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	AL11911081	02/07/2014
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List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G
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= G
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= G
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

0000-Initial Comments
An unannounced complaint survey was conducted on - for CCR#2014000564 and CCR#2014000992 at the Cities Pavilion Assisted Living Facility. The facility had deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on record review and interview the facility failed to ensure the AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010 was complete for 1 of 8 sampled residents (#1).

The findings are:

Record review for sampled resident #1 revealed an admission date of . Review of the most recent Resident Health Assessment for Assisted Living Facilities AHCA form 1823 dated revealed the section: "Does the individual need help with taking his or her medication Yes_ NO___. If yes, please place a checkmark in front of the appropriate box below. ___Needs assistance with Self-Administration of Medications" or "___Needs medication administration." had not been completed. Further review of this 1823 revealed page 5 of the form which requires a list of the resident's services offered or arranged by the facility for the resident which must be completed by the ALF administrator or designee was blank. Interview with the facility director on at 10:08 AM confirmed this assessment was not complete as both sections should have been completed for this resident as they are applicable to this resident.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and interview the facility failed to ensure the resident's rights were honored by failing to ensure the residents lived in a safe environment for 2 of 8 sampled residents (#6 and #1) by failing to ensure medications were secure and by failing to report missing to the police.

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The findings are:

Interview with sampled staff F, resident aide/medication tech at 10:39AM on revealed that she discovered sampled resident #1's, entire punch card of missing from the medication overflow cabinet yesterday afternoon ( ). She stated she told the lead med tech, sampled staff G, yesterday and it is still missing. She stated the resident did not get her pain medication this morning or last night, because she does not have any. Record review of the resident's 2014 medication administration record for the resident's - 10-325 one table by mouth twice daily was initially done on at approximately 2:38PM. This review was done with the facility director the review revealed the staff initialed and circled their initials on the 8PM and the 8AM dose of - 10-325; when the facility director was asked what these documentation's meant, she stated the resident did not get her - 10-325 because she does not have any. When asked why she does not have any of this medication, the facility director replied because they discovered yesterday afternoon, that the resident's next punch card of 30 count of - 10-325 was missing from the medication overflow cabinet and the medication has been reordered at the facility's expense.

An interview was conducted with sampled resident #6 at approximately 8:40AM on . She stated about two weeks ago, on a Thursday or Friday, (or) sampled staff B told her that she only had 5 pain pills left the resident asked her why and she told her there was missing medications. Interview with sampled staff B on at 9:28AM stated the resident never ran out of her routine pain medication ( ). Interview with sampled staff G and with the facility director, present on at approximately 10:21AM revealed sampled staff G discovered on sampled resident #6's next 30 count punch card of - 10-325 ( ) was missing from the overflow medication cabinet in the medication . She reported the missing medications to the facility director on when the director returned to work from a week's vacation.

Interview with the facility director on at approximately 10:00AM revealed that she has not reported the missing for sampled resident #6 and sampled resident #1 to the police until today. She stated she reported the missing only the morning when she also reported that she suspects sampled staff H, of vandalizing the facility building. She stated she reported the missing to the local police today.

Class II

0054-Medication - Records 58A-5.0185(5) FAC
Based on record reviews and interviews the facility failed to ensure medication observation records (MOR'S) for 1 of 3 sampled residents (#6) was accurate and failed to ensure there were no discrepancies between the the resident's MOR and her controlled drug use record.

The findings are:

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An interview was conducted with sampled resident #6, at approximately 8:40AM on . She stated about two weeks ago, on a Thursday or Friday, or , sampled staff B told her that she only had 5 pain pills left; the resident asked her why and she told her there was missing medications. Interview with sampled staff B on at 9:28AM stated the resident never ran out of her routine pain medication, Record review of the resident's 2014 medication observation record (MOR) revealed documentation that the resident was receiving - 10-325 one tablet three times daily for advanced osteoarthosis and ; taken at 8AM, 2PM, 6PM. Record review revealed documentation by various staff that she has been receiving and taking this medication at those times. Interview with sampled staff G with the facility director present on at approximately 10:21PM revealed sampled staff G discovered on sampled resident #6's next 30 count punch card of - 10-325 ( ) was missing from the overflow medication cabinet in the medication . She stated the resident had 5 left; so she ordered more which came in on Sunday, , the resident had enough 's to take as ordered over the weekend. She stated the resident never did without her routine . The interview continued sampled staff G at approximately 10:30AM and with the facility director. Record review of the resident's MOR for 2014 was done with these two staff. The review revealed documentation by various staff that the resident received her routine ( ) tablet three times a day, one at 8AM, one at 2PM and one at 6PM on , and . Record review of the controlled drug use record for for sampled resident #6 for thru was also done with these two staff. Review of this controlled drug use record revealed documentation entered by staff on the resident received one at 8:15am, 7:50pm and then there is documentation stating on 9A medication taken. Documentation on revealed one taken at 7:30PM. There is no documentation that staff provided the dose at 2PM or 6PM on . The next documentation by staff revealed the resident received the medication on at 8:50AM, 2:00PM and 8:00PM. Review of this document, the controlled drug use record, revealed documentation by the staff that the resident did not receive her medication three times a day as ordered on , yet the MOR revealed documentation the medication was taken as ordered. One of these records is documented inappropriately. Interview and review of these records with the facility director and sampled staff G, lead med tech/resident aide, at this time revealed they agreed there is a discrepancy between the two records, the controlled drug use record and the resident's MOR. The facility director tried to explain the situation by saying the staff must have entered the wrong dates on the controlled drug use record and she was not aware of the this issue prior to the surveyor mentioning it to her and she could not explain the discrepancy.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observations, record reviews and interviews the facility failed to ensure resident's medications were securely stored for 3 of 8 sampled residents (#8, #1 and #6)

The findings are:

Upon entrance to the facility on at approximately 8:50AM this surveyor requested the last six months of Adverse Incidents reports. At approximately 10:30AM the facility director presented the surveyor with a folder which contained one adverse incident report. Interview with facility director at this time revealed this is the only adverse incident she has filed. Review of the report revealed the adverse incident report was for another resident and not for sampled resident #8. Interview with the facility director on at approximately 2:45PM revealed

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she has not filed an adverse incident report for sampled resident #8 for the incident when he was discovered ill and with a bottle of that belonged to another resident, was transferred to the hospital and later . She stated she did not realize she needed to file an adverse incident report until she spoke with the Attorney General's staff who came again today, . She stated she plans to complete the report tomorrow. She now believes it was an adverse incident because someone else was in the possession of another resident's medication and had to go to the hospital. On the facility director presented this surveyor with a copy of the One Day Adverse Incident report she filed on for date of incident (should be) for sampled resident #8. Review of this Adverse Incident report revealed the facility director completed the form as " yes, the events causing or resulting in the adverse incident represent a potential risk to other patients " because " medication was left unsecured in the medications accessible to residents" .

Interview with sampled resident # 9 and the wife of sampled resident #8 at 9:24AM on revealed she has lived in the facility for almost two years. She lived in the same her husband. Interview with her revealed that her husband had on / , stated she was told that a staff, sampled staff #G. left another resident's full bottle of on her desk in the medication her husband picked them up. She stated she did not know he had the pills until he got sick one night and she found them in his pocket and she turned the half full bottle into the staff. She stated was unsure who the medication belonged to. She stated the night he got sick, he was getting ready for bed, he needed her help to go to the , he got weaker as he was going to the , so she returned him to the bed and she called the staff, by blowing her whistle, sampled staff H came; he tried to get him to the , couldn't do it, he obtained his vital signs and his was low and he called . He was fine the whole day prior to him getting sick that night, the symptoms came on him all of a sudden. She stated her husband's normal cognition was times of , so she thinks he may have not known what he was doing, if he indeed took the medication; but does not know for sure if he took any of the pills. She stated the medication never been locked, even when staff was not in the medication , not since she has been here. She stated they just started locking the medication her husband's .

Interview with lead med tech/resident aide, sampled staff G, at approximately 11:17AM on revealed she has worked at the facility for 13 years as of this year. In reference to sampled resident #8, she was not working when he "supposedly" got the medication off her desk. She stated that the medication was not labeled with a name and she is assuming it was sampled resident #4's medications, he was a new admit on , 2013 and she found the medication on her desk one or two days later when she returned to work on the following Monday. She placed it in a plastic thing on her desk and then later placed it in the top left drawer of her desk, does not know why she placed it in her desk, should have locked it up in the cabinet which keeps the overflow medication. Does not know how sampled resident #8 got the medications, she was not working. Saturday sampled staff H found the in sampled resident #8 possession before the resident left for the hospital due to low , when she returned on the following Monday, sampled staff H had put the bottle back in her desk drawer. She stated the bottle contained the same number of pills that it had in it prior to sampled resident #8 taking the bottle, a little less than half full. She confirmed she did not count the number of pills when she initially got the bottle, nor did she count the pills when sampled staff H returned the bottle to her after sampled resident #8 had the bottle and was sent to the hospital. Interview sampled staff B on at 2:07PM works 8:30-4:30PM worked here four years and she is resident care assistant, does ADL'S, does an occasional med pass. In reference to sampled resident #8 she saw the little brown amber colored bottle of medications, tablets on sampled staff G's desk in a clear plastic box like a paper clip holder on or about 12/9 or and they stayed there for a few weeks. She kept asking sampled staff G if she was going to put them away and she would become very confrontational about it, so she did not say anything else. She did not tell anyone else but everyone else could see them on her desk. The

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facility director did a memo to the staff, yesterday, that the med are to be locked and concerning not leaving medications unlocked.

An interview was conducted with sampled resident #6 at approximately 8:40AM on . She stated about two weeks ago, on a Thursday or Friday , (or) sampled staff B told her that she only had 5 pain pills left the resident asked her why and she told her there was missing medications. Interview with sampled staff B on at 9:28AM stated the resident never ran out of her routine pain medication ( ). Record review of the resident's 2014 medication observation record (MOR) revealed documentation that the resident was receiving - 10-325 one tablet three times daily for advanced osteoarthosis and ; taken at 8am, 2PM, 6PM. Record review revealed documentation by various staff that she has been receiving and taking this medication at those times. Interview with sampled staff G and with the facility director, present on at approximately 10:21PM revealed sampled staff G discovered on sampled resident #6's next 30 count punch card of - 10-325 ( ) was missing from the overflow medication cabinet in the medication . She stated the resident had 5 left; so she ordered more which came in on Sunday, , the resident had enough 's to take as ordered over the weekend. She stated the resident was never out her routine / . The interview continued with sampled staff G, at approximately 10:30AM with the facility director present. Record review of the resident's medication observation record (MOR) for 2014 was done with these two staff. The review revealed documentation by various staff that the resident received her routine / ( ) tablet three times a day, one at 8AM, one at 2PM and one at 6PM on and . Record review of the controlled drug use record for / for sampled resident #6 for / thru was also done with these two staff. Review of this controlled drug use record revealed documentation entered by staff on the resident received one / at 8:15am, 7:50pm and then there is documentation stating on 9A medication taken. Documentation on revealed one taken at 7:30PM. There is no documentation on this controlled drug use record the staff provided the dose at 2PM or 6PM on . The next documentation by staff revealed the resident received the medication on at 8:50AM, 2:00PM and 8:00PM. Review of this document, the controlled drug use record, revealed documentation by the staff that the resident did not receive her medication three times a day as ordered on , yet the MOR revealed documentation the medication was taken as ordered, three times a day on . One of these records is documented inappropriately. Interview and review of these records with the facility director and sampled staff G, lead med tech/resident aide, at this time revealed they agreed there is a discrepancy between the two records, the controlled drug use record and the resident's MOR. The facility director tried to explain the situation by saying the staff must have entered the wrong dates on the controlled drug use record and she was not aware of the this issue prior to the surveyor mentioning it to her and she could not explain the discrepancy.

Interview with sampled staff F, resident aide/medication tech at 10:39AM on revealed that she discovered sampled resident #1, entire punch card of missing from the medication overflow cabinet yesterday afternoon ( ). She stated she told the lead med tech, sampled staff G, yesterday and it is still missing. She stated the resident did not get her pain medication this morning or last night, because she does not have any.

Interview with sampled resident #1 on at 8:50AM revealed when asked if she has had any missing pain medications she stated "no, I haven't". She thinks she took her pain medications Thursday morning, . Pain is controlled "pretty well". Stated she has a constant pain in her left ankle, it has been getting worse over the last few weeks. Currently being seen by home health physical . Record review of the resident's 2014 medication administration record for the resident's - 10-325 one

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table by mouth twice daily was initially done on at approximately 2:38PM. This review was done with the facility director. The review revealed the staff initialed and circled their initials on the 8PM and the 8AM dose of 10-325; when the facility director was asked what these documentation's meant, she stated the resident did not get her 10-325 because she does not have any. When asked why she does not have any of this medication, the facility director replied because they discovered yesterday afternoon, that the resident's next punch card of 30 count of 10-325 was missing from the medication overflow cabinet and the medication has been reordered at the facility's expense. Record review again on at approximately 10AM with the facility director revealed documentation again that denoted the resident did not receive her tablet at 8PM on . Documentation revealed the resident received her 8AM dose of this medication on .

An interview and a brief inspection of the overflow medication cabinet was done with the facility director at approximately 2:38PM on . She stated this cabinet contains the overflow medications including the extra that the pharmacy sends to the facility for the residents. She stated that the staff does not count these and does not keep a controlled drug use record on these medications until the staff removes the resident's punch card from this cabinet and places the punch card into the medication cart for the resident's use. Once the resident's punch card is placed in the medication cart a controlled drug use record is completed with the name of the resident, the name and dosage and prescription instructions and the number of contained on the punch card and this form is placed in the MOR book and the count is then maintained by the staff as the resident takes the medication. These overflow are not counted daily at each shift change when the other maintained in the medication carts are counted. When asked how do you know if any medications are missing, if they are not counted daily at each shift change, she stated she does not know. When asked to see some of the medications in this cabinet the facility director stated that yesterday afternoon ( ) the staff discovered missing from this cabinet. When asked how they knew they had missing she stated the staff needed a new card of for sampled resident #1 and there were none. They had to go back and retrieve the pharmacy delivery receipt which revealed the resident's were delivered to the facility on / . It was discovered the punch card containing 30 pills of 10-325 was missing for sampled resident #1 when the staff went to get the new card to place in the box of the medication cart. She does not know when the medication went missing. She stated she reviewed the video camera footage and found no problems. She stated sampled staff A, signed for 60 10-325 on / . She stated she has interviewed sampled staff A and sampled staff G, and no one knows what happened to the . She stated today she is in the process of changing how are stored and handled by the facility staff. The resident's have been reordered at the facility's expense.
The interview with the facility director continued approximately 2:50PM on and she stated In reference to sampled resident #8 she stated as she understands sampled resident #4 was being admitted to the facility on and sampled staff G was developing a MOR for his medications and there was a bottle presented which did not contain a label with his name. Sampled staff G placed the bottle of on her desk in the medication ; the facility director stated she does not know why the staff did not lock up the bottle of , as she should have. When asked if she saw the bottle of the facility director stated she never saw the medication on sampled staff G's desk. Sampled staff A and sampled staff G were responsible for developing the MOR and securing the medications. It was her understanding that the medication was in sampled staff G's desk drawer and sampled resident #8 entered the went thru the desk and took the bottle of . She stated the staff did not count the pills in the bottle, so they do not know how many pills were in the bottle when sample resident #8 took the bottle. She stated the medication not properly secured and he was not properly supervised. Since this incident the director contacted a RN

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consultant and she will be doing mandatory inservice on medications . When asked why this inservice is not being done earlier she stated because "this came to heat since attorney general's office came in this past Monday, ". When asked what steps she did to ensure this did not happen again, she stated she had been assured by sampled staff G, that it appeared sampled resident #8 had not taken any of the . Sampled staff G has worked for the facility for 13 years and she did not think she needed to do anything further at that time. She stated she realizes now she should have done more. She stated because sampled staff G was a long time employee and she had spoken with her she did not feel it necessary to do anything else.
In reference to sampled resident #6 missing medications continued interview with the facility director revealed the first she was aware medications were missing for this resident was when she returned to work on , she had been out on a week's vacation. She was informed some was missing. Investigation revealed at that time sampled staff H, had opened the pharmacy bin and was the last one to have access to the bin. She continued the investigation by writing a memorandum to him and called him and asked him to come in. She planned to continue the investigation by having him drug tested but he quit, yesterday, and the drug test was not done. He did not respond to her written memorandum. On at approximately 4:00PM the facility director provided the surveyor with a copy of the memorandum she addressed to sampled staff H which is dated / which is prior to the missing medications of . She also presented the surveyor with a copy of a "Staff Notes- " she stated she provided to her direct care staff and medication techs. Review of these "Staff Notes- " revealed it does not address the security of medications including . The facility director offered no other documentation at this time.
Continued interview with the facility director revealed her statement that as of today ( ) she has now collected the keys to the medication/ overflow cabinet from sampled staff G, A and B because they were the only ones with the keys and now no one else has the keys except her. Additionally she will do random drug screens on sampled staff A and sampled staff G and had already done a random drug screen on sampled staff B and the results are not back yet. She has removed sampled staff G from the responsibility of handling or assisting residents with medications and she will now be working on the floor and the kitchen and sampled staff B will be working on the floor but no longer the resident care assistant which allowed her to access to any of the records, coordination of all the services. The facility director stated this is being done at the suggestion of the Attorney General's staff that was here today ( ). Instituted a policy yesterday ( ) that the bin from the pharmacy now requires two medication trained staff to be present when the container is opened to verify the medication name, the dosage and the quantity against the delivery receipt from the pharmacy and both staff will have to sign, in the past it was just one staff. The next step will be that there will be an inventory and log and a sheet for each of the overflow , no staff will be able to just pull a needed punch card.

Review of the personnel file for sampled staff G revealed it only contained an Employee Reprimand dated but not signed by the employee or the facility director until in which it covered the employee violations of leaving unsecured medications on the desk on , 2014 which were accessed by a resident and destroying said medication which was not properly tabled and later determined to be evidence in an investigation. Additional concerns addressed on this document included remaining onsite when new resident is admitted until all documentation (MOR, Narc Sheet) is complete and medication is properly secured in the med cart. proper monitoring of resident aides to assure compliance with facility policy and procedures regarding assistance with and securing of medications, remain current on assistance with self administered medications certification, maintaining medications neat and orderly manner, have two person present when opening containers from pharmacy to document any discrepancies. There is no documentation of any formal inservice for this staff in regards to security of medications. Record review for seven other sampled employees who provide assistance with self-administration of medications failed to reveal any documentation of any formal inservice's in relations to security of medications since these incidents of missing medications has occurred.

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0077-Staffing Standards - Administrators 58A-5.019(1) FAC
Based on observation, staff interview and record review, the administrator failed to ensure unlicensed staff were able to demonstrate competency in assistance with self- administration of medications. The administrator filed to ensure unlicensed staff kept all medications including controlled medications in a secure location away from unauthorized staff or resident access, failed to contact law enforcement when controlled medications were discovered missing, and failed to ensure unlicensed staff maintained a complete and accurate medication observation record (MOR). This 3 of 8 sampled residents (#1, #6, #8)

Findings:

Upon entrance to the facility on at approximately 8:50AM this surveyor requested the last six months of Adverse Incidents reports. At approximately 10:30AM the facility director not the administrator of record presented the surveyor with a folder which contained one adverse incident report. Interview with facility director at this time revealed this is the only adverse incident she has filed. Review of the report revealed the adverse incident report was for another resident and not for sampled resident #8. Interview with the facility director on at approximately 2:45PM revealed she has not filed an adverse incident report for sampled resident #8 for the incident when he was discovered ill and with a bottle of that belonged to another resident, was transferred to the hospital and later . She stated she did not realize she needed to file an adverse incident report until she spoke with the Attorney General's staff who came again today, . She stated she plans to complete the report tomorrow. She now believes it was an adverse incident because someone else was in the possession of another resident's medication and had to go to the hospital. On the facility director presented this surveyor with a copy of the One Day Adverse Incident report she filed on for date of incident (should be) for sampled resident #8. Review of this Adverse Incident report revealed the facility director completed the form as " yes, the events causing or resulting in the adverse incident represent a potential risk to other patients " because " medication was left unsecured in the medications accessible to residents " . The administrator was not available for interview during the 2 day survey 2/6- .

Interview with sampled resident # 9 and the wife of sampled resident #8 at 9:24AM on revealed she has lived in the facility for almost two years. She lived in the same her husband. Interview with her revealed that her husband had on , stated she was told that a staff, sampled staff #G. left another resident's full bottle of on her desk in the medication her husband picked them up. She stated she did not know he had the pills until he got sick one night and she found them in his pocket and she turned the half full bottle into the staff. She stated was unsure who the medication belonged to. She stated the night he got sick, he was getting ready for bed, he needed her help to go to the , he got weaker as he was going to the , so she returned him to the bed and she called the staff, by blowing her whistle, sampled staff H came; he tried to get him to the , couldn't do it, he obtained his vital signs and his was low and he called . He was fine the whole day prior to him getting sick that night, the symptoms came on him all of a sudden. She stated her husband's normal cognition was times of , so she thinks he may have not known what he was doing, if he indeed took the medication; but does not know for sure if he took any of the pills. She stated the medication never been locked, even when staff was not in the medication , not since she has been here. She stated they just started locking the medication her husband's .

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Interview with lead med tech/resident aide, sampled staff G, at approximately 11:17AM on revealed she has worked at the facility for 13 years as of this year. In reference to sampled resident #8, she was not working when he "supposedly" got the medication off her desk. She stated that the medication was not labeled with a name and she is assuming it was sampled resident #4's medications, he was a new admit on , 2013 and she found the medication on her desk one or two days later when she returned to work on the following Monday. She placed it in a plastic thing on her desk and then later placed it in the top left drawer of her desk, does not know why she placed it in her desk, should have locked it up in the cabinet which keeps the overflow medication. Does not know how sampled resident #8 got the medications, she was not working. Saturday sampled staff H found the in sampled resident #8 possession before the resident left for the hospital due to low , when she returned on the following Monday, sampled staff H had put the bottle back in her desk drawer. She stated the bottle contained the same number of pills that it had in it prior to sampled resident #8 taking the bottle, a little less than half full. She confirmed she did not count the number of pills when she initially got the bottle, nor did she count the pills when sampled staff H returned the bottle to her after sampled resident #8 had the bottle and was sent to the hospital. Interview sampled staff B on at 2:07PM works 8:30-4:30PM worked here four years and she is resident care assistant, does ADL'S, does an occasional med pass. In reference to sampled resident #8 she saw the little brown amber colored bottle of medications, tablets on sampled staff G's desk in a clear plastic box like a paper clip holder on or about 12/9 or and they stayed there for a few weeks. She kept asking sampled staff G if she was going to put them away and she would become very confrontational about it, so she did not say anything else. She did not tell anyone else but everyone else could see them on her desk. The facility director did a memo to the staff, yesterday, that the med are to be locked and concerning not leaving medications unlocked.

An interview was conducted with sampled resident #6 at approximately 8:40AM on . She stated about two weeks ago, on a Thursday or Friday , (or) sampled staff B told her that she only had 5 pain pills left the resident asked her why and she told her there was missing medications. Interview with sampled staff B on at 9:28AM stated the resident never ran out of her routine pain medication (/). Record review of the resident's 2014 medication observation record (MOR) revealed documentation that the resident was receiving - 10-325 one tablet three times daily for advanced osteoarthosis and ; taken at 8am, 2PM, 6PM. Record review revealed documentation by various staff that she has been receiving and taking this medication at those times. Interview with sampled staff G and with the facility director, present on at approximately 10:21PM revealed sampled staff G discovered on sampled resident #6's next 30 count punch card of - 10-325 ( ) was missing from the overflow medication cabinet in the medication . She stated the resident had 5 left; so she ordered more which came in on Sunday, , the resident had enough 's to take as ordered over the weekend. She stated the resident was never out her routine / . The interview continued with sampled staff G, at approximately 10:30AM with the facility director present. Record review of the resident's medication observation record (MOR) for 2014 was done with these two staff. The review revealed documentation by various staff that the resident received her routine / ( ) tablet three times a day, one at 8AM, one at 2PM and one at 6PM on , and . Record review of the controlled drug use record for / for sampled resident #6 for / thru was also done with these two staff. Review of this controlled drug use record revealed documentation entered by staff on the resident received one / at 8:15am, 7:50pm and then there is documentation stating on 9A medication taken. Documentation on revealed one taken at 7:30PM. There is no documentation on this controlled drug use record the staff provided the dose at 2PM or 6PM on . The next documentation by staff revealed the resident received the medication on at 8:50AM, 2:00PM and

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8:00PM. Review of this document, the controlled drug use record, revealed documentation by the staff that the resident did not receive her medication three times a day as ordered on , yet the MOR revealed documentation the medication was taken as ordered, three times a day on . One of these records is documented inappropriately. Interview and review of these records with the facility director and sampled staff G, lead med tech/resident aide, at this time revealed they agreed there is a discrepancy between the two records, the controlled drug use record and the resident's MOR. The facility director tried to explain the situation by saying the staff must have entered the wrong dates on the controlled drug use record and she was not aware of the this issue prior to the surveyor mentioning it to her and she could not explain the discrepancy.

Interview with sampled staff F, resident aide/medication tech at 10:39AM on revealed that she discovered sampled resident #1, entire punch card of missing from the medication overflow cabinet yesterday afternoon ( ). She stated she told the lead med tech, sampled staff G, yesterday and it is still missing. She stated the resident did not get her pain medication this morning or last night, because she does not have any.

Interview with sampled resident #1 on at 8:50AM revealed when asked if she has had any missing pain medications she stated "no, I haven't". She thinks she took her pain medications Thursday morning, . Pain is controlled "pretty well". Stated she has a constant pain in her left ankle, it has been getting worse over the last few weeks. Currently being seen by home health physical . Record review of the resident's 2014 medication administration record for the resident's 10-325 one table by mouth twice daily was initially done on at approximately 2:38PM. This review was done with the facility director. The review revealed the staff initialed and circled their initials on the 8PM and the 8AM dose of 10-325; when the facility director was asked what these documentation's meant, she stated the resident did not get her 10-325 because she does not have any. When asked why she does not have any of this medication, the facility director replied because they discovered yesterday afternoon, that the resident's next punch card of 30 count of 10-325 was missing from the medication overflow cabinet and the medication has been reordered at the facility's expense. Record review again on at approximately 10AM with the facility director revealed documentation again that denoted the resident did not receive her tablet at 8PM on . Documentation revealed the resident received her 8AM dose of this medication on .

An interview and a brief inspection of the overflow medication cabinet was done with the facility director at approximately 2:38PM on . She stated this cabinet contains the overflow medications including the extra that the pharmacy sends to the facility for the residents. She stated that the staff does not count these and does not keep a controlled drug use record on these medications until the staff removes the resident's punch card from this cabinet and places the punch card into the medication cart for the resident's use. Once the resident's punch card is placed in the medication cart a controlled drug use record is completed with the name of the resident, the name and dosage and prescription instructions and the number of contained on the punch card and this form is placed in the MOR book and the count is then maintained by the staff as the resident takes the medication. These overflow are not counted daily at each shift change when the other maintained in the medication carts are counted. When asked how do you know if any medications are missing, if they are not counted daily at each shift change, she stated she does not know. When asked to see some of the medications in this cabinet the facility director stated that yesterday afternoon ( ) the staff discovered missing from this cabinet. When asked how they knew they had missing she stated the staff needed a new card of for sampled resident #1 and there were none. They had to go back and retrieve the pharmacy delivery receipt which revealed

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the resident's were delivered to the facility on / . It was discovered the punch card containing 30 pills of 10-325 was missing for sampled resident #1 when the staff went to get the new card to place in the box of the medication cart. She does not know when the medication went missing. She stated she reviewed the video camera footage and found no problems. She stated sampled staff A, signed for 60 10-325 on . She stated she has interviewed sampled staff A and sampled staff G, and no one knows what happened to the . She stated today she is in the process of changing how are stored and handled by the facility staff. The resident's have been reordered at the facility's expense.

The interview with the facility director continued approximately 2:50PM on and she stated In reference to sampled resident #8 she stated as she understands sampled resident #4 was being admitted to the facility on and sampled staff G was developing a MOR for his medications and there was a bottle , presented which did not contain a label with his name. Sampled staff G placed the bottle of on her desk in the medication ; the facility director stated she does not know why the staff did not lock up the bottle of , as she should have. When asked if she saw the bottle of the facility director stated she never saw the medication on sampled staff G's desk. Sampled staff A and sampled staff G were responsible for developing the MOR and securing the medications. It was her understanding that the medication was in sampled staff G's desk drawer and sampled resident #8 entered the went thru the desk and took the bottle of . She stated the staff did not count the pills in the bottle, so they do not know how many pills were in the bottle when sample resident #8 took the bottle. She stated the medication not properly secured and he was not properly supervised. Since this incident the director contacted a RN consultant and she will be doing mandatory inservice on medications . When asked why this inservice is not being done earlier she stated because "this came to heat since attorney general's office came in this past Monday, .". When asked what steps she did to ensure this did not happen again, she stated she had been assured by sampled staff G, that it appeared sampled resident #8 had not taken any of the . Sampled staff G has worked for the facility for 13 years and she did not think she needed to do anything further at that time. She stated she realizes now she should have done more. She stated because sampled staff G was a long time employee and she had spoken with her she did not feel it necessary to do anything else.

In reference to sampled resident #6 missing medications continued interview with the facility director revealed the first she was aware medications were missing for this resident was when she returned to work on , she had been out on a week's vacation. She was informed some was missing. Investigation revealed at that time sampled staff H, had opened the pharmacy bin and was the last one to have access to the bin. She continued the investigation by writing a memorandum to him and called him and asked him to come in. She planned to continue the investigation by having him drug tested but he quit, yesterday, and the drug test was not done. He did not respond to her written memorandum. On at approximately 4:00PM the facility director provided the surveyor with a copy of the memorandum she addressed to sampled staff H which is dated / which is prior to the missing medications of . She also presented the surveyor with a copy of a "Staff Notes- " she stated she provided to her direct care staff and medication techs. Review of these "Staff Notes- " revealed it does not address the security of medications including . The facility director offered no other documentation at this time.

Continued interview with the facility director revealed her statement that as of today ( ) she has now collected the keys to the medication/ overflow cabinet from sampled staff G, A and B because they were the only ones with the keys and now no one else has the keys except her. Additionally she will do random drug screens on sampled staff A and sampled staff G and had already done a random drug screen on sampled staff B and the results are not back yet. She has removed sampled staff G from the responsibility of handling or assisting residents with medications and she will now be working on the floor and the kitchen and sampled staff B will be working on the floor but no longer the resident care assistant which allowed her to access to any of the records, coordination of all the services. The facility director stated this is being done at the suggestion of the

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Attorney General's staff that was here today ( ). Instituted a policy yesterday ( ) that the bin from the pharmacy now requires two medication trained staff to be present when the container is opened to verify the medication name, the dosage and the quantity against the delivery receipt from the pharmacy and both staff will have to sign, in the past it was just one staff. The next step will be that there will be an inventory and log and a sheet for each of the overflow , no staff will be able to just pull a needed punch card. At no time during the survey was the adminsitrator available.

Review of the personnel file for sampled staff G revealed it only contained an Employee Reprimand dated but not signed by the employee or the facility director until in which it covered the employee violations of leaving unsecured medications on the desk on , 2014 which were accessed by a resident and destroying said medication which was not properly tabled and later determined to be evidence in an investigation. Additional concerns addressed on this document included remaining onsite when new resident is admitted until all documentation (MOR, Narc Sheet) is complete and medication is properly secured in the med cart. proper monitoring of resident aides to assure compliance with facility policy and procedures regarding assistance with and securing of medications, remain current on assistance with self administered medications certification, maintaining medications neat and orderly manner, have two person present when opening containers from pharmacy to document any discrepancies. There is no documentation of any formal inservice for this staff in regards to security of medications. Record review for seven other sampled employees who provide assistance with self-administration of medications failed to reveal any documentation of any formal inservice's in relations to security of medications since these incidents of missing medications has occurred.

Class II

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on record reviews and interview the facility failed to ensure direct care staff, who were not nurses, certified nursing assistants, or home health aides received 3 hours of in-service training within 30 days of employment that covers resident behavior and needs and providing assistance with the activities of daily living for 2 of 8 sampled direct care staff employees (#C and #E).

The findings are:

Record review for sampled employee #C revealed a hire date of and is a resident aide; record failed to reveal documentation of completion of the required 3 hour Activities of Daily Living and Behavioral Needs Training within 30 days of employment. Record review on for sampled employee #E with a hire date of , a resident aide; failed to reveal documentation of completion of the require 3 hour Activities of Daily Living and Behavioral Needs Training within 30 days of hire. Interview with the facility director on at approximately 12:52PM also confirmed these findings.

Class III

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0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC
Based on record reviews and interviews the facility failed to ensure an unlicensed staff who was providing assistance with self-administered medications obtained annually 2 hours of continuing education on providing assistance with self-administered medications for 1 of 8 sampled employees (#G).

The findings are:

Record review for sampled employee #G revealed she is the lead medication technician with a hire date of and is unlicensed. Record review for this employee revealed the most recent Assistance with Self-Administered Medications annual 2 hour update was done on . The certificate was expired as of . Interview with sampled employee #G on at approximately 11:00AM revealed that she had been assisting with self-administered medications with the residents thru when the facility director discovered her certificate was expired. At that time she was no longer allowed to assist with self-administered medications and she is scheduled to take the class on . Random review of resident medication observation records (MOR's) for and 2014 confirmed the last day her initials are noted on the MOR's is . Interview with the facility director at 1:05PM confirmed these findings.

Class III

0090-Training - 58A-5.0191(11) FAC
Based on record reviews and interview the facility failed to ensure newly hired direct care staff received at least one hour of training in the facility's policy and procedures regarding within 30 days of employment for 2 of 8 employees (#C and #E).

The findings are:

Record review of the personnel files for sampled employee #C with a hire date of and E with a hire date of failed to reveal documentation the staff had received the required one hour of training within 30 days after employment for the facility's Policy and Procedure. Interview with the facility director on beginning at 12:46PM confirmed these findings for sampled employee #C and E and her statement she thought this just had to be done yearly.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on record review and interview the facility failed to file required state reports by failing to appropriately file an initial adverse incident report for sampled resident #8.

The findings are:

Upon entrance to the facility on at approximately 8:50AM this surveyor requested the last six months of

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Adverse Incidents reports from the facility director. At approximately 10:30AM she presented the surveyor with a folder which contained one adverse incident report. Interview with facility director at this time revealed this is the only adverse incident she has filed. Record review of the report revealed the adverse incident report was for another resident and not for sampled resident #8. Interview with the facility director on at approximately 2:45PM revealed she has not filed an adverse incident report for sampled resident #8 for the incident when he was discovered ill and with a bottle of that belonged to another resident and the facility does not know if he took some or all of the medication and he had to be transferred to the hospital. She stated she did not realize she needed to file an adverse incident report until she spoke with the Attorney General's staff who came again today, . She stated she plans to complete the report tomorrow. She now believes it was an adverse incident because someone else was in the possession of another resident's medication and had to go to the hospital. On the facility director presented this surveyor with a copy of the One Day Adverse Incident report she filed on for date of incident (should be) for sampled resident #8. Review of this Adverse Incident report revealed the facility director completed the form as " yes, the events causing or resulting in the adverse incident represent a potential risk to other patients " because " medication was left unsecured in the medications accessible to residents " .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Cities Pavilion
1053 John Sims Parkway
Niceville, FL 32578

Dear Administrator:

This letter reports the findings of a complaint survey (CCR #2014000564, 2014000992) conducted on 6-7, 2014, by a representative of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G
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= G
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= G
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Directed Corrective Actions:

1. Due to your citations related to medication management, you must employ (on staff or by contract) the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse. The initial on-site consultant visit shall take place within 7 working days of the date of this letter, and utilize the curriculum from DOEA (Department of Elder Affairs) on assistance with self administration of medications for retraining. The facility shall have available for review by the agency a copy of the pharmacist's or registered nurse's license and a signed and dated recommended corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. The facility shall provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required.
2. The Assisted Living Facility is required to develop and implement a system of records of receipt and

... Cities Pavilion
, 2014

disposition that accounts for all controlled medications, and a system for periodic reconciliation of controlled medications including frequency, method, and by whom.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call . Catherine Anne Avery, Survey and Certification Support Branch, at (850) 412-4505.

Sincerely,

Patricia McIntire, RN

Donah Heiberg, M.S.W.
Field Office Manager

DH/pm

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