| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11965032 | 04/04/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**PAVILION AT BAYVIEW (THE)** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**161 B MARINE STREET**<br>**SAINT [redacted], FL 32084** | |

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

**0000 Initial Comments**

A complaint investigation (CCR #2015012583) was conducted at Pavillion at Bayview on . Pavillion at Bayview had deficiencies at the time of the investigation.

**0008 Admissions - Health Assessment**

Based on observations, a review of resident records, and interview with staff, the facility failed to obtain complete and accurate information on the Resident Health Assessment (AHCA form 1023) for 3 of 8 sampled residents whose records were reviewed (Residents #3, #4 and #9), out of a total of 9 sampled residents.

The findings included:

1. A record review for Resident #3 revealed a Resident Health Assessment signed by the examining practitioner on [redacted]. On page #1 of the assessment, under the heading "Diagnosis", the examiner noted "see attachment". There was no attachment. A corresponding physician's visit note dated [redacted], the same day as the assessment, found no diagnoses were listed. A comprehensive review of Resident #3's clinical record found no diagnoses were included. Section 3 of the health assessment, which is required to be completed by the Administrator to list services offered or arranged by the facility for Resident #3, was left blank.

2. An observation of Resident #4 was conducted on at 9:03 am. Employee A, a Medication Technician, was observed placing several spoonfuls of pills and applesauce directly into Resident #4's mouth. The resident did not participate in the medication administration, other than to swallow his pills.

A review of Resident #4's record found a Resident Health Assessment dated [redacted]. Diagnoses included, but were not limited to, [redacted]. The examining practitioner failed to indicate whether this resident required medications to be administered, or whether he needed assistance with the self-administration of medications. All boxes were left blank. Section 3, which was required to be completed by the Administrator to list services offered or arranged by the facility for Resident #3, was left blank.

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3. An observation of Employee A, Medication Technician, was conducted at 9:20 am on . He was observed to dispense 9 different medications from their pharmacy-labeled packages into a small cup. He took the cup into Resident #9's . Resident #9 requested some applesauce to take her medications with, and the employee obliged, and poured the pills into the bowl of applesauce. Resident #9 was then observed to feed herself her medications independently using a spoon. A review of the Resident Health Assessment for Resident #9 found the examining practitioner indicated she needed to have her medications administered. In addition, section #3 was missing entirely.

An interview was conducted with the Administrator at 1:20 pm on . She reviewed the health assessments and records for Residents #3, #4 and #9 and confirmed the missing documentation/omissions. She also confirmed Resident #9's would need to be corrected to reflect assistance with self-administration of medications.

Class III

**0052 Medication - Assistance with Self-Admin**

Based on observations, resident record review, and interviews with staff, the facility failed to assist with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule, by neglecting to have staff read the medication labels in the presence of the residents for 3 of 4 residents observed for medication assistance (Residents #3, #5, and #9). In addition, the facility failed to ensure safe and proper procedures with assistance for self-administration by permitting the preparation of 2 of 4 sampled residents medications's at the same time (Residents #3 and #4).

The findings included:

1. An observation of Employee A was conducted at 8:55 am on . He was at the medication cart, and had already dispensed 10 pills into a small paper souffle cup. He then dispensed the following into a second small plastic medication cup: Nefidical (used to treat ) 30 milligrams (mg), 600 mg, Oxycarbazepine (an anti-convulsant) 300 mg, D 100 units, 1000 micrograms (mcg), and Flecanide (used to treat )100 mg. Employee A explained that he was preparing medications for Residents #3 and #4 (husband and wife). Employee A took both cups containing the pills into the unit Residents #3 and #4 shared. He approached Resident

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SUMMARY STATEMENT OF DEFICIENCIES
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#3, and without telling her what she would be taking, poured her medications directly into her hand. Resident #3 took the pills independently, then requested a cup of water. Employee A then proceeded to Resident #4 and administered his pills directly into his mouth.

2. At 9:10 am on , Employee A dispensed the following medications into a small plastic cup: 2 667 mg capsules, Acidophilus (a probiotic) 100 mg, 1 Renavite ( ) tablet, and (used to treat or stomach ) 20 mg. He then measured t teaspoon of (an ) oral solution into a small graduated medication cup. He took the pills into Resident #5's unit. Without telling her what she was receiving, he handed her the cup, and she took her medications independently.

3. At 9:20 am on , Employee A dispensed the following into a cup: ( ) 500 mg, (used for stomach ) 15 mg, ( ) 10 mg, D 3 2000 units, Doc-q-lace (stool softener) 100 mg, (used to treat ) 20 mg (2 tablets), (an anti-depressant) 100 mg, and (anti-hypertensive)5 mg. He entered Resident #9's set the medications in front of her on a table. She requested applesauce, which he provided, and she took her pills in the applesauce without assistance. At no time did the employee tell the resident what she was taking.

4. An interview was conducted with Employee A at 1:05 pm on . He acknowledged he should be reading the medication labels in the presence of the residents he assisted with self-administration of medications. In an interview with the Administrator at 1:20 pm on , she confirmed the rule requires the labels to be read in the presence of the residents who receive assistance with self-administration. She also confirmed that Resident #3 and #4's medications should have been dispensed separately, not together.

Class III

**0053 Medication - Administration**

Based on observation, record review, and interviews with staff, the facility failed to provide a licensed staff member to administer medications to 1 of 1 employee observed for medication administration (Resident #4) out of 4 sampled residents observed for assistance with the self-administration of

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SUMMARY STATEMENT OF DEFICIENCIES
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medications.

The findings included:

An observation of Employee A conducted at 8:55 am on found he had dispensed 10 pills into a small paper souffle cup. He took the pills into Resident #4's . The pills were then placed into a small bowl of applesauce, and Employee A spooned the applesauce containing the pills into Resident #4's mouth.

At 9:07 am, after administering the medications, Employee A went to Resident #4's wheelchair and removed the plastic tubing from the attached portable tank. He removed Resident #4's nasal canula. He attached new tubing to a nearby concentrator, which was already running at 3 liters per minute. Employee A placed the new nasal canula back on Resident #4's face. An interview conducted with the employee at this time found he was a Medication Technician, not a nurse.

Employee A returned to Resident #4's 9:35 am on . He carried a plastic ampule containing clear liquid. Employee A then unscrewed the top of Resident #4's reservoir, removed the cap to the plastic ampule, and dispensed all of the clear liquid into the 's reservoir. He replaced the mouth piece, handed the mouth piece to resident, and turned on the . Employee A then left the approximately 15 minutes. Employee A returned to Resident #4's 9:50 am. Resident #4 did not have the mouthpiece to the in his mouth, although the machine was still running. Resident #4 stated he had just removed the mouthpiece. Employee A picked up the , and asked the resident to turn it off.

Record review for Resident #4 found he had physician's orders for Ipratopium 0.5 mg and (medications that open up the airways) 3 mg, use 1 vial via every 8 hours.

A review of the personnel file for Employee A confirmed he was not a licensed nurse.

An interview was conducted with the Administrator at 1:20 pm on , she confirmed the rule requires licensed staff to administer medications, and to assist with and treatments. She

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confirmed Employee A was not a nurse.

Class III

**0078 Staffing Standards - Staff**

Based on observations, interviews, and employee record reviews, the facility failed to ensure 1 of 1 staff member observed (Employee A) was qualified to perform his assigned duties consistent with his level of education and training. The facility failed to ensure Employee A did not provide services which required him to be appropriately licensed or certified, including medication administration, and assistance with and treatments.

The findings included:

An observation of Employee A conducted at 8:55 am on found he had dispensed 10 pills into a small paper souffle cup. He took the pills into Resident #4's . The pills were then placed into a small bowl of applesauce, and Employee A spooned the applesauce containing the pills into Resident #4's mouth.

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Record review for Resident #4 found he had physician's orders for Ipratopium 0.5 mg and (medications that open up the airways) 3 mg, use 1 vial via every 8 hours.

A review of the personnel file for Employee A confirmed he was not a licensed nurse.

An interview was conducted with the Administrator at 1:20 pm on , she confirmed the rule requires licensed staff to administer medications, and to assist with [redacted] and [redacted] treatments. She confirmed Employee A was not a nurse.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, , 2016

Administrator
The Pavilion At Bayview
161 B Marine Street
Saint , FL 32084

**RE: CCR #2015012583**

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2016 by a representative 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. Should you have any questions please call this office at -4201.

Sincerely,

(Meyering) QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LL/JM/sm
Enclosure
XG90

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