record (MOR) of . . . . . D3 supplement for 1 (Resident #13) of 5 residents surveyed. The facility had been providing 1 soft gel capsule of 1000 International Units (IU) for self-administration, once daily at 9:00 am. Absent of surveyor intervention, the error may have continued.

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The findings include:

1. During the Medication Pass on at 9:50 a.m., the supplement was found to be 1000 IU per capsule. The physician's order read: Take, 1 capsule of 5000 IU by mouth, once daily." After surveyor intervention the Medication Technician stopped and called the Nursing Director and advised that they had the wrong concentration of the D3 supplement for Resident #13. The Medication Technician then proceeded to provide 5, 1000 IU soft gel capsules of the supplement D3 1000IU per capsule.

2. On at 10:20 a.m., the Nursing Director stated she had electronically edited the physician's order to read, which now indicated that 5 capsules were to be given = 5,000IU of D3.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation, interview and record review, it was determined the facility failed to ensure 3 (Residents #13, #14 and #16) of 6 residents reviewed, who are assisted with their medications, had their medications stored in safe and secure manor.

The findings include.

On at around 11:45 a.m., while on tour of the facility observed Resident #16 had a bottle of NPH in his refrigerator. On top of the refrigerator was 12 syringes. Resident #16's wife stated in an interview the nurse left the syringes on top of the refrigerator but sometime they leave it on the kitchen counter. She also stated she tries to keep an eye on her husband to make sure he doesn't try and take the by himself.

On at around 9:00 a.m., during the medication observation with Staff G of Resident #14, it was noted the resident has a bottle of Lantus 100 units and a bottle of 0.4mg tablets (which, according to Staff G, is given to someone who is having chest paint) in her refrigerator. On the counter in a cup was 10 syringes. Staff G stated Resident #14 is listed as needing assistance with medication because she is not safe. Since the medication is kept in her , she could take the medication at any time without them knowing.

On at around 12:42 p.m., the Director of Nursing (DON) stated Resident #13 is also on Inspection of Resident #13's the DON noted she has 100 units and a Flex pen, which is an fast acting The DON also found 10 syringes in the cabinet. The DON stated because the syringes are in the the , the resident could take the medication without supervision.

On at 1:15 p.m., during review of Residents #13, #14 and #16 medical records, the DON stated the Health Assessment (1823) conducted by their health care provider stated each resident is unable to take medication without staff assistance. The DON stated when medications are left in a resident's does an evaluation to ensure it is safe to leave medications in the She further stated each resident had a comprehensive assessment which revealed they needed assistance with their medication. The DON also stated because the residents were deemed unsafe to take their own medications and the lin's bottles, the

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0.4mg and the Flex pen should not have been in the resident's . . . . . Because the medications were left unsecured in the the resident could of taken the medications without staff supervision or knowledge they had taken the medication.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observations, interviews and record review, the facility failed to ensure 3 (Residents #14, #15 and #16) of 5 residents' medication reviewed revealed their medication labels did not match the Medication Observation Record (MOR) and the physician orders. This could lead to the resident receiving the incorrect medication and/or the incorrect dose.

The findings include.

1. On . . . . . at 9:00 a.m., during the medication observation Staff G tock several medication cards into Resident #14's . . . . . She then read each medication out load, put them into a medicine cup and gave them to the resident. Resident #14 then swallowed each medication. Upon review of the medication cards, it was noted Staff G had given Resident #14 1 tablet of . . . . . 50mg by mouth. The medication label on the . . . . . medication card stated the medication is schedule to be given at noon.

On . . . . . at 9:35 a.m., an interview was conducted with Staff G about why she had given Resident #14 . . . . . 50mg when the medication label said the medication was schedule to be given at noon. She said she had made a mistake.

Review of Resident #14's medical records revealed 4 total . . . . . 50 mg tablets. Three of the labels said . . . . . 50mg by mouth 3 times daily. The 4th label said give . . . . . 50mg 1 tablet at noon. The MOR said . . . . . 50mg give 2 tablets three times a day at 9:00 a.m., 5:00 p.m., and 9:00 p.m. Staff G had signed the 9:00 a.m. as given 2 tablets even though she had only given 1 tablet. A physician progress note dated . . . . . for Resident #14 noted the resident is receiving . . . . . 2 tablets every 8 hours and 1 tablet at noon.

On . . . . . at 10:00 a.m., an interview with the Director of Nursing (DON), after she reviewed Resident #14's medical records, confirmed the medication labels of the . . . . . 50mg said take 1 tablet three times a day which did not match the MOR which said take 2 tablets 3 times a day at 9:00 a.m., 5:00 p.m. and 9:00 p.m. She also confirmed both the MOR and the medication label did not match the physician progress note dated . . . . . which state the resident is on . . . . . 50mg 2 tablets 8 hours a day. She then called the pharmacy to ask them why the MOR did not match the medication labels. After she hung-up with the pharmacist, she said they had all three orders but did not clarify which order the physician wanted. She stated Staff G should of caught the medication label did not match the MOR and the . . . . . 50mg orders should have been clarified since there was 3 conflicting orders for the same medication.

2. On at 9:25 a.m. during the medication observation Staff G tock several medication cards in to

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Resident #15's . . . . She then read each medication out load to Resident #15, put them into a medicine cup and gave them to the resident. Upon review of the medication cards, it was noted Staff G had given Resident #15 1 capsule of DR 30 mg . The medication label stated the medication should be given before meals. An eaten banana was noted on a breakfast tray on the dining . . . . . .

On . . . . at 9:35 a.m., an interview with Staff G was conducted about why she had given Resident #15 DR 30 mg when the medication label said it should be given daily before meals. She said she thought the resident had not eaten her breakfast and did not notice the breakfast tray on the table.

On . . . review of Resident #15's medical records revealed a Health Assessment (1823) dated . . . . . which when compared against the MOR and the medication label noted an order on the 1823 for . . . . . 100mg daily but the order was not on the MOR nor was the medication present. The 1823 had . . . . . 5mg by mouth daily, the MOR said the medication should be taken daily but the medication label said to take the medication at every evening. A medication card for . . . . . 80mg 1 tablet by mouth daily was observed and noted on the MOR, but the facility was unable to find a physician order for the . . . . 80mg.

On . . . . . at 11:15 a.m., interview with the DON after she reviewed Resident #15's medical records confirmed she had a physician order for . . . . . 100mg daily but it was not listed on the MOR and there is no medication card for the . . . . . 100mg. She stated she was unable to find a physician order for . . . . 80mg even though the medication is listed on the MOR and in the medication cart. She also confirmed the . . . . . 5mg medication label did not match the MOR or the physician order on the 1823. The DON confirmed the 1823 state the DR 30mg is to be given at 6:00 a.m. before breakfast not at 9:35 a.m. after breakfast when Staff G gave the medication to Resident #15. The DON called the pharmacy and they told her they did not have the physician order for the . . . . . 80mg on file and did not know why the . . . . . 100mg was not delivered as per the 1823.

3. On . . . . . at around 12:00 p.m., a review of Resident #16's . . . . . in his refrigerator with the DON noted the label on the . . . said . . . . . N inject 40 units . . . . . (SQ) in the morning and 14 units in the evening. Review of the MOR noted it said . . . . . N inject 40 units SQ in the morning and 15 units in the evening. A physician progress noted dated . . . . . notes the physician state the resident is on . . . . . N give 40 units in the morning and 14 units in the evening. The DON state the label on the . . . . . N . . . . . does not match the MOR and should have been clarified.

On . . . . . at 4:00 p.m., interview with the DON stated again Residents #14, #15 and #16 medications should have been clarified and the MOR, medication label, and the physician orders should all match because it could cause the resident to get the incorrect medication and/or incorrect dose of the medication.

Class III

0057-Medication - Over The Counter (OTC) Products 58A-5.0185(8) FAC
Based on observation, record review and staff interviews, the facility failed to properly label an OTC (Over the

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Counter) supplement for 1 (Resident #13) of 5 residents surveyed prior to and failed to input the resident's name, ordered dose, or frequency on the manufacture's label and failed to provide a supply of the D3, consistent with the physician order, (concentration per capsule).

The findings include:

1. During the Medication Review for Resident #13 on beginning at 9:05 a.m., the OTC supplement D3 1,000 International Units (IU)", for Resident #13, was in its original manufacture's container with only its original manufacture's label affixed. The resident's name, dose and frequency ordered by the physician were missing.

2. The OTC supplement D3-1000 IU", for Resident #13 was not the proper dose per soft gel capsule to be used for the order of: "5,000 IU to be taken: 1 soft gel capsule, by mouth, once daily." The medication technician had poured one capsule to provide one capsule to Resident #13. With surveyor intervention, the technician stopped and called the Nursing Director. The Medication Technician stopped and called the Nursing Director and advised that they had the wrong concentration of the D3 supplement for Resident #13. The Medication Technician then proceeded to provide 5, 1000IU capsules of the D3 supplement.

3. On at 9:50 a.m., when taking her medications, the Resident #13 commented: "There sure are a lot of pills today", It is unknown how long the under dosing of D3 had been occurring for Resident #13.

4. On at 11:10 am, The Nursing Director acknowledged that she had, based on her employee's report, added a brief statement in parenthesis on the Medication Observation Record (5 tablets=5000IU).

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Desoto Palms Assisted Living Community
5601 N Honore Ave
Sarasota, FL 34235

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on . 2014 by representatives 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 2014 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 surveyors. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. williams
Field Office Manager

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Enclosure: State Form

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