STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953542	09/25/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Cornerstone At Longwood (the)	480 East Church Avenue Longwood, FL 32750	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:
0010-Admissions - Continued Residency-09/25/2014
0078-Staffing Standards - Staff-09/25/2014

Revisit Repeat Tags:
0000-Initial Comments-
0008-Admissions - Health Assessment-58a-5.0181(2) Fac
0030-Resident Care - Rights & Facility Procedures-58a-5.0182(6) Fac; 429.28 Fs
0052-Medication - Assistance With Self-Admin-58a-5.0185(3) Fac
0055-Medication - Storage And Disposal-58a-5.0185(6) Fac

Specific Tag Findings:
0000-Initial Comments
A re-visit in conjunction with the re-licensure survey and complaint inspection #2014-07622 was conducted on and The Cornerstone at Longwood had deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

A-008 remained uncorrected
Based on record review and interview the facility failed to ensure that 1 of 8 sampled residents record reviewed (#2) contained a health assessment form that contained all of the required information.

Findings:

Record review for resident #2 revealed a Resident Health Assessment form (1823) dated The section for the health care provider to indicate the type of assistance needed with medications was left blank; the form did not include the type of assistance the resident required with his medications and the type of diet he required. Further review of the 1823 revealed there was no address or telephone number for the health care provider that completed the form.

During an interview with the Administrator on at approximately 2 PM, she confirmed the findings.

Class III

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0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Deficiency A 030 remained uncorrected

Based on record review and interview the facility failed to ensure: 1. that the use of physical restrains was limited to half-bed rails only for 1 sampled resident (#4) and: 2. to preserve the residents rights to be treated with consideration and respect and with due recognition of personal dignity, individuality and the need for privacy for 30 of 30 residents who lived in the memory care unit and 2 of 20 Random Sampled Residents (RS#16 and RS#17).

Findings:

1. Observations during the facility tour on [redacted] at approximately 9:45 AM noted the bed in [redacted] # [redacted] B had had full bed rails in place. In an interview with the unit supervisor on [redacted] at approximately 9:45 AM who stated the resident was under the care of hospice and the bed had been delivered a few days ago with the full rails.

Resident record review on [redacted] at approximately 10 AM for resident #4 revealed a delivery sheet that indicated a delivery date of [redacted] at 6 PM for a hospital bed with half- bed rails. Continued review revealed that an order for half-bed rails was not available.

In an interview with the administrator on [redacted] at approximately 11 AM who stated she was sure there was an order and needed some time to locate it. An opportunity was given to locate the documentation.

At approximately 3 PM the administrator provided a hospice physician order that indicated clarification of order [redacted] -hospital bed, full electric with half-bed rails and floor matt. The order was signed by the hospice nurse [redacted]

2. Observations on [redacted] at approximately 11 AM noted 4 pages posted on the wall by the dining area. The page indicated "evening shift 4-12 Dinner" and had 10 residents' names listed. The next page indicated "evening shift 4-12 Dinner" and listed 6 resident's names. The next page indicated "evening shift 4-12 Dinner" and listed 10 residents. The last page indicated "evening shift 4-12 Dinner" and listed 4 residents.

In an interview with the unit supervisor on [redacted] at approximately 11:15 who stated the posting was a reminder for the staff about sitting arrangements.

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3. Observation on [redacted] at 9 AM revealed resident RS#16 was self-propelling in a wheelchair in a common area. RS#17 was observed on [redacted] at approximately 2 PM in a wheelchair in the common area. There was a [redacted] drainage bag attached to the back of RS#16 and RS#17's wheelchairs, that had [redacted] draining into the bag. The drainage bags were not covered and were within sight of other residents and visitors.

In an interview with the administrator on [redacted] at 2 PM who stated she was not aware the [redacted] drainage bags were not covered.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation, record review and interview the facility failed to ensure when staff provided assistance with self-administration of medications, the staff followed the appropriate procedure to take the medication, in its dispensed, properly labeled container to the resident, in the presence of the resident, read the label, open the container, remove a prescribed amount of medication from the container, close the container, return to storage and document on the Medication Observation Record (MOR) for 1 of 18 sampled residents (#7).

Findings:

Observation of the medication pass for resident #7 on [redacted] at 10:45 AM revealed staff F, an unlicensed staff, obtained medication from locked storage, compared the MOR to the label, poured water in a cup, charted on the MOR that the medication was given, handed the resident his medication. Staff F did not read the label to the resident and returned medication to storage.

Staff F did not follow the appropriate procedure to assist residents with self-administration of medications, did not take the medication, in its dispensed, properly labeled container to the resident, in the presence of the resident, read the label, open the container, remove a prescribed amount of medication from the container, close the container, return to storage and document on the MOR for Resident #7,

In an interview with the administrator on [redacted] at approximately 2:30 PM who stated, she was not aware the unlicensed staff was not following proper procedures when assisting the residents with self-administration of medications.

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0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Deficiency A-055 remained uncorrected

Based on observation record review and interview, the facility failed to ensure that: 1 the medications for 13 of 13 Random Sampled residents (RS#1, 2, 3, 5, 6, 7, 9, 10, 11, 12, 13, 14 and 15 were returned to residents or representatives upon discharge; 2 expired/discontinued medications were not stored with current medications for sampled residents (RS #19 and 20; & Residents # 3 & 12); and 3. medications for (RS#1) were properly labeled; and 4 that all medications centrally stored were secure at all times for 3 of 18 sampled residents (# 6, 16 and 17).

Findings:

1. Observations at approximately 10:30 AM during the secure memory care unit noted the nurse's office was ajar. The office was located to the left of the common area accessible to residents and visitors alike. In an interview with the unit supervisor on [redacted] at approximately 10:30 AM who stated the hospice comfort packs were maintained in side. The refrigerator did not have a lock. Continued observations noted the following medications were kept in the refrigerator: [redacted] 25 milligrams (mg), a hospice comfort pack, resident #6 had [redacted] 100 mg per ml (20mg/ml) & a comfort pack; resident # 16 had [redacted] 100 mg; [redacted] eye drops and resident # 17 had [redacted] 0.5mg.

2. Continued tour revealed a locked [redacted] had a med cart. The cart was locked. The unit supervisor stated it contained overflow and discontinued medications. She did not have the keys. She went downstairs to retrieve the keys. Returned and stated the facility registered nurse and co-owner had the keys and had been called.

The key was never provided and access to medication cart was not granted until [redacted] at approximately 9:30 AM when the administrator stated the key had been retrieved and the cart was empty. She added the cart was not locked the day before when the surveyor attempted to open it. In an interview with the unit supervisor on [redacted] at approximately 9:45 AM who stated that she drove all the way yesterday to retrieve the key and it was not even locked. The surveyor reminded her that in her presence an attempt was made to unlock the cart to no avail. She did not reply. She added that the cart was empty any way. I reminded her of the statement she made the day before about the discontinued and over flow medications and she did not reply.

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3. In an interview with staff F on at approximately 3 PM who stated there was a file cabinet on the first floor were overflow and discontinued medications was kept. "No we do not use the medications in that cabinet."

The following medications were expired and were maintained in the file cabinet drawers with other current medications. They were not labeled "discontinued".

Random sampled resident #1 (current facility resident) had Mag 400 mg expired and Citracal plus D expired OTC

Random sampled #2 discharged on had 200 mg that expired Oxybutin 10 mg expired and 30 mg that had not expired. The expiration date was

Random sample #3 discharged had Patch 9.5 mg expired and 2 boxes Patch 4.6 mg expired

Random sampled #5 (current facility resident) had Lumigan 0.03% expired , Lumigan expired , Lumigan expired and Lumigan expired

Random sampled #6 (current resident) had 3 inhalers that expired

Resident #3 had 0.5 mg expired

Random sample #7 had 1 mg expired

Resident #12 had Tamulosin 0.4 mg expired

Continued observations noted the medication for random sampled resident #19 a current facility resident noted 100 mg as needed for , 10 mg at bedtime and 81 mg one daily among the medications that were expired. A physician updated medication list dated indicated the above listed medications.

Random sampled resident # 20 a current facility resident had 0.25 mg one twice daily for agitation at 9AM and 9PM. The prescription was filled on and the original prescription was dated

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The facility's policy and procedure regarding The Cornerstone at Longwood medication practice included

(a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises; or in their [redacted] or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the [redacted] or apartments or in some other secure place that is out of sight of other residents. However, both prescription and over-the-counter medications for residents must be centrally stored if:

1. The facility administers the medication;

2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request;

3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;

4. The resident fails to maintain the medication in a safe manner as described in this paragraph;

5. The facility determines that because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents; or

6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 58A-5.0181, F.A.C.

(b) Centrally stored medications must be:

1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, [redacted] or area at all times;

2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or

by keeping the area in which refrigerator is located locked;

3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and

4. Kept separately from the medications of other residents and properly closed or sealed.

(c) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider.

(d) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (e).

(e) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.

(f) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C.

In an interview with the administrator on [redacted] at approximately 3PM who stated the nurse was the person responsible for the medications. There was no documentation to confirm that residents and or representatives were contacted after discharge to inform them that medications were available at the facility and they could come and retrieve them otherwise 15 days later the medications would be deemed abandoned and destroyed 30 days later. The discontinued medications were not labeled "discontinued" and were all mixed together. The administrator provided no response when informed the facility did not follow their policy

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regarding medication practices.

Observation on at approximately 2 PM revealed there were medications locked in 2 file cabinets in the drawers, in the staff office. Review of the Admission/Discharge log revealed the following residents were discharged from the facility, their medications were not returned to them or to their representative and the medications were mixed with current medications.

RS#9 one box of patch 0.2 milligrams (mg)/24 hr. patch and a card of 0.1 mg tablets

RS#3 500 mg capsules, 9.5 mg/24 hr. patches

RS#10 2 mg tablets, 2 mg tablets, Megestrol 40 mg tablets and 1 mg tablets

RS#2 a card of B12 tablets and ER 10 mg tablets

RS#11 2 cards of 0.5 mg tablets

RS#12 a card of ER 20 tablets

RS#13 1 card of 350 mg tablets

RS#14 1 card of 7.5 mg tablets

RS#15 2 cards of 1 mg tablets and one card of 0.5 mg tablets

Review of medication for RS#1 revealed a bottle of Extra Strength that had a hand a handwritten label attached to it that stated, "As needed follow bottle instructions".

In an interview at 4 PM on with administrator who stated she who was not aware the medications were not returned to the residents upon discharge, medications did not have a pharmacy label on them and current medications were mixed with medications for discharged residents and medications were not properly labeled.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Cornerstone At Longwood (the)
480 East Church Avenue
Longwood, FL 32750

RE: Revisit to CCR#2014003941

Dear Administrator:

This letter reports the findings of a complaint investigation revisit survey conducted on 25, 2014by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2014.**

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. Should you have any questions please call this office at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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