STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965768	**08/04/2015**
NAME OF PROVIDER OR SUPPLIER **THORNTON GARDENS**	STREET ADDRESS, CITY, STATE, ZIP CODE **618 E CENTRAL BLVD. ORLANDO, FL 32821**	

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

0000 Initial Comments

Mid cycle monitoring conducted on . Thornton Gardens Assisted Living had deficiencies found at the time of the visit.

0008 Admissions - Health Assessment

Based on record review and interview the facility failed to ensure that 1 of 4 sampled resident records had a completed health assessment that addressed all the required criteria (#3).
Findings:
Resident record review for resident #3 revealed a health assessment report AHCA form 1823 dated / / . Continued review revealed the assessment did not address the resident's needs regarding transferring. That portion of the form was blank.
In an interview with the administrator / at approximately 10 AM, who stated she overlooked the form.
Class III

0025 Resident Care - Supervision

Based on observations, record review and interview the facility failed to ensure it provided care and services appropriate to meet the needs of the residents accepted for admission to the facility and did not follow the direction for use of a medications and did not obtain orders to crush medications prior to crushing the medications for 1 of 4 sample resident (2).
Findings:
Observations during the facility tour on / at approximately 7:30 AM noted a medication cart was in the kitchen. The staff stated she was going to make breakfast and put the cart away. The staff was asked why she was putting the cart away. She stated she was getting it ready and medications were done by 8-8:15 am.
Observation of the medication cart noted each resident was assigned a drawer. Continued observations of the medication cart noted that: Resident #2 had a plastic cup with 4 pills inside (2 small white, 1 rust color and 1 caplet). The medication for the morning were Tamulosin 04. Milligrams (mg) daily, 0.5 mg daily, one daily on an empty stomach before meals and , 5 mg daily.
Resident #2 was wheeled to the dining staff #A. She retrieved the medications that were previously poured in a cup and placed in the med cart. She signed the MOR before the resident took the medication. She stated "I had these medications ready". She crushed the medications and poured them in apple sauce. She fed the apple sauce to the resident. She added the resident had breakfast already.
The staff was asked to review the directions for the that indicated take on an empty

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stomach before meals, she offered no response.
Resident record review for resident #2 revealed no evidence to confirm that a healthcare provider had given orders for the resident's medications to be crushed. The health assessment report from 1823 dated / indicated the resident needed medication administration.

In an interview with the administrator/ Registered Nurse on / at approximately 10:30 AM who stated she did not have a crush medication order available.
Class III

0030 Resident Care - Rights & Facility Procedures

Based on observations and interview the facility failed to ensure the use of physical restrains was limited to half-bed rails only for 1 of 4 sampled residents (#2) and with a healthcare provider's order.
Findings:
Observations during the medication pass on / at approximately 8:30 AM noted resident #2 was . He sat in a wheelchair. He had a seat belt strap on across his lap. He was asked to remove the strap. He did not attempt to release the strap and nor did he respond. The staff was asked to remove the belt, she was hesitant and asked what if he ? She said he was not able to release the strap at will.
On at approximately 8:30 AM the administrator was informed of the above findings. She offered no comment.
Class III

0052 Medication - Assistance with Self-Admin

Based on observations and interview the facility failed to ensure the unlicensed staff who assisted 4 of 4 sampled resident (#1, 2, 3, and 4) with self-administration of medications followed the correct procedure.
Findings:
Observations during the facility tour on / at approximately 7:30 AM noted a medication cart was in the kitchen. The staff stated she was going to make breakfast and put the cart away. The staff was asked why she was putting the cart away. She stated she was getting it ready and medications were done by 8 -8:15 am.
Observation of the medication cart noted each resident was assigned a drawer. Continued observations of the medication cart noted that:
Resident #2 had a plastic up with 4 pills inside (2 small white, 1 rust color and 1 caplet). The medication for the morning were Tamulosin 04.milligrams (mg) daily , 0.5 mg daily, one daily on an empty stomach before meals and 5 mg daily.
Resident #1 had a plastic cup with 2 white pills in cup. Morning medications were 10 mg, and

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Resident # 3 had 2 1/2 tablets in a cup and another cup indicated 1/2 (half)
In an interview with staff #A on at approximately 8:05 AM who stated she had no idea who put those pills in the cups inside the cart.
Staff #A assisted resident #1 in the following manner: She poured the medications in a cup, signed the Medication Observation Record (MOR) before the resident took the medications. She took the medication cup to resident #1 and told her what medications were in the cup. The resident stated "OK I'll take them" and continued to eat breakfast. The staff said "No I need you to take them now". The resident had a puzzled looked but took the medications with the assistance of staff who brought the residents hand to her mouth.
Staff #A then assisted resident #4 in the following manner she put the medications in a cup, signed the MOR before the resident took the medication. She walked to where resident #4 sat, told him what the medications were. She put the pills in his hand and brought his hand to his mouth. In the meantime a pill fell off his hand. She looked at his hand and said it was D3. The staff was asked if she knew which medication fell off. She stated "I know the medication. I take it too". She took another pill and gave it to the resident.
Resident #2 was wheeled to the dining staff #A. She retrieved the medications that were previously poured in a cup and placed in the med cart. She signed the MOR before the resident took the medication. She stated I had these medications ready. She crushed the medications and poured them in apple sauce. She fed the apple sauce to the resident.
Staff #A assisted resident #3 in the same manner .She cut the pill in half, since the resident was to take a lower dosage of the medication. She put the medications in a cup, signed the MOR before the resident took the medication.
The residents were upset that they had to wait for the staff today, normally she give them the cup with pills and they take it. The staff commented the residents acted like today was the first time they did it this way.
In an interview with the administrator at approximately 10 AM, who offered no comment.
Class III

0055 Medication - Storage and Disposal

Based on observations and interview the facility failed to ensure that centrally store medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, or area at all times for 8 of 8 facility residents.
Findings:
Observations upon entering the facility on at approximately 7:30AM noted the front gate was locked. Staff #A came outside to open and grant access.
Observations during the facility tour on / at approximately 7:30 AM noted a medication cart was in

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the kitchen. There were 4 residents who sat in the living . The staff stated she was the sole caregiver at the time, another staff was due to come in at 8 AM. The medication cart did not have a lock. At approximately 7:25 AM the staff locked the cart in a closet by the dining area.
Observations during the medication pass on /15 at approximately 8 AM noted 7 residents were at the tables, having breakfast. Staff #A began to pass medications. As she went from resident #1, to other residents she left the cart out in the open; stationary, accessible to the residents.
In an interview with the administrator at approximately 10:30 AM, who offered no comment.
Class III

0056 Medication - Labeling and Orders

Based on observations and interview the facility failed to ensure that except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another for 3 of 4 sampled residents (#1, #2, and #3) and failed to ensure that any changes made to a prescription label were only done by a pharmacist for 1 of 4 sample residents (#1).
Findings:
Observations during the facility tour on at approximately 7:30 AM noted a medication cart was in the kitchen. The staff stated she was going to make breakfast and put the cart away. The staff was asked why she was putting the cart away. She stated she was getting it ready and medications were done by 8 -8:15 am.
Observation of the medication cart noted each resident was assigned a drawer. Continued observations of the medication cart noted that:
Resident #2 had a plastic up with 4 pills inside (2 small white, 1 rust color and 1 caplet). The medication for the morning were Tamulosin 04. Milligrams (mg) daily, 0.5 mg daily, one daily on an empty stomach before meals and 5 mg daily.
Resident #1 had a plastic cup with 2 white pills in cup. Morning medications were 10 mg one tablet daily. The MOR listed 10 mg one twice a day at 8 AM and 5 PM, and a healthcare provider's order dated / / indicated 10 mg one twice daily. The bubble pack did not have an alert label that directed the staff to follow the direction on the MOR, as order was changed.
Resident # 3 had 2 1/2 tablets in a cup and another cup indicated 1/2 (half)
In an interview with staff #A on at approximately 8:05 AM who stated she had no idea who put those pills on the cups inside the cart.
Staff #A assisted resident #3 in the same manner .She cut the pill in half, since the resident was to take a lower dosage of the medication. She placed the half pill in the bubble pack and secure it with tape. She put the medication in a cup, signed the MOR before the resident took the medication. The prescription label dated / 5 mg take one tablet once daily hand written in the label was

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"1/2 tablet". A doctor's order dated / indicated 2.5 mg daily. The MOR indicated 2.5 mg daily. The bubble pack did not have an alert label that directed the staff to follow the direction on the MOR, as order was changed.
Resident #2 was wheeled to the dining staff #A. She retrieved the medications that were previously poured in a cup and placed in the med cart. She signed the MOR before the resident took the medication. She stated I had these medications ready. She crushed the medications and poured them in apple sauce. She fed the apple sauce to the resident.
In an interview with the administrator / at approximately 10 AM, who offered no comment.
Class III

0057 Medication - Over The Counter (OTC) Products

Based on observations and interview the facility failed to ensure that over the counter (OTC) medications were labeled with the residents' names.
Findings:
Observations on at approximately 7:45 AM noted there was a drawer in the medication cart that had the following over the counter medications that were not labeled with the resident's name(s): 2 bottles of Certizine, 1 bottle of Fish oil, 1 bottle of , 1 bottle of , 1 bottle of S.
Another drawer had had 2 bottles of and 1 bottle of not labeled with the resident's name.
The drawer labeled with the name of resident #2 had OTC and 81 milligrams (mg), the bottles were not labeled with the resident's name.
In an interview with the administrator / at approximately 10:30 AM, who stated she would speak with the staff.
Class III

0078 Staffing Standards - Staff

Based on observations, record review and interviews the facility failed to ensure that all staff were assigned duties consistent with his/her level of education, training, preparation, and experience and allowed unlicensed staff to administer medications to 4 of 4 sampled residents (#1, #2, #3, and #4).
Findings:
Observation on at approximately 8 AM noted staff #A assisted resident #1 in the following manner: She poured the medications in a cup, signed the Medication Observation Record (MOR) before the resident took the medications. She took the medication cup to resident #1 and told her what medications were in the cup. The resident stated "OK I'll take them" and continued to eat breakfast. The staff said "No I need you to take them now". The resident had a puzzled looked but took the

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medications.
Staff #A then assisted resident #4 in the following manner she put the medications in a cup, signed the MOR before the resident took the medication. She walked to resident #4 sat, told him what the medications were. She put the pills in his hand and brought his hand to his mouth. In the meantime a pill off his hand. She looked at his hand and said it was D3. The Agency representative asked how she know which medication off. She stated "I know the medication. I take it too". She took another pill and gave it to the resident.
Resident #2 was wheeled to the dining staff #A. She retrieved the medications that were previously poured in a cup and placed in the med cart. She signed the MOR before the resident took the medication. She stated I had these medications ready. She crushed the medications and poured them in apple sauce. She fed the apple sauce to the resident. She added the resident had breakfast already.
Staff #A assisted resident #3 in the same manner .She cut the pill in half, since the resident was to take a lower dosage of the medication. She put the medications in a cup, signed the MOR before the resident took the medication. She walked to resident #2 sat, told him what the medication was.
Personnel record review for staff #A revealed she was not a licensed nurse, therefore not able to administer medications.
In an interview with the administrator / at approximately 10 AM, who offered no comment.
Class III

0162 Records - Resident

Based on observations, record review and interview the facility failed to ensure 1 of 4 sampled resident records (#3) contained all the required documentation.
Findings:
Observations during the medication pass on at approximately 8 AM, noted that staff #A assisted resident #3 with self-administration of medications.
Resident record review for resident #3 revealed a health assessment report AHCA form 1823 was dated //_ that indicated he needed assistance with self-administration of medications. The review revealed the informed consent form regarding assistance with self-administration of medications was present in the record; however the form did not indicate if the staff who provided such assistance would be or not supervised by a nurse.
Personnel record review for staff #A revealed she was not a licensed nurse.
In an interview with the administrator / at approximately 10 AM, who stated she overlooked the form.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Thornton Gardens
618 E Central Blvd.
Orlando, FL 32821

RE: Mid Cycle Monitoring

Dear Administrator:

This letter reports the findings of a state licensure monitoring survey that was conducted on , 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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