STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968650	07/13/2016
NAME OF PROVIDER OR SUPPLIER **ENCLAVE ASSISTED LIVING II**	STREET ADDRESS, CITY, STATE, ZIP CODE **2518 BERNICE COURT** **MELBOURNE, FL 32935**	

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

0000 Initial Comments

A Complaint investigation #2016003639 was conducted on and . Enclave Assisted Living II, License #12514 had deficiencies at the time of the visit.

0008 Admissions - Health Assessment

Based on resident record review and interview the facility did not ensure that the Health Assessment contained all the required information for 1 of 5 sampled residents (#5).

Findings:

Resident Record Review for Resident # 5 revealed a Health Assessment dated / / that did not have a height and weight indicated for the resident. The provider completing the health assessment failed to include the printed name, address or credentials of the provider.

Class

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview, the facility failed to treat with due consideration, respect personal dignity and need for privacy by posting personal information on the bulletin board for 3 of 5 sampled residents (#1, #3, and #5).

Findings:

Observation on at 11 AM, resident #1 had posted in view for anyone to see on the bulletin board stating that resident "needs a straw to drink out of or will choke; need plastic utensils-regular ones are too heavy for him". Also, the bulletin board is near the kitchen posted resident #1's St. Jude Medical card with personal and confidential information exposed.

Observation on at 11 AM, resident #3 had posted in view for everyone to see a listing of his medications dated from Rockledge Discount Pharmacy to deliver (scribbled out), , , and .

Observation on at 11 AM, resident #5 had posted in view for anyone to see next appointment

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dated at 2 PM for lab work to be completed.

During an interview on at 2 PM with staff A who stated that the information posted because it is a reminder for staff to remind residents and or resident's family members.

During an interview on at 6 PM with the administrator who confirmed the information is posted to serve as a reminder only. The Administrator instructed staff A to immediately remove the information from the bulletin board.

Class III

0056 Medication - Labeling and Orders

Based on observation, record review and interview, the facility failed to make every effort to ensure that prescriptions for residents receiving assistance with self-administration of medications were refilled in a timely manner, and allowed the supply of 5 medications for 2 of 5 residents (#2, #4) to run out. In addition, the facility failed to follow, or clarify, the physician orders when assisting with self-administration of medications for 1 out of 5 sampled residents (#5).

Findings:

1) On a tour of the facility on at 10 AM, 5 medication bottles were observed on an open shelf in the kitchen/dining . Names of the residents as well as the medications were visible. Upon inspection, each of the 5 bottles were empty. Staff A stated at 10:00 AM on , that this was a reminder to her that she is waiting for the refills to come from the pharmacy. Prescriptions are filled by Rockledge Pharmacy and delivered to the facility owner's other facility in Rockledge. The owner brings them to Enclave II in Melbourne.
Review of each empty bottle and interview with Staff A on at 2:50 PM revealed 4 of the empty bottles belonged to Resident #2.
Resident #2 was out of 4 medications on the day of the survey: 40mg, 10mEq, 25mg and 50mg.
Staff A stated she faxed the pharmacy "about 2 days ago" and was waiting for the refills to arrive. She stated she thought she had to wait until 2 days before they ran out to order a refill.
Staff A called the pharmacy at 3:00 PM on and was informed that all the ordered meds had been delivered to Enclave I in Rockledge. She then inquired if future deliveries could be made directly to

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Enclave II in Melbourne, to which the pharmacist agreed. She also asked how early she could request refills and was told 5-7 days before they run out.
At 3:50 PM , the owner, who was at her other facility on the day of the survey, stated she was not coming to this facility with the medications until the next day, . This left the Residents without her medications.
In a phone interview with the pharmacist on at 2:54 PM. he stated Resident #2's refill for 25mg was delivered to Rockledge on . The 40 mg, 10 mEq, and 50 mg refills were all delivered to Rockledge on / /. He stated that the previous arrangement was for delivery to the Rockledge address for both facilities. He also confirmed that Staff A had spoken with him on and he was very willing to deliver directly to the Melbourne facility, and that refill orders can be placed 5-7 days ahead of the medication running out.

2) Review of each empty bottle and interview with Staff A on at 2:50PM revealed that 1 of the empty bottles belonged to Resident #4. Resident #4 was out of 40mg. Her last dose was given on / /.

Staff A stated she faxed the pharmacy "about 2 days ago" and was waiting for the refills to arrive. She stated she thought she had to wait until 2 days before they ran out to order a refill. Staff A called the pharmacy at 3:00 PM on and was informed that all the ordered meds had been delivered to Enclave I in Rockledge. She then inquired if future deliveries could be made directly to Enclave II in Melbourne, to which the pharmacist agreed. She also asked how early she could request refills and was told 5-7 days before they run out.
At 3:50PM pm , the owner, who was at her other facility on the day of the survey, stated she was not coming to this facility with the medications until the next day, . This left the Resident without her medication.

In a phone interview with the pharmacist on at 2:54 PM, he stated that Resident #4 's 40 mg refill was delivered to Rockledge on . He stated that the previous arrangement was for delivery to the Rockledge address for both facilities. He also confirmed that Staff A had spoken with him on and he was very willing to deliver directly to the Melbourne facility, and that refill orders can be placed 5-7 days ahead of the medication running out.

3) Review of the resident record for Resident #5 revealed an order dated / / for " 12.5mg PO. Hold for SBP less than or equal to 120mmHg or Rate less than or equal to 60." The

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facility did not have a nurse on staff to administer medications with parameters.
During review of the medication for Resident #5 on , a container of . that was stored in the locked medicine cabinet was observed. The prescription label read, " 25mg tablet. Take ½ tablet by mouth twice daily. CVS, 90 pills." The label showed a fill date of , which was prior to the resident arriving at the facility and prior to the current physician order in the resident's record. The name of prescribing doctor was not legible on the container (worn off).
A log was found in the resident record. readings were dated / through /. No readings were recorded after /. Handwritten notes on the log indicated parameters for giving or holding the medication that did not match the provider's order.
MOR from 2016 has handwritten notes along the top stating "If bottom number is under 60- hold , and give only," "call doctor if under 60, Nurse told us to do this" and "Doctor said no just give."
No orders from a provider were found in the record discontinuing the parameters for administration.
There was no documentation of any contact with the physician to clarify the order.
In a phone conversation with the CVS Pharmacist, Ann, on at 6:45 PM, she stated that the only prescription she had for for this resident was order by Dr. Gilbert Fortus on , and was written without parameters.

In an interview with Staff A on at 3:45 PM, she stated she did not take . on Resident #5 prior to giving the . She said she was not aware that there was an order stating that need to be measured and medication held at certain levels. She added she was new and only was told to give what was indicated on the bottle and in the MOR.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Enclave Assisted Living II
2518 Bernice Court
Melbourne, FL 32935

RE: CCR #2016003639

Dear Administrator:

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

XG90

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