STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967095	12/01/2015
NAME OF PROVIDER OR SUPPLIER **THORNTON GARDENS II**	STREET ADDRESS, CITY, STATE, ZIP CODE **1516 MONTCALM STREET** **ORLANDO, FL 32806**	

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

0000 Initial Comments

On / / an Abbreviate Biennial re-licensure Survey was conducted at Thornton Gardens II Assisted Living Facility. Deficient practice was identified during the survey.

0054 Medication - Records

Based on Medication Observation Record (MOR) review and interview, the facility failed to maintain an accurate MORs for 1 of 2 sampled residents (#1).

Findings:

Review of the MOR for / / for Resident #1 revealed there were blank spaces on the MOR and there were not any notations documenting the reasons for the omissions as follows:
8.8/5 cc 1 teaspoon 2 times daily was left blank at 9 AM and 5 PM on / and at 5 PM on / /.
C 500 milligrams (mg) 1 twice daily at 9 AM and 5 PM was left blank on / . There were circles around staff initials on / and / .
0.5 mg at 9 AM was left blank on / /
50 mg 1/2 tablet one daily was left blank at 9 AM on /
0.5 mg 2 tablets at 9 PM was left blank on /
3 mg 2 tablets at 9 PM was left blank on /
on / / at 11:30 AM, the Administrator said she was not aware the MOR was not signed each time the medication was given.
Observations during the medication pass on / / at 9:45 PM, Staff B was providing assistance with medication for Resident #1. Review of the medication bubble package revealed the prescription label noted (used for high ,) 1/2 tablet twice a day-25 Milligrams (mg). The 1/2 tablet equaled 25 mg. The prescription label was dated / . The pills were dispensed in a dosage of 1/2 tablets in a separate bubble.
Review of the Medication Observation Record (MOR) revealed it noted 50 mg 1 daily.
The prescription label and the MOR were different.
On / / at 11 AM, the administrator had to call to get clarification of the order. She said the pharmacy had informed her the health care provider had given them an order for 25 mg- 1/2 tablet twice a day and was the order Resident #1 had when he was in a previous facility. She further stated when she spoke with the Advance Registered Nurse Practitioner (ARNP) over the telephone, she had just informed her to follow the order of the previous health care provider to give 50 mg- 1/2 tablet twice daily (25 mg).
The administrator stated she was not aware that the label on the medication had different directions than

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what was on the MOR. She stated she would make the new MORs monthly without comparing the prescription labels to the MORS for accuracy.

Class III

0056 Medication - Labeling and Orders

Based on Record Review, Medication Observations Record (MOR), Observations and Interviews, the facility failed to obtain and follow a physician order when there was a change in directions for the use of a medication and did not make every reasonable effort to ensure that prescription were refilled in a timely manner for 1 of 2 sampled residents (#1).

Findings:

Observations during the medication pass on / / at 9:45 PM, Staff B was providing assistance with medication for Resident #1. Review of the medication bubble package revealed the prescription label noted (used for high) 1/2 tablet twice a day-25 Milligrams (mg). The 1/2 tablet equaled 25 mg. The prescription label was dated . The pills were dispensed in a dosage of 1/2 tablets in a separate bubble.
Staff B removed two of the 1/2 tablets that would equal 50 mg and placed them in a cup to crush.
Review of the Medication Observation Record (MOR) revealed it noted 50 mg 1 daily.
Before the medication was provided to Resident #1, Staff B was asked why was she going to give 50 mg when the label noted 25 mg.
On / / at 9:55 AM, Staff B said she gave the medication according to what was on the MOR not the prescription label.
Record review revealed a Resident Health Assessment form 1823 dated / noted 50 mg 1 daily.
Further review of the Medication Label revealed there was no alert label on the medication label regarding the change of direction.
The administrator who was a Registered Nurse was informed the MOR and the medication label were not the same directions. The Administrator called the pharmacy and Health Care provider for clarification at the time.
On / at 11 AM, the administrator said the pharmacy had informed her the health care provider had given them an order for 25 mg- 1/2 tablet twice a day and was the order Resident #1 had when he was in a previous facility.
She further stated when she spoke with the Advance Registered Nurse Practitioner (ARNP) over the telephone, she had just informed her to follow the order of the previous health care provider to give 50 mg- 1/2 tablet twice daily (25 mg). She stated the ARNP told her, the previous health care

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provider possibly did not want the resident to take 50 mg at one time and divided the dosages up. The administrator took the telephone order and the ARNP did fax the change in direction for the use of the medication to the facility. The administrator stated she was not aware that the label on the medication had different directions than what was on the MOR. She stated she would make the new MORs monthly without looking at the prescription labels.

On / / at 9:45 AM, during the medication Pass Staff B said, she had just ordered Resident #1 C last night and she did not have any to give him because he was out.
Record review for Resident #1 revealed the 1823 noted he was to have C 500 mg 1 twice daily.
Review of the empty prescription bottle revealed it noted C 500 mg 1 twice daily.
Record review revealed there was no documentation found to confirm that the staff had tried to order the medication prior to it running out.
On / / at 10:15 AM the administrator said the staff were to order the Medication 7 days in advance.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

_ _ _ _ _ _ _ _ _ _, 2015

Administrator
Thornton Gardens II
1516 Montcalm Street
Orlando, FL 32806

RE: Relicensure

Dear Administrator:

This letter reports the findings of a state licensure 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents 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

XG90

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