RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Grand Villa Of Altamonte Springs
433 Orange Drive
Altamonte Springs, FL 32701

RE: Revisit to biennial relicensure

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 15, 2015 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 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 surveyor(s). Should you have any questions please call Lorraine Henry at

Sincerely,

Theresa DeCanio,RN
Field Office Manager

LH/be
Enclosure
XG90

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910126	R 04/15/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701	

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

0000 - Initial Comments

Conducted revisit to the re-licensure survey with Limited Nursing Services (LNS) on ... and ... Grand Villa of Altamonte Springs Assisted Living Facility had deficiencies found at the time of the visit.

0025 - Resident Care - Supervision - 58A-5.0182(1) FAC

THE FOLLOWING DEFICIENCY REMAINED UNCORRECTED:
Based on record review and interview the facility failed to provide care to meet the resident's needs by not following physician's orders and failed to provide documentation of significant changes to the resident including missed medications for 1 of 53 sampled residents (#28).

Findings:

Review of the Adverse incident report for resident #1 dated ... revealed ... (a controlled substance for pain) 75 milligrams (mg) was missing from the medication cart and was not found. The resident assistant stated she gave the medications to the Resident Care Supervisor (RCS) in late ... as she had extra medication and did not want to leave it in her med cart. The RCS was the only nurse, at that time, to have the keys to the medication closet. On ... the staff member went to the nursing office to refill her medication with the resident #28's ... as the medication was running low, and it was missing. A search was made by the Executive Director (ED) for the medication on ... and ... and she could not find the medication. The ED requested the nurse get a telephone order and or script from resident #28's doctor and the community paid for the medication. The facility received the ... 75 mg on ... The number of pills missing was not documented.

Review of the police department sworn statement by the ED dated ... revealed she was informed by the nurse Staff L that 30 ... 75 mg pills were missing.

Resident record review revealed an Assisted Living Facility Health Assessment Form (1823) updated 4/1/15 that indicated diagnoses of ... and ... The resident needed assistance with self-administration of medications.

Review of facility notes revealed:
... (late entry- no time mentioned) this nurse was told by the med tech that resident had a card of ... in the med closet. Attempted to locate the ... in the med closet and med cart. Later was also assisted by the office assistant to locate the medication. We couldn't find it. She questioned the med tech and called the pharmacy and was told that the medication was sent in ... and given to another nurse to put in the closet. The manager agreed to pay $182 for another card of ... It was delivered by pharmacy at this time. Was also informed the resident missed 2 1/2 days. Resident was aware. Her Power of Attorney was called and the physician was made aware.
Review of physician order dated ... revealed ... 75 mg twice a day.
Review of the Medication Observation Record (MOR) for ... 2015 revealed:

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75 mg take one twice a day for pain at 8 AM and 5 PM. The MOR was initialed and the the initials were circled on at 8 AM and 5 PM, at 8 AM and 5 PM, on at 8 AM and at 5 PM initials were in the box and it was charted as given.
The back of the MOR stated the medication was on order on at 9 AM and 8 PM, at 9 AM, and on at 9 AM.
Review of the Medication Count sheet revealed on:
on the 3-11 shift 75 mg was charted as given, and the amount remaining was zero.
on the 3-11 shift 75 mg was charted as given.
The resident missed five doses of 75 mg from through .
75 mg twice a day was not given on 2/9, and . The facility did not ensure physicians ordered were followed for the .
In an interview with the ED on at approximately 2 PM who stated the medication was reported missing, was not located and a police investigation was conducted. The RCS was terminated earlier the same week the medication was missing. The facility attempted to obtain the medication from the pharmacy but was unable to get the medication as there had been insurance issues with refilling the medication. The facility was not able to fill the medication at a local pharmacy. The facility paid for the medication and was able to get it from their new pharmacy.
In an interview with the nurse, Staff L, on at approximately 2:45 PM who stated she was not working on the day the RCS was terminated. She usually worked on weekends but was working during the week, since the RCS was gone the facility paid a lot of money for the . She looked in the closet for it and could not find it. She called the pharmacy and found out it was filled in 2014. We knew there was a card of medication left that was locked up. She would try to get the medication from the local pharmacy, if the resident ran out. The office manager wrote a note to the pharmacy that the facility would pay for the medication. She could not remember if she tried to call the local pharmacy or not. Sometimes there might have been a problem locally getting meds filled. she could not remember. She would have gotten a script from the doctor, since it was a . There were problems with the pharmacy filling meds, the resident also had problems with her credit card.
Review of the 2015 MOR revealed:
hormone) 50 micrograms (mcg) daily at 6 AM was not charted as given, the initials that were in the box were circled on . The back of the MOR indicated the medication was on order and not in the cart.
Flexeril (muscle relaxant) 5 mg twice a day was not given on through at 8 AM and 5 PM. The initials were in the box and were circled. The back of the MOR indicated the medication was on order.
(for stomach 20 mg twice a day was not charted as given from to at 9 AM and 5 PM. The initials were in the box and were circled. The back of the MOR indicated the medication was on order.
Midorine (for 5 mg at 9 AM, 2 PM and 7 PM was not given on at 7 PM. The initials were in the box and were circled. The back of the MOR indicated the medication was on order.
(for incontinence) 5 mg three times a day was not given on through at 9 AM, 2 PM and 4 PM. The initials were in the box and were circled. The back of the MOR indicated the medication was on order.
Review of the facility notes revealed there was no documentation to review that indicated the resident was out of meds and the facility attempting to obtain them.

AGENCY FOR HEALTH CARE ADMINISTRATION

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In an interview with the administrator on at approximately 2:30 PM who stated she was aware there were issues with the resident's medications being refilled. She stated the facility changed to a different pharmacy because of the issues. She also stated the resident had issues with her credit card and the pharmacy would not fill her meds.
Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

THE FOLLOWING DEFICIENCY REMAINED UNCORRECTED:
Based on observation, interview and record review the facility failed to ensure residents who were identified at risk(AR) of elopement had identification (ID) on their person that included their name, the facility's name, address, and telephone number for 24 of 41 sampled (AR) residents (#34, 36, 38, 39, 41, 42, 43, 44, 45, 47, 48, 49, 50, 51, 52, 53, 55, 56, 57, 58, 59, 61, 62, 63, and 72).

Findings:

In an interview with the administrator on at approximately 9:45 AM, all of the residents in the secure Memory Care Unit (MCU) were identified as at risk of elopement.

The MCU census was 47 residents.

Tour of the MCU on at approximately 10 AM revealed 41 residents were observed for elopement identification (ID). There were 24 of the 41 residents who had elopement ID bracelets that were missing, or did not contain the required information. There were residents observed, during the tour, who were able to remove their bracelets from their wrists. Resident #39 had an ID bracelet on that was not legible, resident #51 and #56 did not have an ID on their person and resident #62 had his name only. Residents #34, 36, 38, 41, 42, 43, 44, 45, 47, 48, 49, 50, 52, 53, 55, 57, 58, 59, 61, 63, and 72 did not have ID that contained the facility's complete address and/or phone number, on their person.

The elopement book was requested and reviewed for . The MCU staff were checking elopement ID's and documenting daily at breakfast, lunch and dinner, to ensure the residents had their ID's on their person.

The elopement ID's did not contain the required information.

In an interview with the administrator on at approximately 1 PM who was not aware the above resident's did not have the required information on their ID bracelets on their person.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

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Based on observation, interview and record review the facility failed to ensure that a staff member (Staff J) licensed to administer medications, administered the medication in accordance with a health care provider's orders or prescription label for 1 of 53 sampled residents (Resident #27).
Findings:
Resident review for resident #27 revealed he was admitted on Most recent 1823 is dated reveals a diagnosis of NOS and DO NOS. Further review reveals Resident's Condition log as follows: - 3pm: "resident is still agitated and combative towards others. Request for an increase of his meds or to add another like - same as , waiting on new orders."
- 11am: "received new orders for .5mg tab one every 8 hours, MD stated he would call it into pharmacy."
- 3:30pm: "Dr. informed about med error - no new orders at this time - family notified and have no concern at this time will monitor resident."
Review of a prescription for medication reveals health care provider prescribed .5mg 1 tablet by mouth every 8 hours on to resident # 27.
Review of the Adverse Incident report dated reveals: On a resident (#27) had a behavior. Staff K called nurse, staff J and left a voice mail message. Staff K then called the ED (Executive Director also the Administrator) to inform her of the incident. Staff K then called 911 and paramedics came out and tried to calm the resident #27 down, but refused to him as he was a resident and was not trying to harm himself. On staff J (nurse) called doctor to get an order for .5mg. On it was reported from two members that Nurse, staff J of memory care had given a resident .5mg from a resident medications. The ED/Administrator, investigated incident and found the bubble wrap of .5mg along with the Controlling Drug Record for decease resident and observed four pills were missing and unaccounted for. On ED met with Nurse, staff J to discuss missing medication from the . Staff J and learned the decease persons medication was given to Resident #27. The ED fired staff J, then contacted the Board of Health, DCF, Police, MD and family to notify and report incident. The physician did give verbal order for .5mg on ED writes we do not have this medication available in our community and all medications must have an order and script. The nurse did not document that she administered to this resident as she was taking this medication form a resident that had recently expired, however had the same dose. According to the resident's bubble pack 4 pills are missing, no documentation from nurse of the administration to resident, however staff witnessed he giving it to the resident including our memory care director. Resident #27's prescription of .5mg was received Our communities' policy for obtaining medication in a crisis situation as well as routinely is that we need to obtain a doctors order, script and fax it to the pharmacy. Medication is normally received within 24 hours.
Review of the photo of the bubble package from the resident, reveals 4 missing pills of .5mg 1 tablet by mouth every 8 hours. It is not known where the missing pills were.
On at approximately 11:30 an interview with med tech (Staff E) was completed. She stated the resident knows his medication. She stated she heard the resident ask Staff J, what she was giving him because it was not his. Staff E stated that the nurse (Staff J) told the resident that it was to calm him down. She stated later she found the bubble pack of the resident's medication with 4 missing pills of and told her supervisor.
Review of Resident's Condition log for resident #27 reveals that on the facility contacted the health care

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provider for orders and notification of resident receiving medication in error and family notified."
The nurse (Staff J), had an order for .5mg, 1 tablet by mouth every 8 hours daily. The nurse did not have the medication in the medication cart or at the facility. The nurse pulled the medication from elsewhere, the resident's (#73) medication. The nurse did not chart on the Medication Observation Record that she gave the medication to the resident. The nurse failed to document that she administered the medication to the resident (#27)
On at approximately 1:00 pm in an interview with the Administrator she stated this was not brought to her attention until after the fact. She stated since that time she has started using a new pharmacy and she terminated the nurse.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, interview and record review the facility failed to ensure that the Medication Observation Record (MOR) was immediately updated each time the medication is offered or administered for 1 of 52 sampled residents (#27).
Findings:
Resident record review for Resident #27 revealed he was admitted on . Most recent 1823 dated revealed a diagnosis of NOS, and DO NOS. Further review reveals Resident's Condition log:
- 3pm: "resident is still agitated and combative towards others. Request for an increase of his meds or to add another like - same as , waiting on new orders."
- 11am: "received new orders for .5mg tab one every 8 hours, MD stated he would call it into pharmacy."
- 3:30 pm: "Dr. informed about med error - no new orders at this time - family notified and have no concern at this time will monitor resident."
Review of a prescription for medication reveals health care provider prescribed .5mg 1 tablet by mouth every 8 hours on to resident # 27.
Review of MOR (Medication Observation Record) revealed (generic for) was not available until at 3pm.
Review of the Adverse Incident report dated reveals: On a resident (#27) had a behavior. Staff K called nurse, staff J and left a voice mail message. Staff K then called the ED (Executive Director also the Administrator) to inform her of the incident. Staff K then called 911 and paramedics came out and tried to calm resident #27 down, but refused to him as he was a resident and was not trying to harm himself
On Nurse, staff J called the doctor to get an order for .5mg. On it was reported from two members that staff J (nurse) of the memory care unit had given a resident .5mg from a resident medications. The ED/Administrator, investigated incident and found the bubble wrap of .5mg along with the Controlling Drug Record for the resident (#73) and observed four pills were missing and unaccounted for.
On ED met with staff J to discuss missing medication from the resident's medications. The ED fired staff J, then contacted the Board of Health, DCF, Police, MD, and family to notify and report incident. The

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physician did give verbal order for .5mg on . ED writes we do not have this medication available in our community and all medications must have an order and script. The nurse did not document that, she administered to this resident as she was taking this medication form a resident who had the same dose of medication that was ordered for resident #27. According to the resident's bubble pack 4 pills are missing There was no documentation that the nursed administered the above medication to the resident. However, staff witnessed staff J give resident #27 the medication.
Review of the photo of the bubble package from decease resident reveals 4 missing pills of .5mg 1 tablet by mouth every 8 hours. It is not known where the missing pills were. It is also unknown where the medication was stored.
On at approximately 11:30 am interview with Staff E (med tech) was completed. She stated the resident knows his medication. She stated she heard the resident ask Staff J, what she was giving him because it was not his. Staff E stated Staff J (nurse) told the resident that it was to calm him down. She stated later she found the bubble pack of the resident's (#73) with 4 missing pills of and told her supervisor.
Review of Resident's Condition log for resident #27 revealed that on the facility contacted the health care provider for orders and notification of resident receiving medication in error, and family notified."
Review of admission/discharge log reveals resident #73 was discharged to the hospital as unresponsive on and then went to rehab where she expired on .
The staff J had an order for .5mg, 1 tablet by mouth every 8 hours daily. The nurse did not have the medication in the medication cart or at the facility. The nurse pulled the medication from a resident's medication. The nurse did not chart on the Medication Observation Record that she gave the medication to the resident. The nurse failed to document that she administered the medication to the resident #27 on the Medication Observation Record (MOR). The MOR must be immediately updated each time the medication is offered or administered per Rule 58A-5.0185(5).
On at approximately 1:00 pm in an interview with the Administrator she stated that this was not brought to her attention until after the fact. She stated since that time she has started using a new pharmacy and she terminated the nurse and reported everything to police, the Department of Health and made an Adverse Incident to the Agency for Health Care Administrations. She stated that the residents' health care provider and family were notified. Resident #27 was discharged from the facility on to a higher level of care. The executive director/administrator explained that according to their communities' policy for obtaining medication in a crisis situation as well as routinely is that we need to obtain a doctors order, script and fax it to the pharmacy. Medication is normally received within 24 hours.

Class III

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

Based on record review and interview the facility failed to ensure that controlled medication, that was kept in locked storage, was kept safe and secure at all times, to prevent theft for 2 of 53 sampled residents (#27 and #28) and failed to dispose of abandoned medication within 30 days of being determined abandoned for 1 of 53 sampled residents (#73).

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Findings:

1. Review of the Adverse incident report for resident #1 dated ... revealed ... (a controlled substance for pain) 75 milligrams (mg) was missing from the medication cart and was not found. The resident assistant stated she gave the medications to the Resident Care Supervsior (RCS) in late ... as she had extra medication and did not want to leave it in her med cart. The RCS was the only nurse, at that time, to have the keys to the medication closet. On ... the staff member went to the nursing office to refill her medication with the resident #28's ..., as the medication was running low and it was missing. A search was made by the Executive Director (ED) for the medication on ... and ... and she could not find the medication. The ED requested the nurse get a telephone order and or script from resident #28's doctor and the community paid for the medication. The facility received the ... 75 mg on ... The number of pills missing was not documented.

Review of the police department sworn statement by the ED dated ... revealed she was informed by the nurse, Staff L that 30 ... 75 mg pills were missing.

Resident record review revealed an Assisted Living Facility Health Assessment Form (1823) updated 4/1/15 that indicated diagnoses of ... and ... The resident needed assistance with self-administration of medications.

Review of facility notes revealed:
... (late entry- no time mentioned) this nurse was told by the med tech the resident had a card of ... in the med closet. Attempted to locate the ... in the med closet and med cart. Later was also assisted by the office assistant to locate the medication. We couldn't find it. I questioned the med tech and called the pharmacy and was told that the medication was sent in ... (2014) and given to another nurse to put in the closet. The manager agreed to pay $182 for another card of ... It was delivered by the pharmacy at this time. Was also informed the resident missed 2 1/2 days of medications. Resident was aware. Her Power of Attorney was called and the physician was made aware.
Review of physician order dated ... revealed ... 75 mg twice a day give 30 capsules, with 5 refills.
Review of the Medication Observation Record (MOR) for ... 2015 revealed:
... 75 mg take one twice a day for pain at 8 AM and 5 PM. The MOR was initialed and the the initials were circled on ... at 8 AM and 5 PM, ... at 8 AM and 5 PM, and on ...l/15 at 8 AM and at 5 PM.
The back of the MOR stated the medication was on order on ... at 9 AM and 8 PM, ... at 9 AM, and on ... at 9 AM.
Review of the ... Medication Count sheet revealed on:
... on the 3-11 shift ... 75 mg was charted as given, and the amount remaining was zero.
... on the 3-11 shift ... 75 mg was charted as given.
The resident missed five doses of ... 75 mg from ... through ...
... 75 mg twice a day was not given on 2/9, ... and ... The facility did not ensure physicians ordered were followed for the ...

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In an interview with the ED on [redacted] at approximately 2 PM who stated the medication was reported missing, was not located and a police investigation was conducted. The RCS was terminated earlier the same week the medication was missing.
In an interview with the nurse, Staff L, on [redacted] at approximately 2:45 PM who stated she was not working on [redacted], the RCS was terminated that day. She usually worked on weekends but was working weekdays since the RCS was gone. She looked in the closet for the missing medication and could not find it. She called the pharmacy and found out the medication was filled in [redacted] 2014. We knew there was a card of medication left that was locked up.

2. Review of the admission/discharge log revealed resident #73 was sent to hospital and discharged on [redacted]
Resident #73 later expired on [redacted]
Resident #73 was prescribed [redacted].5mg tablet 1 by mouth every 8 hours.
Review of the MORS for Resident #73 revealed she had 41 of 90 pills left when she was discharged on [redacted]
On [redacted], resident #27 was administered one pill resident #73 [redacted].5 mg tablet by Staff J
There are a total of 4 missing [redacted].5 mg tablets, three of the pills are unaccounted for.
In an interview with the administrator on [redacted] at approximately 2:45 pm, she stated she cannot account for the 3 other missing pills.
The facility did not destroy or dispose of the medications for resident #73 in a timely manner. Which was more than 45 days from the date of discharge.
In an interview with the administrator on [redacted] at approximately 12:00 pm, she put the medication in the destroy box in the memory care unit, but does not know why the medication was not destroyed.
Class III

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

Based on medication review and interview the facility did not make every reasonable effort to ensure that prescriptions were refilled in a timely manner for 2 of 53 sampled residents who received assistance with self-administration of medications (#27 and #28).

Findings:

1. Review of the Adverse incident report dated [redacted] revealed [redacted] (controlled substance for pain) 75 milligrams (mg) was missing from the medication cart and was not found. The resident assistant stated she gave the medications to the Resident Care Supervisor (RCS) in late [redacted] as she had extra medication and did not want to leave it in her med cart. The RCS was the only nurse at that time to have the keys to the medication closet. On 2/1/15 the staff member went to the nursing office to refill her medication with the resident #28's [redacted], as the

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medication was running low and it was missing. A search was made by the Executive Director (ED) for the medication on [redacted] and [redacted] and could not find the medication. The ED requested the nurse to get a telephone order and or script from resident #28's doctor and the community paid for the medication. The facility received the [redacted] 75 mg on [redacted]. The number of pills missing was not documented.

Resident record review revealed an Assisted Living Facility Health Assessment Form (1823) updated [redacted] that indicated diagnoses of [redacted] and [redacted]. The resident needed assistance with self-administration of medications.

Review of facility notes revealed:
[redacted] (late entry- no time mentioned) this nurse was told by the med tech that resident had a card of [redacted] in the med closet. Attempted to locate the [redacted] in the med closet and med cart. Later was also assisted by the office assistant to locate the medication. We couldn't find it. I questioned the med tech and called the pharmacy and was told that the medication was sent in [redacted] and given to another nurse to put in the closet. The manager agreed to pay $182 for another card of [redacted]. It was delivered by pharmacy at this time was. Was also informed the resident missed 2 1/2 days. Resident was aware. Her Power of Attorney was called and the physician was made aware.
Review of physician order dated [redacted] revealed [redacted] 75 mg twice a day.
Review of the Medication Observation Record (MOR) for [redacted] 2015 revealed:
[redacted] 75 mg take one twice a day for pain at 8 AM and 5 PM. The MOR was initialed and the initials were circled on [redacted] at 8 AM and 5 PM, [redacted] at 8 AM and 5 PM, on [redacted] at 8 AM and at 5 PM initials were in the box and it was charted as given.
The back of the MOR stated the medication was on order on [redacted] at 9 AM and 8 PM, [redacted] at 9 AM, and on [redacted] at 9 AM.
Review of the [redacted] Medication Count sheet revealed on:
[redacted] on the 3-11 shift [redacted] 75 mg was charted as given, and the amount remaining was zero.
[redacted] on the 3-11 shift [redacted] 75 mg was charted as given.
The resident missed five doses of [redacted] 75 mg from [redacted] through [redacted].
[redacted] 75 mg twice a day was not given on 2/9, [redacted] and [redacted]. The facility did not ensure physicians ordered were followed for the [redacted].
In an interview with the administrator on [redacted] at approximately 2 PM who stated the medication was reported missing and was not located and a police investigation was conducted. The RCS was terminated earlier the same week the medication was missing. The facility attempted to obtain the medication from the pharmacy but was unable to get the medication as there had been insurance issues with refilling the medication. The facility was not able to fill the medication at a local pharmacy. The facility paid for the medication and was able to get it from their new pharmacy.
In an interview with the nurse, Staff L, on [redacted] at approximately 2:45 PM who stated she was not working on [redacted], the RCS was terminated that day. She usually worked on weekends but was working since the RCS was gone the facility paid a lot of money for the [redacted]. She looked in the closet for it and could not find it. She called the pharmacy and found out it was filled in [redacted] 2014. We knew there was a card of medication left that was

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910126	R 04/15/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701	

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

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locked up. She would try to get the medication from the local pharmacy, if the resident ran out. The office manager wrote a note to the pharmacy, that the facility would pay for the medication. She could not remember if she tried to call the local pharmacy or not. Sometimes there might be a problem locally getting meds filled, she could not remember. She would have gotten a script from the doctor, since it was a [redacted]. There were problems with the pharmacy filling meds; the resident also had problems with her credit card.

Review of the [redacted] 2015 MOR revealed:

[redacted] hormone) 50 micrograms (mcg) daily at 6 AM was not charted as given, the initials were in the box were circled on [redacted]. The back of the MOR indicated the medication was on order and not in the cart.

Flexeril (muscle relaxant) 5 mg twice a day was not given on [redacted] through [redacted] at 8 AM and 5 PM. The initials were in the box and were circled. The back of the MOR indicated the medication was on order.

[redacted] (for stomach [redacted] 20 mg twice a day was not charted as given from [redacted] to [redacted] at 9 AM and 5 PM. The initials were in the box and were circled. The back of the MOR indicated the medication was on order.

Midorine (for [redacted] 5 mg at 9 AM, 2 PM and 7 PM was not given on [redacted] at 7 PM. The initials were in the box and were circled. The back of the MOR indicated the medication was on order.

[redacted] (for [redacted] incontinence) 5 mg three times a day was not given on [redacted] through [redacted] at 9 AM, 2 PM and 4 PM. The initials were in the box and were circled. The back of the MOR indicated the medication was on order.

Review of the facility notes revealed there was no documentation to review that indicated the resident was out of meds and they were attempting to obtain them.

In an interview with the administrator (ED) on [redacted] at approximately 2:30 PM who stated she was aware there were issues with medications being refilled. She stated the facility changed pharmacies because of the issues. She also stated the resident had issues with her credit card and the pharmacy would not fill her medications.

Resident record review for Resident #27 revealed he was admitted on [redacted]. Most recent 1823 is dated [redacted] reveals a diagnosis of [redacted] NOS, and [redacted] DO NOS. Further review reveals Resident's Condition log:

[redacted] - 3pm: "resident is still agitated and combative towards others. Request for an increase of his meds or to add another like [redacted] - same as [redacted], waiting on new orders."

[redacted] - 11am: "received new orders [redacted] .5mg tab one every 8 hours, MD stated he would call it into pharmacy."

[redacted] - 3:30pm: "Dr. informed about med error - no new orders at this time - family notified and have no concern at this time will monitor resident."

Review of a prescription for medication reveals health care provider prescribed [redacted] .5mg 1 tablet by mouth every 8 hours on [redacted] to resident # 27.

Review of MOR (Medication Observation Record) reveals that the [redacted] (generic for [redacted] was not available until [redacted] at 3 pm.

Further review of resident #27's file revealed no notes regarding the facility making every reasonable effort to ensure the prescription was filled in a timely manner.

Review of the Adverse Incident report dated [redacted] revealed: On [redacted] a resident (#27) had a behavior. Staff K called nurse, staff J and left a voice mail message. Staff K then called the ED (Executive Director also the Administrator) to inform her of the incident. Staff K then called 911 and paramedics came out and tried to calm the

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GRAND VILLA OF ALTAMONTE SPRINGS	**433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701**	

SUMMARY STATEMENT OF DEFICIENCIES
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resident #27 down, but refused to [redacted] him as he was a [redacted] resident and was not trying to harm himself. On [redacted], staff J (nurse) called the doctor to get an order for [redacted].5mg. On [redacted] it was reported from two staff members that staff J (nurse) of memory care had given a resident [redacted].5mg from a [redacted] resident medications. The ED/Administrator, investigated incident and found the bubble wrap of [redacted].5mg along with the Controlling Drug Record for the decease resident and observed four pills were missing and unaccounted for. On [redacted] ED met with staff J (nurse) to discuss missing medication from the [redacted] resident (#73). Staff J stated she gave the decease persons medication to Resident #27. The ED fired staff J, then contacted the Board of Health, DCF, Police, MD, and family to notify and report incident. The physician did give verbal order for [redacted] .5mg on [redacted]. ED writes we do not have this medication available in our community and all medications must have an order and script. The nurse did not document that, she administered [redacted] to this resident as she was taking this medication form a resident that had recently expired, however had the same dose. According to the [redacted] resident's bubble pack 4 pills are missing, no documentation from nurse of the administration to resident, however, staff witnessed her giving it to the resident including our memory care director. Resident #27's prescription of [redacted].5mg was received [redacted]. Our communities' policy for obtaining medication in a crisis situation as well as routinely is that we need to obtain a doctors order, script and fax it to the pharmacy. Medication is normally received within 24 hours.
Review of the photo of the bubble package from decease resident reveals 4 missing pills of [redacted].5mg 1 tablet by mouth every 8 hours. It is not knows where the missing pills were. It is unknown where the medication was stored. Staff J was able to access the medication of the [redacted] resident (#73) and provide it to resident #27. It is unknown if the medication was stored and/or disposed of properly.
On [redacted] at approximately 11:40 am in an interview with the Administrator she stated that the medication not being filled was not brought to her attention until [redacted]. She stated had she known she could have gone out and purchased the medication herself. She stated since that time she has started using a new pharmacy. She stated that the residents' health care provider and family were notified. The Administrator stated that the resident was discharged from the facility on [redacted] to a higher level of care.
Class III

0077 - Staffing Standards - Administrators - 58A-5.019(1) FAC

THE FOLLOWING DEFICIENCY REMAINED UNCORRECTED:
Based on record review and interview, the administrator, who was responsible for the operation of the facility, the management of all staff and the provision of adequate care to all residents failed to ensure: 1. Physician's orders were followed for pain medications for 1 of 52 sampled residents (#28) and 2. Residents who were identified at risk (AR) of elopement had identification (ID) on their person that included their name, the facility's name, address, and telephone number for 24 of 41 sampled AR residents (#34, 36, 38, 39, 41, 42, 43, 44, 45, 47, 48, 49, 50, 51, 52, 53, 55, 56, 57, 58, 59, 61, 62, 63, and 72).

Findings:

1. Review of the Adverse incident report dated [redacted] revealed [redacted] (a controlled substance for pain) 75

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milligrams (mg) was missing from the medication cart and was not found. The resident assistant stated she gave the medications to the Resident Care Supervisor (RCS) in late as she had extra medication and did not want to leave it in her med cart. The RCS was the only nurse at that time to have the keys to the medication closet. On the staff member went to the nursing office to refill her medication with resident #28's as the medication was running low, and it was missing. A search was made by the Executive Director (ED) for the medication on and and she could not find the medication. The ED requested the nurse get a telephone order and or script from resident #28's doctor, and the community paid for the medication. The facility received the 75 mg on The number of pills missing was not documented on the Adverse Incident Report.

Resident record review revealed an Assisted Living Facility Health Assessment Form (1823) updated that indicated diagnoses of and The resident needed assistance with self-administration of medications.

Review of facility notes revealed:
(late entry- no time mentioned) this nurse was told by the med tech that resident had a card of in the med closet. Attempted to locate the in the med closet and med cart. Later was also assisted by the office assistant to locate the medication. We couldn't find it. I questioned the med tech and called the pharmacy and was told that the medication was sent in (2014) and given to another nurse to put in the closet. The manager agreed to pay $182 for another card of It was delivered by the pharmacy at this time. Was also informed the resident missed 2 1/2 days of medications. Resident was aware. Her Power of Attorney was called and the physician was made aware.
Review of physician order dated revealed 75 mg twice a day give 30 capsules, with 5 refills.
Review of the Medication Observation Record (MOR) for 2015 revealed:
75 mg take one twice a day for pain at 8 AM and 5 PM. The MOR was initialed and the the initials were circled on at 8 AM and 5 PM, at 8 AM and 5 PM, and on at 8 AM and at 5 PM.
The back of the MOR stated the medication was on order on at 9 AM and 8 PM, at 9 AM, and on at 9 AM.
Review of the Medication Count sheet revealed on:
on the 3-11 shift 75 mg was charted as given, and the amount remaining was zero.
on the 3-11 shift 75 mg was charted as given.
The resident missed five doses of 75 mg from through
75 mg twice a day was not given on 2/9, and The facility did not ensure physicians ordered were followed for the
In an interview with the administrator, ED on at approximately 2 PM who stated the medication was reported missing, was not located and a police investigation was conducted. The RCS was terminated earlier the same week the medication was missing.
In an interview with the nurse, Staff L, on at approximately 2:45 PM who stated she was not working on when the RCS. She usually worked on weekends but was working during the week, since the RCS was gone. She looked in the closet for the and could not find it. She called the pharmacy and found out it was

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SUMMARY STATEMENT OF DEFICIENCIES
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filled in [redacted] 2014. She knew there was a card of medication left that was locked up.

2. In an interview with the administrator on [redacted] at approximately 9:45 AM, all of the residents in the secure Memory Care Unit (MCU) were identified as at risk of elopement.

The MCU census was 47 residents.

Tour of the MCU on [redacted] at approximately 10 AM revealed 41 residents were observed for elopement identification (ID). There were 24 of the 41 residents who had elopement ID bracelets that were missing, or did not contain the required information. There were residents observed, during the tour, who were able to remove their bracelets from their wrists. Residents #39's ID was not legible, #51 and #56 did not have an ID on their person and resident #62 had his name only. Residents #34, 36, 38, 41, 42, 43, 44, 45, 47, 48, 49, 50, 52, 53, 55, 57, 58, 59, 61, 63, and 72 did not have ID that contained the facility's complete address and/or phone number.

The elopement book was requested and reviewed for [redacted]. The MCU staff were checking ID's and documenting daily at breakfast, lunch and dinner, to ensure the residents had their ID's on their person.

In an interview with the administrator, ED on [redacted] at approximately 1 PM who was not aware the resident's above did not have the required information on their ID bracelets on their person.

Class III

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11910126	A. Building B. Wing	4/15/2015

Name of Facility

GRAND VILLA OF ALTAMONTE SPRINGS

Street Address, City, State, Zip Code

433 ORANGE DRIVE
ALTAMONTE SPRINGS, FL 32701

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **A0010** Reg. # **58A-5.0181(4) FAC** LSC		ID Prefix **A0078** Reg. # **58A-5.019(2) FAC** LSC		ID Prefix **A0167** Reg. # **58A-5.025 FAC** LSC	
ID Prefix **AZ821** Reg. # **59A-35.110, FAC** LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** L. Kent for J. Deeman	**Date:** 4/26/15	**Signature of Surveyor:**		**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**		**Date:**

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**