STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963719	01/06/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Wyndham Lakes	10660 Old St. Road Jacksonville, FL 32257	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= G
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= G

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR # 2015000031, was conducted on Wyndham Lakes Assisted Living Facility had deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on record review and staff interview, the facility failed to achieve a completed Health Assessment for 1 of 3 sampled residents, (Resident #1).

Record review for Resident #1 revealed the Health Assessment form 1823 was signed by the physician, but there was no date when the physician examined Resident #1. There is a fax date at the top of each page dated

On at 3:38 PM an interview with the Health and Wellness Director confirmed the Health Assessment for Resident #1 was not dated. She said she did not know when the Health Assessment was completed.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC
Based on record review and staff interview, the facility failed to ensure that staff administered medication in accordance with the providers order and prescription label for 2 of 3 sampled residents, (Resident #1, Resident #3).

The findings include:

1) Record review for Resident #1 revealed he was admitted on at approximately 7:00 PM. Resident #1 arrived to the facility with 3 sets of medication orders which comprised of a 6 page hospital discharge instructions list (dated , a separate medication listing from the hospital (unknown date) and a 5 page doctors visit from an appointment in 2014. Resident # 1 ' s health assessment, not dated, read that he needed his medication provided and administered to him. Section 2-3 A of the health assessment stated " see attached list " for medications. A five page doctor visit note dated was attached to Resident #1 ' s health assessment and included a list of the resident ' s medication. The listed medications included (100 units/milliliters (ml) (SC) solution, 55 units in the AM and 45 units in the PM .

The six page Patient Discharge Instructions dated for Resident #1 was reviewed. The discharge instructions listed " New Medications " with an order for Aspart (a fast acting that lowers the glucose in the 0.06 ml, (equal to 6 units) beneath the skin, 3 times a day with meals, and " Other Medication " listed current order for Determir , a long acting that may work up to 24 hours)

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0.1 ml (equal to 10 units) at bedtime and Detemir 0.1 ml (equal to 10 units) daily. In an interview with Employee A (a Licensed Practical Nurse (LPN) on at 10:32 AM, she confirmed that Resident #1 was admitted to the facility with the discharge instructions.

Resident #1 ' s chart also revealed a separate medication listing for Resident #1 from the hospital dated That date was across the top of the page and was made from a fax machine. This medication listing listed 55 units in AM and 45 units in PM with an order date of A copy of the first page of the 1823 health assessment for Resident #1 was attached to this list.

An observation of the electronic Medication Administration Record (e-MAR) for Resident #1 dated 2014 revealed that was listed as " 100 units at bedtime. " was signed on as 100 units given, recorded by Employee B with time stamped as 22:22 (10:22 PM).

An observation was made on of Resident #1 ' s unopened vials of , dated as filled on The pharmacy label recorded, 100u/ml vial, 55 units in the morning and 45 units in the evening.

A progress note dated at 11:00 PM read that Resident #1 ' s sugar was 232 and " 100units was given " .

In an interview with the Health and Wellness Director on at 10:20 AM, she stated there was a recent medication error for Resident #1. She stated a 1 day adverse was sent to the state. She said the administrator was going to send the 15 day report to the Agency for Health Care Administration (ACHA) today. She said Employee B, misread the medication orders on admission for Resident #1. She stated that Employee A and the night nurse went to check on Resident #1 after his breakfast was served on and found him non responsive. She stated Resident #1 was sent to the hospital on

On at 10:32 AM, an interview was conducted with Employee A, LPN. She said there was a MOR being used for Resident #1 that was sent from Resident #1 ' s pharmacy that required additional information regarding the orders. She stated that she observed Resident #1 on the morning of asleep. She said it was reported to her that Resident #1 was up all night. She stated that the night nurse returned with a glucometer and checked Resident #1 ' s sugar and reported it was 32. Employee A stated that she got orange juice and sugar and attempted to give it to Resident #1, but was unable to get him to drink it. She said she called 911. Employee A stated that she knew Resident #1 had his dose the night before because the night nurse had told her Resident #1 received it, in change of shift report. She stated Resident #1 ' s sugar was 14 when rescue arrived.

On at 1:30 PM, a telephone interview with Employee B was conducted. Employee B reported " I remembered what happened, Resident #1 came in between 7-8 PM (on . His guardian was with him and she had a lot of paper work " . Employee B stated that " I saw the discharge papers from the hospital were the current orders " . She said she read it and saw 100 units. She said it read 0.1 ml beneath the skin. Employee B said Resident #1 ' s sugar was 232 when she checked it around 9 or 10:00 pm on Employee B said she explained the order to Resident #1 and stated it read 100 units, 0.1 ml, but she said she did

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not understand the order. Employee B stated she drew up 60 units of and stated that she did not know why she drew up that amount. She said she administered Resident #1 60 units, between 9 and 10 PM and he was ok. Employee B reported that she borrowed from another patient residing at the ALF, Resident #2. Employee B stated that she was hesitant to borrow the medicine but reported that Employee C said to borrow the medication since Resident #1 's had not been delivered from the pharmacy. Employee B stated that when she came to work on Employee A told her about what happened to Resident #1. Employee B reported that she told Employee A she gave Resident #1 60 units. Employee B stated that she was adhering to the most current orders for Resident #1, not what was attached to the 1823. She stated there was not an order for 60 units, but she figured it was better than giving 100 units.

In an interview with the Administrator on at 11:20 AM, he stated he found out Wednesday morning about the medication error involving Resident #1. He reported that he interviewed Employee B and she stated she gave 60 units of instead of the 100 units she had signed for. The Administrator confirmed that Resident #1 never an order for 60 units of He stated that he suspended Employee B on , and stated that she admitted to the medication error. He stated that he was unaware that Resident #1 was given another resident 's and reported that , " I assumed the was Resident #1 ' s, I hope it was his ". He stated he completed the 15 day Adverse Incident Report because the investigation was completed, but the Agency had not cleared the 1 day report so he could not submit it.

On at 11:35 AM an interview with Employee C, LPN manager, was conducted. She stated that she was informed on at 8:30 PM about the incident with Resident #1. She stated that Employee B reported the order for Resident #1 ' s read to give 100 units and reported that she gave it. She stated she does not know whose was given to Resident #1.

On at 12:27 PM, a follow up interview with the Health and Wellness Director was conducted. She reported that the facility does not borrow medications from residents. She stated that she was unaware that Resident #1 ' s had never been opened.

Review of facility policy revised entitled Medication and Treatment-Assistance stated medication assistance and administration must be given in accordance with the prescribers orders. The individual assisting or administering medication must verify the residents identity before giving the resident his medication, and must check the label 3 times to verify the right medication, right dosage before giving the medication. The General guidelines revised stated appropriately trained licensed associates administering medication should follow the 7 rights of Medication Administration: right medication, right dose, right time, right route, right resident, right documentation and right to refuse. It also stated that medication directions on the pharmacy label should correlate with the medication directions on the MAR.

2) Record review revealed Resident #3 was admitted on . The 1823 Health Assessment orders listed Guaifensen 5 milliliters (ml), take 4 times a day and discontinue on and 25 Milligrams (mg) tablet by mouth every 8 hours as needed for (SBP) greater than 160. The Guaifensen was not recorded on the 2014 MOR. On at 1:00 AM the SBP recorded on the MOR was . The medication was not signed as given on . Review of Resident #3 MOR revealed were not recorded on the MOR on , or

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the morning of

On at 3:38 PM an interview was conducted with the Wellness Nurse. She stated she does not know why Resident #3 syrup was not added to the MOR when he was admitted. She said there was a dose or two that he should have received. She said the 25 mg should have been given for the of on She also confirmed the were not recorded on the MOR or in the medical record since .

Class II

Based on record review and staff interview the facility failed to ensure that the Medication Observation Record was accurately transcribed for 2 of 3 residents, (Resident #1 & #3).

The findings include:

1) An observation of the electronic Medication Administration Record (e-MAR) for Resident #1 dated 2014 revealed that was listed as " 100 units at bedtime. " was signed on as 100 units given, recorded by Employee B with time stamped as 22:22 (10:22 PM).

A progress note dated at 11:00 PM read that Resident #1 ' s sugar was 232 and " 100units was given " .

An observation was made on of Resident #1 ' s unopened vials of dated as filled on . The pharmacy label recorded, 100u/ml vial, 55 units in the morning and 45 units in the evening.

Record review for Resident #1 revealed he was admitted on at approximately 7:00 PM. Resident #1 arrived to the facility with 3 sets of medication orders which comprised of a 6 page hospital discharge instructions list (dated , a separate medication listing from the hospital (unknown date) and a 5 page doctors visit from an appointment in 2014. Resident #1 ' s health assessment, not dated, read that he needed his medication provided and administered to him. Section 2-3 A of the health assessment stated " she attached list " for medications. A five page doctor visit note dated was attached to Resident #1 ' s health assessment and included a list of the resident ' s medication. The listed medications included (100 units/milliliters (ml) (SC) solution, 55 units in the AM and 45 units in the PM .

The six page Patient Discharge Instructions dated for Resident #1 was reviewed. The discharge instructions listed " New Medications " with an order for Aspart (a fast acting that lowers the glucose in the 0.06 ml, (equal to 6 units) beneath the skin, 3 times a day with meals, and " Other Medication " listed current order for Detemir a long acting that may work up to 24 hours) 0.1 ml (equal to 10 units) at bedtime and Detemir 0.1 ml (equal to 10 units) daily. In an interview with

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Employee A (a Licensed Practical Nurse (LPN) on at 10:32 AM, she confirmed that Resident #1 was admitted to the facility with the discharge instructions.

Resident #1 ' s chart also revealed a separate medication listing for Resident #1 from the hospital dated . That date was across the top of the page and was made from a fax machine. This medication listing listed 55 units in AM and 45 units in PM with an order date of . A copy of the first page of the 1823 health assessment for Resident #1 was attached to this list. Resident #1 ' s chart also revealed a separate medication listing for Resident #1 from the hospital dated . That date was across the top of the page and was made from a fax machine. This medication listing listed Sliding Scale Coverage (SSC) and 55 units in AM and 45 units in PM with an order date of . A copy of the first page of the 1823 health assessment was attached to this list.

On at 1:30 PM, a telephone interview with Employee B was conducted. Employee B stated that " I saw the discharge papers from the hospital were the current orders " . She said she read it and saw 100 units. She said it read 0.1 ml beneath the skin. Employee B said Resident #1 ' s sugar was 232 when she checked it around 9 or 10:00 pm on Employee B said she explained the order to Resident #1 and stated it read 100 units, 0.1 ml, but Employee B said she did not understand the order. Employee B stated she drew up 60 units of and stated that she did not know why she drew up that amount. She said she administered Resident #1 60 units, between 9 and 10 PM and he was ok. Employee B reported that she told Employee A she gave Resident #1 60 units. Employee B stated that she was adhering to the most current orders for Resident #1, not what was attached to the 1823. She stated there was not an order for 60 units, but she figured it was better than giving 100 units.

Review of facility policy revised entitled Medication and Treatment-General Guidelines for Medication Administration read " Medication directions on the pharmacy label should correlate with the medication directions on the MAR (Medication administration record)

2) Record review revealed Resident #3 was admitted on The 1823 Health Assessment orders listed Guaifensen 5 milliliters (ml), take 4 times a day and discontinue on and 25 Milligrams (mg) tablet by mouth every 8 hours as needed for (SBP) greater than 160. The Guaifensen was not recorded on the 2014 MOR. On at 1:00 AM the SBP recorded on the MOR was The medication was not signed as given on Review of Resident #3 MOR revealed were not recorded on the MOR on , or the morning of .

On at 3:38 PM an interview was conducted with the Wellness Nurse. She stated she does not know why Resident #3 syrup was not added to the MOR when he was admitted. She said there was a dose or two that he should have received. She said the 25 mg should have been given for the of on . She also confirmed the were not recorded on the MOR or in the medical record since .

Class II

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

Mr. Matthew Heald
CSH-ING WYNDHAM LAKES LP, d/b/a
Wyndham Lakes
10660 Old ST. Rd.
Jacksonville, FL 32257

Dear Mr. Matthew Heald,

This letter reports the findings of a complaint survey conducted on 2015 by a representative of the Agency for Health Care Administration. Attached is the provider's copy of the State (5000) Form, which indicates there were deficiencies noted during the inspection.

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

1) A0053- Medication Administration - Class II

The Assisted Living Facility failed to administer according to the health care provider's order. This resulted in Resident #1 being sent to the hospital for low sugar.

2) A0054- Medication Records- Class II

The Assisted Living Facility failed to ensure the Medication Administration Record was accurately transcribed for Resident #1 & Resident #3. This resulted in Resident #1 being administered an inaccurate dose of which caused the resident to be sent out to the hospital.

Your are directed to complete the following tasks:

1) The facility must employ, on staff or by contract, the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse to address auditing medication observation records in comparison with physician orders. The facility must employ the pharmacist or Registered Nurse, no later than The consultant must develop a written plan of action for addressing the deficient medication practices identified in the statement of deficiencies. The consultant must conduct monthly audits of the medication observation records in comparison to current physician orders for each resident for a minimum of 3 months. The results of these audits must be sent to the Field Office for review. You must provide the agency a copy of the pharmacist's or registered nurse's license and a signed and a dated recommended corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit.

2727 Mahan Drive • Mail Stop #
Tallahassee, FL 32308
AHCA.MyFlorida.com

921 North Davis Street, A-115
Jacksonville, Florida 32209
(904) 798-4201
Fax (904) 359-6054

2) The facility shall provide the agency with, at a minimum, monthly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required.

3) A written, detailed plan of how the facility will create and implement a system to ensure that newly admitted residents physician's orders are accurate and accurately transcribed onto the Medication Administration Record (MAR) before residents receive their first dose of medication. The plan must be created and implemented on or before .....

4) In-Service training for all staff that assist with medication administration regarding the facility's policy and procedures for medication administration. This training must include the facilities responsibilities with medication administration and medication records as stated in Florida Administrative Code 58A-5.0185. This training must be completed by ..

All required documentation set forth above, should be directed to the attention of Mrs. Jana Meyering, Health Facility Evaluator Supervisor and sent to:

Agency for Health Care Administration
Health Quality Assurance, Jacksonville Field Office
Attention: Jana Meyering
921 N. Davis Street, Bldg. A, Suite 115
Jacksonville, FL 32209
Phone: (904) 798-4201
Fax: (904) 359 - 6054

Nothing in this Directed Plan of Correction limits the Agencies authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call .... Laura Manville, Survey and Certification Support Branch, at 727-552-1955.

Sincerely,

Jana Meyering

Jana L. Meyering, Q.I.D.P.
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JD/JM/RED/sm