| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11967991 | 10/15/2014 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| Grand Oaks | 203 SE 2nd Street Okeechobee, FL 34974 | |
| SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION) | | |

**List of Tags Cited:**

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
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= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= B

**Specific Tag Findings:**

**0000-Initial Comments**

An unannounced Abbreviated Relicensure with Limited Nursing Services (LNS) survey was conducted on 2014 at Grand Oaks. 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 an interview, the facility failed to ensure a health assessment (AHCA Form 1823) had been completed within the required timeframe, 60 days before admission or within 30 days after admission, for 1 out of 1 sampled residents (Resident #8).

The findings include:

On at approximately 3:00 PM, the licensed practical nurse (LPN) and Office Manager/med tech were interviewed and stated Resident #8 received assistance at times with bathing and toileting for occasional incontinence.

The resident was admitted to the facility on Review of the resident's health assessment dated showed the resident was independent with toileting (inaccurate) and did not document the level of assistance required for bathing, dressing or self care Further record review failed to indicate any documentation regarding aforementioned missing information.

During further interview with the LPN and Office Manager at 4:00 PM, they acknowledged that the assessment had not been completed.

Class III

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**0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC**
Based on observation and an interview, the facility failed to ensure residents who received assistance with self-administration of medication were receiving medication taken from properly labeled containers from unlicensed staff; and that only residents who were able to self-administer medication (without assistance) were using pill organizers, for 5 out of 5 sampled residents (Residents #2, #3, #5, #6, and #7).

The findings include:

Observation of the medication cart with the licensed practical (LPN) nurse on duty revealed the medications for all residents are kept in pill organizers. The LPN said at 11:15 AM the medications come to the facility in bottles, not bubble packets so she fills all the residents' pill organizers herself to be administered on day shift from Monday to Friday and to be provided to residents by the resident aides/med techs (unlicensed staff) on evening shifts and on weekends. She said med techs/CNA's (certified nursing assistants) are trained by the pharmacist to assist with medications and they assist the residents by giving the medications in the evenings and weekends when she is not here, from the pill organizers. She said when the medications are sent in from the pharmacy, she fills the pill organizers for a week or two at a time . She agreed and verified the med techs/CNAs give the medications from the pill organizers on the evening shifts and weekends to residents who require assistance with their medications as there is no nurse on duty at these times.

The LPN was observed during the medication observation pass conducted on between 11:15 AM and 12:00 PM, preparing medications for the pill organizers for 5 of the residents to include Residents #2, #3, #5, #6, and #7.

Class III

**0054-Medication - Records 58A-5.0185(5) FAC**
Based on record review and interview, the facility failed to ensure the daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration, was accurate and up-to-date. This affected 1 out of 5 residents (Resident #3).

The findings include:

Review of the physician order dated for Resident #3 revealed: 10 mg take one tablet by mouth three times per day for . Review of the medication observation record (MOR) dated 2014 revealed documentation of: 10 mg three times a day (per the

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order), but the times documented as 8 AM, Noon, 5 PM and 8 PM. The MOR times revealed the medication was provided to the resident four times a day.
Review of the file and medication orders for Resident #3 with the Office Manager/med tech also revealed there was no recent order to change to [redacted] 10 mg to four times a day.

Interview with the licensed practical nurse (LPN) at 1:55 PM revealed she fills in the 'times' on the MOR (8 AM, Noon, 5 PM and 8 PM) and this is her mistake as the MOR has times for four times a day and she documented that. She said she thought the evening dose at 8 PM was not given but observation of the pill organizer with her and 'filled by her' revealed it had a [redacted] 10 mg in it for the 8 PM dose.

At approximately 2:20 PM, she provided an additional copy of the MOR that had a line though the 8 PM medications and said 'this is a medication error'. She agreed the medication was given to the resident at 8 PM in error. The nurse agreed the MOR was inaccurate and did not reflect the physician order for three times a day.

Class III

**0056-Medication - Labeling and Orders 58A-5.0185(7) FAC**
Based on observation, record review and interview, the facility failed to ensure that changes in directions for use of a medication for which the facility is providing assistance with self-administration or administering medication was accompanied by a written medication order issued and signed by the resident's health care provider, or a faxed or electronic copy of such order. The facility failed to place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record (MOR), or obtain a revised label from the pharmacist. This affected 2 of the 9 sampled residents (Resident #7 and #8).

The findings include:

1. Observation during the noon medication observation pass conducted for Resident #7 at approximately 11:52 AM revealed the licensed practical nurse (LPN) provided the resident with two pills and the nurse said one of the pills was [redacted] (from pill organizer). The nurse obtained the pill bottle which read [redacted] 25 mg.
Review of the healthcare provided/physician order in the file for Resident #7 revealed: order of [redacted] for 'V[redacted] 25 mg capsule every 8 hours as needed for itching/s

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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

Review of the healthcare provided / physician order for Resident #7 revealed: 25 mg capsule every 8 hours as needed for itching/s Review of a physician order (fax) dated revealed 25mg (three times a day) for 90 caps with no refills' (one month supply).

Review of the medication observation record (MOR) for the month of 2014 revealed: 25 mg one tablet three times a day'. The MOR had evidence the was provided to the resident three times a day at 8 AM, noon, and 8 PM. Review of the label on the pill bottle for revealed Pam equivalent to 25mg for itching as needed'.
There was no label to say there was an order change from 'as needed' to three times a day. The nurse confirmed there was no documentation to say there was a change.

Further review of the file for physician orders revealed no order to change the 'as needed' (PRN) to a routine three times a day (order on was for one month only). The pharmacy was contacted at approximately 12:45 PM. Interview with the pharmacy representative revealed she had an order dated for 'V 25 mg take by mouth one tab three times a day'.

There was no evidence as to why the label on the bottle had not been changed. The nurse said she only asked for refills when she sends to pharmacy so she was not sure why the label remained for 'as needed'.

2. On at 12:20 PM, Resident #8's observed with 2 "puffers" labeled , a prescribed medication inhaler. During interview with the resident at this time, she stated she kept this medication in her was assisted by staff with all of her other medications.

During interview with the licensed practical nurse (LPN) at 2:30 PM, she confirmed that the resident did not receive assistance with this medication and that the resident was able to self-administer and keep the medication in her .

Review of the resident's record revealed a health assessment dated that indicated the resident had an order for "Pro Air" inhaler to be taken as needed with no documentation that the medication could be self-administered without supervision. Additionally, the assessment had marked "yes" for the requirement that the resident received assistance with self-administered medication.

During interview with the LPN as noted above, she confirmed that the resident did not have a copy of the order for the inhaler on file and that "Pro Air" was equivalent to the inhaler the resident kept in her .

Class III

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

Based on record review and an interview, the facility failed to ensure a staff member was determined to be free from signs or symptoms of communicable based on a "health care provider's" statement for 1 out of 3 sampled staff (Staff C); and, failed to ensure a "health care provider" documented on an annual basis a negative examination or statement that the individual does not constitute a risk of communicating for 1 out of 3 sampled staff (Staff B).

The findings include:

On the personnel files were reviewed for Staff B and C. The following discrepancies were identified:

a) Staff B was hired on . The personnel file contained a "health care provider's" statement that the employee shows no signs or symptoms of a communicable including dated . However, where the "physician's signature" was indicated, a doctor of chiropractic medicine signed to verify this statement. Only a licensed "health care provider" defined under the F.A.C. above is qualified to sign this required statement. A doctor of chiropractic medicine is licensed under Chapter 460, F.S. (Florida Statutes), so is not an approved signer.

b) Staff C was hired on . The personnel file contained a communicable questionnaire signed by a registered nurse that the employee completed on . There was no statement by a "health care provider" that the employee had a negative examination or statement that the individual does not constitute a risk of communicating . Only a licensed "health care provider" defined under the F.A.C. above is qualified to sign this required statement.

These findings were acknowledged during interview with the office manager at 4:00 PM on .

Class III

**0093-Food Service - Dietary Standards 58A-5.020(2) FAC**

Based on record review and an interview, the facility failed to ensure regular and therapeutic menus as served, with substitutions noted before or when the meal is served, were kept on file in the facility for 6 months.

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The findings include:

On , the planned menu approved by the dietician on was reviewed and showed a different meal for lunch than what was documented on the daily menu posted on the wall. During interview with the food service designee at 12:30 PM, she confirmed that the facility did not follow the approved menu on a weekly basis, substituted it with items of comparable nutritional value based the preferences of the residents, and documented the substitute weekly menu in a binder. The binder was reviewed and did not contain documentation of the acknowledged substitutions since at least 2014. The food service designee confirmed the facility has had substitutions since 2014 and failed to document this.

During an interview with the office manager at approximately 3:45 PM on , the findings were acknowledged.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Grand Oaks
203 SE 2nd Street
Okeechobee, FL 34974

**RE: Relicensure Survey**

Dear Administrator:

This letter reports the findings of a Relicensure survey that was conducted on , 2014 by representatives 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 after 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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