STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922334	08/28/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Spring Haven Retirement Community	**1225 Havendale Blvd Nw Winter Haven, FL 33881**	
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
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= G

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2014008524, was conducted on .

Spring Haven Retirement Community, assisted living facility, had deficiencies at the time of the visit.

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

Based on observation and interview the assisted living facility failed to provide assistance with self-administration of medication per the guidelines as noted in 429.256, F.S. The facility failed to ensure qualified staff provided assistance with self-administration of medications by washing hands, reading the label and opening the container in the 3 of 3 (resident #7, #8 and #9) sampled residents.

Findings include:

1. On , 2014 at approximately 4:00 PM a medication pass observation was conducted. Resident #7 was observed seated in a wheelchair approximately six (6) feet behind Staff A. With her back turned to Resident #7, Staff A was observed pulling Resident #7 ' s medication observation record (MOR) from an electronic database. Staff A was observed reading the MOR of Resident #7 and retrieving medication packages from the medication cart. Staff A retrieved the medication packages one by one, reading the MOR each time and popping the pills from each medication package into a small white paper cup. After Staff was finished preparing all of Resident #7 ' s medications, Staff A checked off each medication in the electronic database and confirmed that the medications was given to Resident #7. Staff A then turned around and handed Resident #7 his medication and observed Resident #7 take his medication. Staff continued onto Resident #8 by pulling resident #8 ' s MOR in the electronic database. Resident #8 was seated approximately 15 feet away around a small corner from Staff A and the medication cart. Staff A continued with the same practice as with Resident #7. Staff A read Resident #8 ' s MOR and popped each pill into a small white paper cup. Once Staff A completed preparing Resident #8 ' s medications, Staff A confirmed in the electronic system that the medications were given to Resident #8. Staff A then walked over to Resident #8 and handed Resident #8 the small paper cup and observed Resident #8 take her medications. Staff A then returned to the medication cart and continued on to Resident #9 by pulling the MOR for Resident #9. Resident #9 was seated approximately 6 feet behind Staff A. With her back turned to Resident #9, Staff A retrieved and prepared Resident #9 ' s medications. When Staff was

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finished preparing the medication, Staff A confirmed that the medication was given to Resident #9. Staff A then turned around and walked over to Resident #9, gave resident #9 the small white cup and stated, " I have your one pill " and observed Resident #9 take the medication.

2. On , 2014 at 5:58 p.m. an interview was conducted with Staff A. Staff A stated she is a Resident Medication Assistant and denied that she was a licensed nurse. Staff A stated she sometimes tells the residents what medications she is giving the residents. Staff A stated, " If there are 6-7 pills I don ' t remember what I punch out into the cup. " Staff A continued on by stating, " Some residents don ' t have their right minds and don ' t watch " her punch out the medications. Staff admitted to pre-signing the MOR stating " I signed the MOR before I gave it to Resident #7, I caught myself after I did it. "

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC

Based on observation, interview and record review the assisted living facility failed to ensure proper disposal of contaminated medications, discontinued medications and abandoned medications within 30 days of being considered abandoned by residents that have moved out of the facility for 14 of 15 sampled residents (#5, #6, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, and #23).

Findings include:

1. On , 2014 at 10:51 a.m. a tour of the assisted living facility Wellness Director ' s office was conducted. Medications belonging to residents #17, #18, #19, #20, #21, #22 and #23 were observed stacked on the desk of the Wellness Director and in a cardboard box on the floor. Medication card observed for Resident #23 was filled on . Observation of a closet in the Wellness Director's office revealed a large amount of various medications stacked approximately 2 feet high from the floor. A sample of the medications located in the closet revealed medications in the closet belong to resident (#4, #5. #6. #12, #13, #14, #15 and #16). Thirty (30) day supply medication cards for Resident #5 was dated , for Resident #6 filled on , Resident #13 filed on , Resident #15 filled on and Resident #16 filled on . Seven (7) day supply medications cards were observed for Resident #12 filled on and Resident #14 filled on . Expired medication card observed for Resident #6 expired on / . (Photos obtained)

2. On , 2014 at approximately 4:00 PM loose medication tablets and capsules were observed on the floor near the resident activity l seating area near the facility elevator. (photo obtained)

3. On , 2014 at 10:51 AM an interview was conducted with the assisted living facility Wellness Director. The Wellness Director stated that the medications have been stored in her office for at least three (3) months. The Wellness Director stated the medication observed in her office are medications belonging to residents that are discontinued, expired, for residents or residents that have moved out. The Wellness Director stated Resident #5 and #6 have been discharged from the facility. The

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Wellness Director stated disposing of medication have become a low priority.

4. On , 2014 at 1:29 PM an interview was conducted with the assisted living facility administrator. The Administrator stated he was aware of the medication being stored in a closet in the Wellness Director ' s office. The Administrator stated the pharmacy disposition log was not able to be located at the time of the survey. The administrator stated he was unaware of the regulations regarding disposal of medication and stated, " we have not done a very good job. "

5. On , 2014 at 4:00 PM the Administrator provided the assisted living facility medication disposal policy and stated the assisted living facility was "clearly not in compliance with our own policy" regarding disposal of medications.

6. A closed record review of Resident #5 and #6 files revealed Resident #5 was discharged from the assisted living facility on and Resident #6 was discharged on .

7. A record review on the assisted living facility medication disposal policy and procedure dated revealed disposal of medications are directed to be completed, "as soon as possible." The Policy and Procedures noted, " Large quantities of medications should be returned to the issuing pharmacy and a medication destruction record must be completed. "

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC

Based on observation, interview and record review the assisted living facility failed ensure residents received assistance with self-administration of medication per physician orders. The Assisted Living Facility also failed to reorder residents ' medication in a timely manner during the time in which the medication was prescribed for 2 of 3 (resident #1 and #11) sampled residents.

Findings Include:

1. On , 2014 at approximately 3:15 PM during a tour, an observation of the second floor medication cart revealed two (2) medication cards containing 325 MG tablets and -Low 81 MG tablets for Resident #1.

2. On , 2014 at 12:54 PM an interview was conducted with Staff B. Staff B stated Resident #1 has lived at the facility for a few weeks and Resident #1 ' s medications " are still not here " . Staff B stated Resident #1 only has two (2) medication cards and she should have 6-8 medication cards.

3. On , 2014 at 2:08 PM an interview was conducted with a nurse from Home Town Home Care. The nurse stated a couple of weeks ago Resident #11 was not getting her over the weekend and Resident #11 ' s sugars were very high.

4. On , 2014 at 3:20 PM an interview was conducted with Staff C. Staff C stated Resident #1 has

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been out of her night medications for a long time, " at least a week and a half " . Staff C stated Resident #1 only has an and iron pill.

5. On , 2014 at 4:43 PM an interview was conducted with Resident #11. Resident #11 stated she has lived at the assisted living facility for two (2) months. Resident #11 stated she " went a long weekend without my drugs. " Resident #11 stated she had her medications but " it got put in the wrong cart and the staff just figured that I did not have any " . Resident #11 stated she takes twice a day and she was without it about two weeks ago Friday, Saturday and Sunday " until they finally found it Monday morning " . Resident #11 stated that her sugars went sky high up to 400.

6. A record review of Resident #11 ' s MOR (Medication Observation Record) revealed the dates of 3rd, 4th and 5th were shaded for 1,000 MG tablet with a notation of " Not Delivered from Pharmacy " . The MOR indicated the medication is ordered to be dispensed twice daily for . Resident #11 Health Assessment Form (AHCA Form 1823) dated revealed Resident #11 needs assistance with self-administration of medications. The Health Assessment Form also noted Resident #11 required routine medications and monitoring.

7. A record review of Resident #1 ' s Health Assessment Form (AHCA Form 1823) dated noted Resident #1 is diagnosed with ' s and needs medication administration. Resident #1 ' s MOR (Medication Observation Record) dated 2014 revealed Resident #1 is ordered to take 12 medications on a daily basis or as needed. The MOR also revealed the following:

   a. Acidophilus Probiotic tab, ordered " take 1 tablet by mouth daily " was notated as " pharmacy notified - awaiting delivery " on , 11, 17, 18, 19, 23, 24, 27 and 28.

   b. 10 MG tablet, ordered " take 1 tablet by mouth daily " was notated as " pharmacy notified - awaiting delivery " on , 17, 18, 19, 20, 21, 22, 23, 24, 26, 27 and 28.

   c. 10 MG tablet, ordered " take 1 tablet by mouth once daily " was notated as " pharmacy notified - awaiting delivery " on , 17, 18, 19, 20, 21, 22, 23, 24, 26, 27 and 28.

   d. Fish Oil 1,200 MG capsule, ordered " take 1 capsule by mouth three times daily " was notated as " pharmacy notified - awaiting delivery " at 4:00 PM on 15 and 8:00 AM and 12:00 PM on 16. The 8:00 AM, 12:00 PM And 4:00 PM doses on , 18, 19, 20, 21, 22, 23, 24, 26, 27 and 28 and the 12:00 PM and 4:00 PM dose on 25 were not given and noted as " pharmacy notified - awaiting delivery. "

   e. .1 MG tablet, order " take 1 tablet by mouth twice daily " was notated as " pharmacy notified - awaiting delivery " on , 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 and the 8:00 AM dose for ").

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f. [redacted] M10 10 MEQ tablet, ordered " take 1 tablet by mouth twice daily " was notated as " pharmacy notified - awaiting delivery " on [redacted], 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 and the 8:00 AM dose for [redacted] th.

g. [redacted] 25 MG Tablet, ordered " take 1 tablet by mouth twice daily " was notated as " pharmacy notified - awaiting delivery " on [redacted], 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 and the 8:00 AM dose for [redacted] th.

h. Panoprazole SOD DR 40 MG tablet, ordered " take 1 tablet by mouth once daily " was notated as " pharmacy notified - awaiting delivery " on [redacted], 18, 19, 20, 21, 22, 23, 24, 26, 27, and 28th.

i. [redacted] 1,000 MCG tablet, ordered " take 1 tablet by mouth twice daily " was notated as " pharmacy notified - awaiting delivery " on [redacted], 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 and the 8:00 AM dose for the [redacted] th.

8. On [redacted], 2014 at 6:26 PM an interview was conducted with the assisted living facility Wellness Director. The Wellness director stated she is responsible for contacting resident health care practitioners if a resident needs a new prescription for a medication refill. The Wellness Director stated she was aware that Resident #1 is currently out of medications. The Wellness Director states the pharmacy will not fill resident #1 ' s prescriptions without new prescriptions from resident #1 ' s doctor. The Wellness Director stated she has not contacted Resident #1 ' s doctor to request new prescriptions since Resident #1 ' s initial move in date on [redacted]. The Wellness Director stated Resident #1 received a 30 day supply of medication after Resident #1 ' s initial move in date and the medications " has not been refilled since then. " Regarding Resident #11, the Wellness Director stated Resident #11 ' s medication was " mistakenly put in the wrong cart. When the Medication Technician went to give the medication it was not in the cart and the technician marked that it was not delivered by the pharmacy. " The Wellness Director stated, " This went on for three days " before it was discovered. The Wellness Director stated Resident #11 had high [redacted] sugars as a result of the misplaced medication.

Class II

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 5, 2014

Administrator
Spring Haven Retirement Community
1225 Havendale Blvd Nw
Winter Haven, FL 33881

RE: CCR# 2014008524

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on September 5, 2014, 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 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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Caufman
for Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

St. Petersburg Field Office
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AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

[redacted], 2014

Spring Haven Retirement Community
1225 Havendale Blvd. NW
Winter Haven, FL 33881

Attn: Bryan Scott Smith, Administrator

Dear Mr. Smith:

This letter reports finding of a complaint survey, CCR# 2014008524, conducted on [redacted], 2014, by representatives of the Agency for Health Care Administration. **Within 10 business** days from receipt of this letter, you are directed to comply with the tangible steps outlined below in order to correct the deficient practice. Attached are the deficiencies noted in the survey.

The investigation resulted in the following findings of noncompliance which directly threatened the physical safety of residents in with the following area:

1) A0056 – Medication – Labeling and Orders – Class II
The Assisted Living Facility failed to ensure residents received assistance with self-administration of medication per physician orders. The Assisted Living Facility failed to reorder residents' medication in a timely manner during the time in which the medication was prescribed.

Your facility must comply with the following:

1. Contract with a consultant pharmacist or registered nurse not connected to the facility to audit your medications, medication carts and storage and medication observation records. The consultant shall also assist with the development of the policy noted in item #3. This must be completed within 10 days of the date of this letter.

2. Consult a Pharmacist to ensure all staff providing assistance with self-administration of medication are following the guidelines of 429.256, F.S. This must be complete within 10 days of the date of this letter.

3. Develop and Revise the facility's policy and procedures for Medication Reordering to include a more in-depth description of the steps the facility will take to avoid the depletion of a resident's medication supply. This must be complete within 10 days of the date of this letter.

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 contact **Paul Brown**, ALF Supervisor, at 727-552-2000.

Sincerely,

Paul Brown

for Reid Caufman
Field Office Manager