RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2014

Administrator
Osprey Lodge
1761 Nightingale Lane
Tavares, FL 32778

Dear Administrator:

This letter reports the findings of a complaint survey, CCR #2014002466, conducted on . 2014 through . 2014, by representatives of the Agency for Health Care Administration (Agency). Enclosed 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 **ten business days** of receipt of this hand delivered report.

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

St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= G

Directed Corrective Actions:

1. The Assisted Living Facility is required to hire a consultant pharmacist, pursuant to Section 465.0125, Florida Statutes, to conduct quarterly onsite consultations in the facility until notified in writing by the Agency. All records and results from the consultation must remain in the facility for Agency review. The first visit by the pharmacist must take place no less than 10 days from receipt of this Directed Plan of Corrections.

2. The Assisted Living Facility is required to immediately remove all unlicensed staff from assisting residents with the self-administration of medications which require judgment or discretion on the part of the unlicensed staff member.

3. The Assisted Living Facility is required to develop a policy and procedure for assisting residents with the self-administration of medication. The policy and procedure shall include a bi-weekly review of medications observations records to check for accuracy. The policy shall

state all unlicensed staff responsible for assisting residents with self-administration of medications shall refrain from assisting residents with medication which require judgment or discretion pursuant to 429.256(4)I Florida Statutes. All whose duties include assisting residents with the self-administration of medication or medication administration shall be trained on this policy. The policy and procedure shall include the notification of a resident's physician when a resident has not received his or her medication (be for refusal or not available) within two (2) consecutive days. Documentation thereof shall remain on the premises of the facility for agency review.

4. The Assisted Living Facility is required to have a pharmacist licensed in pursuit of Section 465.0125 Florida Statutes, provide four (4) hours of training on assisting with the self-administration of medications in accordance with 58A-5.0191, Florida Administrative Code to all unlicensed staff responsible for assisting residents with the self-administration of medication. Staff must be able to show the ability to read medication labels, orders and accurately transcribe them on medication observation records. Staff who have not completed the training and do not demonstrate the ability to perform the aforementioned shall be relieved of duties which involve assisting residents with the self-administration of medication.

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 Jasmine Hayes, Health Facility Evaluator Supervisor, at (386) 462-6201.

Sincerely,

Kriste J. Mennella
Field Office Manager

KJM/jjh

Received by:

Date:

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968349	06/24/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Osprey Lodge	1761 Nightingale Ln Tavares, FL 32778	
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
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Specific Tag Findings:

0000-Initial Comments
An unannounced complaint survey (CCR #2014002466) was conducted at Osprey Lodge in Tavares, Florida on and , 2014. Deficient practice was identified at the time of the survey.

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on interview and record review, the facility failed to ensure 1 of 6 resident sampled (Resident #20) were properly assisted with the self-administration of medication by allowing unlicensed staff member (Staff G and Staff F) to provide medications which required judgment and discretion for interpreting vital signs before the resident could receive the medication.

Findings:

1. A review of the MORs for Resident #20 revealed a transcribed order to hold both (used to treat an elevated and (used to treat elevated by decreasing the amount of fluid in the system) if the Resident #20's is below 110, check the before giving and Continued review of the MORs revealed Resident #20's were recorded on with a result of , and initialed by Staff #G. Staff G documented Resident #20's was held, the resident's was not held. On Resident #20's results were recorded as and initialed by Staff #F, Med Tech. The Resident's and was withheld. On Resident #20's was recorded as , and initialed by Staff #F. The resident's was withheld. On Resident #20's results were recorded as , and initialed by Staff #F. The resident's was withheld.

2. A review of Staff G's and Staff F's employee record revealed both staff members are not licensed nurses.

3. An interview conducted on at 9:38 PM with the Assisted Living Unit Manager revealed the resident's are recorded only when the resident's are below the criteria of 110 and then the medications are held. When asked why the resident's was withheld when the was above 110 on , and the Unit Manager was not able to provide an answer.

An interview conducted on at 11:10 AM Executive Director revealed the initials recorded on the MOR for , and for Resident #20's withheld medications were for Staff #F, Med Tech.

An interview conducted on at 2:31 PM with the DON (Director of Nursing) revealed the initials recorded on the MOR for for Resident #20's withheld medications were for Staff #G, Med Tech.

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An interview conducted on at Staff F. Staff F stated she assisted Resident #20 with based on Resident #20's results.

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on observation an interview, the facility failed to ensure medication observation records (MOR) were properly documented for 3 of 6 residents sampled for a medication records review (Residents #11, 13, and 15). The facility also failed to provide properly transcibe a physcian's order on a medication observation record for 1 of 6 residents sampled for a medication record review (Resident #16).

Findings:

1. A record review of the Resident #13's medication observation record (MOR) for the month of 2014 revealed a transcribed order for (used to treat 0.005% eye drops instill 1 drop in both eyes at bedtime. The MOR was not initialed indicating the drops were not instilled in Resident #13's eyes on through There was no documention on the MOR to show if the medication was provided, refused or withheld. Continued review of Resident #13's MOR revealed an order for (used as a 20 mg tablet take 1 tablet by mouth once daily with evening meal. The MOR was not initialed on , and to show if the medication was provided, refused or withheld.

2. A review of Resident #11's MOR revealed an order for IPRAT-ALBUT (used to prevent breathing difficulties) 0.5 - 3 (2.5) ml 2.5 - 0.5 mg/3 ml inhale 1 vial via four times daily. The MOR was not initialed on and to show if the medication was provided, refused or withheld. Further review revealed this medication was documented as provided three times on , once on , no documentation on twice on , three times on , once on , once on , and twice on . There was no documentation for all four doses where if the medication was provided, refused or withheld on the above mentioned dates.

3. A review of Resident #15's MOR for the month of 2014 revealed a transcribed order for 325 mg take 2 tabs by mouth twice daily for 1 week then start PRN (as needed). Resident #15's MOR was not initialed Resident #15's MOR was not initialed to show 7 out of 14 ordered doses of were provided as ordered from for the morning dose, and only once a day for

4. Record review of the MOR (medication observation log) for Resident #16 revealed a transcribed order for (being used to treat the resident's mood) 500 mg take 4 by mouth daily X 7 days in AM, 1000 mg take 8 by mouth daily at bedtime X 7 days, then decrease to 250 mg take 2 by mouth daily in AM X 7 days, 500 mg take 4 by mouth daily at bedtime X 7 days then decrease 250 mg take 2 by mouth daily at bedtime X 7 days then stop.

5. Record review of Physician's orders dated revealed 500 mg by mouth every AM, and 1000 mg by mouth every hs (hour of sleep) X 7 days, then decrease to 250 mg by mouth every AM and 500 mg by mouth every hs X 7 days then decrease to 250 mg by mouth every hs X 7 days then stop.

6. On at 3:33 PM an interview was condcuted with the Director of Nursing (DON). The DON stated she would not be able to state if Resident #13's and were provided due to the MOR not being initialed which would indicate the medications were or were not provided. The DON stated she would not be able

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to provide proof to show if Resident #11 did not receive his and could not verify if resident #15 did or did not receive tylenol as ordered due to the MOR not being properly completed. An interview conducted on at 3:18 PM with the DON revealed the physician's order was inaccurately transcribed on the MOR.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on record review and interview, the facility failed to ensure medications available for 2 of 6 resdients sampled for a medication review (Resident #11 and #14).

The facility failed to ensure medications were provided as ordered by the physician for 5 out of 6 sampled residents, Residents #11, 13, 14, 15, and 20, and the facility failed to ensure residents' MORs (medication observation records) were transcribed accurately for 1 of 6 sampled residents (Resident #2).

Findings:

Record review of the MOR (medication observation log) for the month of 2014 revealed a transcribed order for Resident #14's for (being used to treat 0.5 mg tab take one tablet by mouth at bedtime. The medication was not provided on through

Record review of the Resident Observation Log revealed there were no entries made regarding the physician or the pharmacy being contacted regarding Resident #14's not being in the facility.

On an interview was conducted with Staff C . Staff C stated Resdient #14 did not recieve his ordered because, "we were waiting for a script from the physician."

An interview conducted on at 4:22 PM with the DON revealed verification that Resident # 14 did not receive his as ordered by the physician for the period of through

A review of Resident #11's MOR for the month of 2014 revealed a transcribed order for (used to treat pain) l25 mcg/hr patch apply 1 patch every 72 hours. Continued review of the MOR revealed Resident #11's Patch was not provided on , and A

On at 3:02 p.m. Resident #11's spouse was interviewed. Resident #11's spouse stated her husband's patch was not available three time during the month of She stated, I was told they were waiting for script from the doctor. Resdient #11's spouse went on to say her husbands pain is difficult to control.

Class II