STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968254	02/10/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Inn On The Pond	2010 Greenbriar Blvd Clearwater, FL 33763	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A biennial state licensure survey with extended congregate care (ECC) services was conducted on , in conjunction with a complaint survey, CCR# 2013013439.

The Inn on the Pond, assisted living facility, had deficiencies at the time of the visit.

0053-Medication - Administration 58A-5.0185(4) FAC

Based on record review, observation and interview, facility failed to ensure staff (E) administered medications in accordance with physician's order for 4 of 6 (#4,17,18,19) residents sampled for medication administration.

Finding include:

1) A record review for resident #4 revealed staff #E failed to administer medication scheduled for 7:30AM in a timely manner. Observation revealed resident #4 failed to receive medication ordered for 7:30AM until 9:45AM. Interview conducted with staff #E on at 9:45AM revealed staff #E did not administer medication until 9:45AM because resident#4 wanted to take ordered medication after breakfast. Staff #E stated the facility had not contacted the physician to obtain a revised medication order with adjusted dosing schedule.

2) A record review for resident #17 revealed staff #E failed to administer medication scheduled for 8:00AM. An interview conducted with staff #E on at 3:09PM revealed staff #E could not find resident #17. Staff #E placed medication cup back into the medication cart. Medication scheduled for 8:00AM was not administered as ordered. Staff #E failed to document missed medication on back of MOR.

3) A record review for resident #18 revealed staff #E failed to administer medication scheduled for 10AM. Interview conducted with staff #E on at 3:09PM revealed that Resident #18 was talking on the telephone at the time of the medication pass and that staff #E placed medication cup back into medication cart. Staff #E failed to return to resident #18 to administer ordered medication. Staff #E failed to document missed medication on back of MOR.

4) A record review for resident #19 revealed staff #E failed to take resident #19 , ( ), as ordered by physician, prior to the administration of medication scheduled for 1PM. The physician order required staff #E to take resident #19 , and to withhold scheduled medication at 1PM if resident #19 was less than 120. An interview conducted with staff #E on at 3:09PM revealed that Staff #E failed to take resident #19 at 1PM and document result on the MOR. As a result, medication scheduled for 1PM was not

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administered.

Class III

0054-Medication - Records 58A-5.0185(5) FAC

Based on record review, observation and interviews, facility failed to ensure the accuracy of charting medication administration in the medication observation record (MOR) for 4 (#4,17,18,19) of 6 residents sampled during medication administration.

Finding include:

1) A record review for resident #4 revealed staff #E initialed MOR for medication ordered for 7:30AM even though medication was not administered to resident #4 until 9:45AM. Observation and interview with staff # E on [redacted] at 9:45 AM revealed staff #E failed to administer ordered medication in a timely manner and failed to document the time the medication was administered on MOR.

2) A record review for resident #17 revealed staff #E initialed MOR for medication ordered for 8AM even though medication was not administered to resident #17 as ordered. Observation revealed staff #E placed medication ordered for resident #17 at 8AM into a medication cup, then placed cup into the medication cart. An interview conducted with staff #E revealed she placed medication ordered for resident #17 at 8AM into medication cup, then placed cup into the medication cart when resident #17 could not be found. Staff #E failed to administer medication scheduled for 8AM as ordered.

3) A record review for resident #18 revealed staff #E initialed MOR for medication ordered for 10AM even though medication was not administered to resident #18 as ordered. Observation revealed that staff #E placed medication ordered for resident #18 at 10AM into medication cup, then placed cup into medication cart. An interview conducted with staff #E revealed she placed resident #18 medication scheduled for 10AM into medication cup, then placed cup into medication cart when staff #E found resident #18 talking on the telephone. Staff #E failed to return to resident #18 and administer medication scheduled for 10AM.

4) Record review for resident #19 revealed staff #E failed to obtain resident #19 [redacted] and document [redacted] result on MOR. Medication ordered for 1PM was ordered to be given if resident #19 [redacted] was greater than 120. Observation revealed staff #E placed medication ordered for resident #19 at 1PM into medication cup then placed cup into medication cart. An interview conducted with Staff #E revealed she failed to take resident #19's [redacted] and document [redacted] result on MOR. Medication ordered for 1PM was not given.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on record review and interview, the facility failed to have three out of three (#A, #B, & #C) personnel files of sampled direct care staff contain a free from communicable [redacted] statement signed by a health care provider.

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Findings include:

A record review on of direct care staff #A's personnel file revealed there was no documentation stating the staff #A who was hired on was free of communicable .

A record review on of direct care staff #B's personnel file revealed there was no documentation stating the staff #B who was hired on was free of communicable .

A record review on of direct care staff #C's personnel file revealed there was no documentation stating the staff #C who was hired on was free of communicable .

The Administrator, during an interview on at approximately 2:30 p.m., verified that the necessary documentation was not in the personnel files of the sampled direct care staff.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Inn on the Pond
2010 Greenbriar Blvd
Clearwater, FL 33763

Dear Administrator:

Re: Biennial with ECC & **CCR# 2013013439**

This letter reports the findings of a biennial state licensure survey that was conducted on , 2014, by representative(s) of this office.

Attached are the provider's copies of the State (5000-3547) Forms, which indicate 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 to verify that the necessary corrections are in place to correct the deficiencies identified on your surveys.

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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

For Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosures: State (5000-3547) Forms

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