STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965743	02/18/2016
NAME OF PROVIDER OR SUPPLIER **FAMILY EXTENDED CARE OF MELBOURNE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **4001 STACK BOULEVARD MELBOURNE, FL 32901**	

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

0000 Initial Comments

Unannounced Complaint Investigation #2016001384 was conducted in conjunction with Complaint Investigation #2105012322 on , , , and /. Family Extended Care Assisted Living Facility had deficiencies at the time of the visit.

0052 Medication - Assistance with Self-Admin

Based on observation, interviews and record reviews, the facility placed residents at risk by failing to ensure residents who receive assistance with the self-administration of medication had prescriptions for medication filled or refilled in a timely manner for 3 of 13 sampled residents (#8, 11 & 12), failed to ensure medication was safely provided as directed to 7 of 13 sampled residents (#1, 2, 3, 4, 5, 6 & 7), and failed to ensure 1 of 7 sampled medical technicians (med techs) was at least prior to providing assistance with the self-administration of medication to residents (D).

Findings:

1. Resident #8's file revealed an order for , a medication. Resident #8's medication observation records (MOR) indicated the facility did not provide on /, /, , , and , for a total of 6 days.

Review of Resident #8's medication packet was dated as being filled on / with one tablet missing from the pack.

On at 2:05 PM, med tech G stated Resident #8 did not get his medication because the medication was lost.

On at 5:27 PM, the administrator and personal care supervisor C stated Resident #8 did move into the facility on / with a 3 day supply of the medication. Personal care supervisor C stated the new medication was ordered by a local pharmacy but it was not delivered because of a problem with the resident's health insurance. They both stated the facility did not get the medication on /. When asked if Resident #8 was out of the medication and how the resident receive the medication on / and / /, personal care supervisor C could not provide an answer. The administrator stated all refills and new medication orders are handled by the med techs. The administrator stated when the health care provider orders new medications, the med techs are responsible for ensuring the orders are filled. The administrator stated the process works and she is not concerned about residents not getting their medication.

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On at 11:27 AM, Resident #8's daughter stated Resident #8 had moved into the facility on with a 3 day supply of . She stated the resident was without the medication for about a week. The daughter stated personal care supervisor C told her the medication was lost.

On at 12:57 PM, a local pharmacist stated medication for Resident #8 was delivered and accepted by the facility on .

On at 1:02 PM, nurse N stated Resident #8 did not get his medication because staff had thrown away the medication.

The facility operating procedure regarding medication management (#6.009) read, "Medications shall be refilled on a timely basis....Verify the resident and dosage."

2. On at 4:13 PM, med tech K stated Resident #12 is supposed to get his 5 PM medication but personal care supervisor C did not order it from the pharmacy. Med tech K stated personal care supervisor C instructed her to sign the MOR for Resident #12 getting his 5 PM dose of medication.

On at 4:40 PM, personal care supervisor C stated Resident #12's medication was not in the medication cart and the facility was waiting for the medication to be delivered. The administrator said she did not know why the facility did not have Resident #12's 5 PM medication.

On at 5:27 PM, the administrator stated Resident #12's medication was held up by the pharmacy. The administrator stated the pharmacy will only deliver a couple of the Methadone tablets for Resident #12 at a time.

Resident #12's MOR revealed his morning medication on was not provided.

On //16 at 10 AM, the local pharmacist stated the methadone for Resident #12 was provided to facility when they called and asked. The local pharmacist provided documentation of the delivery of Resident #12's Methadone on . The pharmacy stated the Methadone provided to Resident #12 was 120 tablets, 1 tablet 3 times per day.

3. Resident #11's MORs indicated the Resident's eye drops had been discontinued by the facility on //. The MORs indicated the eye drops were restarted on //.

On at 5:27 PM, personal care supervisor C stated the facility discontinued the eye drops for Resident #11 because the prescription had run out. She stated the facility restarted the eye drops for Resident #11 when the new prescription was filled.

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SUMMARY STATEMENT OF DEFICIENCIES
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On at 1:53 PM, med tech F stated the facility frequently runs out of resident medication and has had residents get the wrong medication.

On at 3:53 PM, med tech J stated residents run out of medication all of the time. She stated the med techs don't know how to order the medication or don't want to order the medication.

On at 12:52 PM, Resident #11's doctor doctor stated the prescription was sent to the pharmacy on .

On at 1:02 PM, nurse N stated the facility has a lot of missing medication. She stated the med techs are entering a lot of false information on the MORs.

On at 8:01 PM, nurse H stated the facility is always short of medication. He stated, many of the med techs throw away new medication if they don't understand what the medication is for.

On at 9:29 AM, med tech I stated the facility is always running out of medication. She stated since the administrator and personal care supervisor C will not work with the med techs, they don't have any idea of what is happening.

4. During a medication pass on beginning at 1 PM, med tech E provided medication to Resident #1. She E failed to identify Resident #1, wash or sanitize her hands or wear gloves prior to handling Resident #1's medication after handling medication from another resident.

5. During a medication pass on beginning at 1 PM, med tech D provided medication to Resident #2. He failed to identify Resident #2, wash or sanitize his hands or wear gloves prior to handling Resident #2's medication after handling medication from another resident. He failed to enter the information into MORs after providing Resident #2 with her medication.

6. During a medication pass on beginning at 1 PM, med tech D provided medication to Resident #3. He failed to identify Resident #3, wash or sanitize his hands or wear gloves prior to handling Resident #3's medication after handling medication from another resident. He failed to enter the information into the MORs after providing Resident #3 with her medication.

7. During a medication pass on beginning at 1 PM, med tech D provided medication to Resident #4. He failed to identify Resident #4, wash or sanitize his hands or wear gloves prior to handling the Resident #4's medication after handling medication from another resident. He turned to talk to another resident and failed to observe Resident #4 take her medication. The medication label indicated

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Resident #4 was to chew and swallow the medication but Resident #4 only swallowed the medication. He failed to enter the information into the MORs after providing Resident #4 with her medication.

8. During a medication pass on beginning at 1 PM, med tech D provided medication to Resident #5. He failed to identify Resident #5, wash or sanitize his hands or wear gloves prior to handling Resident #5's medication after handling the medication from another resident. He failed to enter the information into the MORs after providing Resident #5 with her medication.

9. On at 12:21 PM, med tech D provided medication to Resident #6. Resident #6 was overheard saying to him when he read the medication label to the Resident, "Why are you doing that, wasting my time, you have never done that before."

On at 12:25 PM, Resident #6 stated it was the first time in the two weeks he has been at the facility that someone read the name of the medication to him. Resident #6 stated generally they just give the medication to him.

On at 1:25 PM, Resident #7 stated staff never read the medication label to her.

10. Med tech D's employee file revealed he was when hired. His employee file revealed he was hired on / and completed the assistance with self-administration of medication training on . His date of birth was / according to the Melbourne Police department Report, dated . He was on / and provided assistance with medication to residents when he was only 17 years and 8 months old.

On at 5:27 PM, the administrator stated med tech D started providing assistance with medication when he completed the class last , 2015. The administrator stated she was not aware med techs needed to be at least

Class II

0054 Medication - Records

Based on record review and interview, the facility failed to maintain completed medication observation records (MORs) for 3 of 13 sampled residents (#2, 8 & 12).
Findings:
1. Resident #2's MOR did not contain the name of her primary health care provider, the primary health care provider's contact number, and a list of her

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On at 5:27 PM, personal care supervisor C was asked to provide copies of the MORs for Resident #2. She stated the copy provided was the official copy of the current MOR.

2. Resident #8's MOR did not contain the name of his primary health care provider, the primary health care provider's contact number, and a list of his

On at 5:27 PM, personal care supervisor C was asked to provide copies of the MORs for Resident #8. She stated the copy provided was the official copy of the current MOR.

3. Resident #12's MOR did not contain the name of his primary health care provider, the primary health care provider's contact number, and a list of his

On at 5:27 PM, personal care supervisor was asked to provide copies of the MORs for Resident #12. She stated the copy provided was the official copy of the current MOR. The MOR provided by personal care supervisor C revealed Resident #12 had missed the 9 AM dose of Methadone.

Class III

0055 Medication - Storage and Disposal

Based on observations, interview and record review, the facility failed to properly dispose of unused and contaminated medication, and failed to safely store medication.

Findings:

On at 4:13 PM, medical technician (med tech) K disclosed the facility is storing unused and discarded medication in a trash can behind the medication carts on the second floor.

On at 4:30 PM, discarded medication was observed in a trash can behind the medication carts on the second floor. The trash can was located in an unsecured closet within reach of any visitors or residents. The trash can contained between 200 and 300 pills and tablets, some still in wrappers.

On at 4:35 PM, med tech J and K both stated this is where they put discarded medication.

On at 4:40 PM, the administrator and personal care supervisor C both stated they were unaware of the trash can filled with discarded medication. Personal care supervisor SC stated to staff J and K, "How did this stuff get in the trash can?"

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On at 5:27 PM, the administrator stated she was unaware of how the medication got into the trash can. She stated she would correct the situation but she is not sure how to dispose of unused medication.

On / / at 1:02 PM, nurse N stated personal care supervisor C had instructed all of the staff to discard unused medication into the trash can. Nurse N stated the medication is stored in the administrator's office based on the theft of medication in the past.

On at 1:32 PM, the administrator stated the facility had discarded the medication. The administrator stated she had secured the discarded medication overnight in the office of the personal care supervisor, then had maintenance staff dump the medication into the dumpster the next day. The administrator stated she was not aware of who has access to the dumpster.

On / at 1:32 PM with the facility administrator, the facility administrator stated the medication is stored in her office because of a prior theft of the medication.

In an e-mail on at 3:53 PM with the facility administrator, she wrote that the theft of the medication was reported to local law enforcement for investigation. She stated the facility made extensive changes to the policy including storing the overflow medication in her office. She stated an adverse incident report was not completed and sent to the Florida Agency for Health Care Administration for either medication theft.

On at 8:01 PM, nurse H stated all of the staff are instructed by personal care supervisor C to discard old and unused medication into the trash can behind the medication cart.

Review of a local law enforcement report revealed the facility notified the police of a missing packet of on . The notification to law enforcement for investigation was made on , three days after the medication was found missing. Another local law enforcement report revealed the facility reported 120 missing pills on / after receiving a call from the pharmacy. The local law enforcement report revealed the pharmacy received an anonymous call about the missing medication.

On / , review of the facility's internal incident report, dated , for the theft on , reflected staff were interviewed but the facility could not determine who was responsible. The medication cart was re-keyed after the medication was noted as missing.

On / / , review of the facility's internal incident report, dated / , for the theft on / , reflected the overflow medication box was physically broken into and staff interviews did not reveal who

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committed the break-in.

On / at 9:29 AM, med tech I stated the facility runs out of medication on a regular basis. She stated the administrator and personal care supervisor C refuse to make sure medications are ordered until a resident runs out of the medication.

Class III

0077 Staffing Standards - Administrators

Based on observations, record review and interviews, the administrator failed to maintain general oversight of the daily operations of the Assisted Living Facility, failed to implement operating procedures to ensure resident medications are filled or refilled in a timely manner for 3 of 13 sampled residents, putting residents at risk of not receiving medication ordered by their health care provider (#8, 11 & 12), and failed to ensure medication is properly secured and discarded.

Findings:

1. Resident #8's record revealed , a medication, was prescribed by the physician. Resident #8's medication observation records (MORs) indicated the facility did not provide the , medication to the resident on / , / , , , and / , a total of 6 days. Resident #8's medication packet was dated as being filled on / , with one tablet missing from the pack.

On at 2:05 PM, medical technician (med tech) G stated Resident #8 did not get his medication because the , medication was lost.

On at 5:27 PM, personal care supervisor C stated Resident #8 moved into the facility on / with a 3 day supply of the , medication. She stated the new , medication was ordered through a local pharmacy but was not delivered because of a problem with the resident's health insurance.

On at 5:27 PM, the personal care supervisor C stated the facility did not get the medication on / . Personal care supervisor C did not respond when asked if Resident #8 was out of the medication and how the resident get medication on / and / / .

On / at 11:27 AM, the daughter of Resident #8 stated the resident had moved into the facility on / with a 3 day supply of the , medication. The daughter of the resident stated the

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resident was without the medication for about a week, and said personal care supervisor C told her the medication was lost.

On at 12:57 PM, a local pharmacist stated the medication for Resident #8 was delivered and accepted by the facility on .

On at 1:02 PM, nurse N stated Resident #8 did not get his medication because staff had thrown away the medication.

2. Resident #11's MORs indicated the resident's eye drops had been discontinued by the facility on . The MORs also indicated the eye drops were restarted on .

On at 5:27 PM, personal care supervisor C stated the facility discontinued the eye drops for Resident #11 because the prescription had run out. She stated the facility restarted the eye drops for the resident when the new prescription was filled.

On at 12:52 PM, Resident #11's physician stated the prescription was sent to the pharmacy on .

3. Resident #12's MOR revealed the resident had not been provided his morning medication of Methadone on .

On at 3:53 PM,, med tech J stated residents run out of medication all the time. She stated the med techs do not know how to order the medication or just don't want too.

On at 4:13 PM, med tech K stated residents run out of medication on a routine basis because no one orders them. She said Resident #12 is supposed to get his 5 PM medication but personal care supervisor C did not ordered it from the pharmacy. Med tech K stated personal care supervisor C instructed her to sign Resident #12's MOR, indicating the resident received his medication.

On at 4:30 PM, personal care supervisor C was asked to produce Resident #12's Methadone for the 5 PM medication pass. She stated the medication for Resident #12 was not in the medication cart and the facility was waiting for the medication to be delivered from the pharmacy. At 4:40 PM, the administrator said she did not know why the medication for Resident #12's 5 PM medication pass was not available.

On at 5:27 PM, the administrator stated Resident #12's medication was held up by the pharmacy. She stated the pharmacy will only deliver a couple of the Methadone tablets at a time for

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Resident #12 .

4. On at 4:13 PM, med tech K disclosed that the facility is storing unused and discarded medication in a trash can behind the medication carts on the second floor.

On at 4:30 PM, discarded medication was observed in a trash can behind the medication carts on the second floor. The trash can was located in an unsecured closet within reach of any visitors or residents. It contained between 200 and 300 pills and tablets, some still in wrappers.

On at 4:35 PM, med techs J and K both stated this is where they put discarded medication.

On at 4:40 PM, the administrator and personal care supervisor C both stated they were unaware of the trash can filled with discarded medication. Personal care supervisor C asked med techs J and K, "How did this stuff get in the trash can?"

On at 5:27 PM, the administrator stated she is unaware of how the medication got into the trash can. The facility administrator stated she was not sure how to dispose of unused medication.

On at 5:27 PM, the administrator stated all refills and new medication orders are handled by the med tech staff. She stated when the health care provider orders new medications, the med techs are responsible for ensuring the order is filled. The administrator stated the process works and she is not concerned about residents not getting their medication.

On / / at 1:02 PM, nurse N stated the facility has lots of missing medication. Nurse N stated med techs are allowed to enter false information and "do their own thing". Nurse N stated the medication is stored in the administrator's office based on the theft of medication in the past.

On / / at 1:02 PM, nurse N stated personal care supervisor C had instructed all of the staff to discard unused medication into the trash can.

On at 1:32 PM, the administrator stated the facility had discarded the medication. The facility administrator stated she had secured the discarded medication overnight in the office of the personal care supervisor, then had maintenance staff dump the medication into the dumpster the next day. The administrator stated she was not aware of who has access to the dumpster. The administrator stated the medication is stored in her office because of a prior theft of the medication.

In an e-mail on / at 3:53 PM with the facility administrator, she wrote that the theft of the medication was reported to local law enforcement for investigation. She indicated there were two

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different incidents.

On / / at 8:01 PM, nurse H stated the facility problem is that med techs are responsible for ordering the medication not the nursing staff. He stated the med techs are allowed to just sign off on medication which is not given to a resident. Nurse H stated personal care supervisor C instructed all staff to place the discarded medication in a trash can behind the med tech carts.

On , a local law enforcement report revealed the facility made notification of a missing packet of on . Another local law enforcement report revealed the facility reported 120 missing pills on / after receiving a call from the pharmacy. The local law enforcement report revealed the pharmacy received an anonymous call about the missing medication.

On at 9:29 AM, med tech I stated the facility runs out of medication on a regular basis because the med techs are supposed to order them. She stated the facility administrator and personal care supervisor C refuse to make the med techs order the necessary medication.

On at 10 AM, the local pharmacist stated the Methadone for Resident #12 was provided to facility when they called and ask. The pharmacist provided documentation of the delivery of Resident #12's Methadone on . The pharmacist stated the Methadone provided to Resident #12 was 120 tablets, 1 tablet 3 times per day.

Review of the facility's "Operating Procedure Regarding Medication Management" read, "Medications shall be refilled on a timely basis....Medications that are supervised shall be centrally stored....All centrally stored medications shall be kept in a locked storage container....Administrator shall request that the pharmacist dispose of the medication and document the disposal...."

Class II

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record reviews and interviews, the facility failed to file an adverse incident with the Florida Agency for Health Care Administration for two incidents of alleged medication diversion which resulted in criminal investigations by local law enforcement.

Findings:

On / at 1:02 PM, nurse N stated the facility's medication is stored in the administrator's office because of the theft of medication in the past.

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On at 1:32 PM, the administrator stated the medication is stored in her office because of a prior theft of the medication.

In an e-mail on at 3:53 PM with the administrator, she wrote that the theft of the medication was reported to local law enforcement for investigation. She indicated it was two different incidents. She indicated an adverse incident report was not completed and forwarded to the Florida Agency for Health Care Administration for either theft which resulted in criminal investigations by local law enforcement.

Review of a local law enforcement report revealed the facility notified law enforcement of a missing packet of on . The notification to law enforcement for investigation was made on . Another local law enforcement report revealed the facility reported 120 missing pills on after receiving a call from the pharmacy. The local law enforcement report revealed the pharmacy received an anonymous call about the missing medication.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Family Extended Care Of Melbourne, Inc
4001 Stack Boulevard
Melbourne, FL 32901

RE: CCR #2016001384

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , , , and , 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 , 2016.** 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

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Family Extended Care of Melbourne, Inc.
4001 Stack Boulevard
Melbourne, Florida 32901

Attention: Tiffany Collins, Facility Administrator

Dear . Collins:

This letter reports findings of a complaint investigation conducted on / / , / / / / / / , / / and / / , by a representative of the Florida Agency for Health Care Administration. You are directed to comply with the tangible steps outlined in order to correct the deficient practices. Attached are the Class II deficiencies noted in the investigation.

The investigation resulted in findings of noncompliance with the follow areas:

A052 Medication- Assistance with Self-Administration of Medication- Class II

The facility placed residents at-risk by failing to ensure residents who receive assistance with the self-administration of medication had prescriptions for medication filled or refilled in a timely manner. The facility failed to ensure medications were provided based on facility operating procedures. The facility failed to ensure medication technicians (med techs) had reached prior to providing assistance with self-administration of medication to residents.

A077 Staffing Standards-Administrator- Class II

The facility administrator placed residents at-risk by failing to maintain general oversight of the daily operations of the facility. The facility administrator failed to implement operating procedures ensuring resident medications are filled or refilled in a timely manner putting residents at risk of not receiving medication ordered by their health care provider. The facility administrator failed to ensure medication is properly secured and discarded.

Your facility must comply with the following:

1- Your facility must write a medication policy including steps to prevent medication diversion, securing or controlled medication and routine audits of the medication cart by at least

two administrative staff or an outside pharmacy.

2- Your facility must write an operating procedure regarding the process of filling and refilling prescriptions for residents who require assistance with self-administration of medication prior to the resident running out of the medication. The operating procedure must document the steps the facility will take to ensure compliance with this task and how the facility administrator will track to ensure staff compliance.
3- Your facility must write an operating procedure regarding the process of securing medication and discarding of unused or contaminated medication. The operating procedure must document the facility administrator's ability to ensure staff compliance.
4- Your facility must train all staff on the above operating procedures regarding the filling and refilling of prescriptions, securing of medication and proper discarding of medication.
5- The facility must re-train all unlicensed med tech staff on the required 4 hour assistance with self-administration of medication training. The training must be taught by a registered nurse or licensed pharmacist.
6- Your facility must provide a sign-in sheet documenting the attendance of staff at all of the trainings. Your facility must maintain a copy of the agenda, name of the instructor and copies of the attendance sheet.

This shall be completed by , 2016.

Please be advised that nothing in this Directed Plan of Correction limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Shall you have any questions, please contact Lorraine Henry, Assisted Living Facility Supervisor at 407-420-2534 or Laura Manville, Assisted Living Facility Enforcement Team Manager at 727-552-1955.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be

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