STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942983	**01/31/2017**
NAME OF PROVIDER OR SUPPLIER **AIDEN SPRINGS**	STREET ADDRESS, CITY, STATE, ZIP CODE **5520 HOWELL BRANCH ROAD** **WINTER PARK, FL 32792**	

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

0000 - Initial Comments

A complaint investigation (CCR# 2017000959) was conducted on . Aiden Springs license # 8419 had deficiencies at the time of the investigation.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review, and interview the facility failed to contact the health care provider for 1 of 6 sampled residents (2) who exhibited a significant change and failed to ensure medications were given as according to the healthcare provider's order for 1 of 6 sampled residents (5).

Findings:

1. Observation of resident #2 revealed the presence of a and cut to the left side of her forehead. During an interview with her on at 10:45 AM, she said, "I did it in my sleep." She did not provide any additional information.

Record review for resident #2 revealed no documentation of the and cut and no documentation the health care provider was notified, as required.

During an interview with the administrator on at 4:35 PM, he said, "I had no idea she had it, "my staff might, but I don't." At 4:46 PM, he said he spoke with his staff and said resident #2 banged herself in the head a couple of days ago with the phone because she was upset the cat . The staff asked her if she wanted to go to the hospital but the resident said no. He said his staff did not tell him about the occurrence because "I guess they didn't think it was a big deal."

2. Resident #5 stated in an interview on at 10 AM that there are times when he ran out of medications.
Resident record review for resident #5 revealed a health assessment report dated listed diagnoses of left food , uncontrolled , high , , , , and .
He needed assistance with self- administration of medication.
The , 2017 Medication Observation Record (MOR) listed 50 milligrams (mg) at 12 PM and 5 PM and was blank on & and ; the medication was marked as given once daily from to . Prescription label dated indicated 50 mg three times a day. The review revealed no written evidence the order dated had been changed; the resident did get the medication as ordered.
Interview with staff A on at 2:30 PM who stated they were having a problem with that medication, and gave no further explanation.

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In an interview with the administrator on . . . . . at 4:30 PM who stated he took the responsibility for the MOR not being correct, as he is the one responsible for maintaining the MOR.
Class III

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on interviews, review of the facility activities schedule, and observations, the facility failed to provide an ongoing activities program for 3 of 5 interviewed residents (1, 5, 7 & 8).

Findings:

1. During an interview with resident #8 on . . . at 10:30 AM, he said the facility was "a little lax in having activities."

2. During an interview with resident #7 on at 11:15 AM, he said there were no activities offered by the facility. He said he and two other residents formed a card group.

3. During an interview with resident #1 on . . . at 12:40 PM, she said the facility did not provide activities and she was not okay with that. She said when she previously spoke with the administrator about her concern; she was told, "it never works, in the past the residents did not participate."

Review of the facility activities schedule revealed an exercise and range of motion activity was scheduled for 'early afternoon' on . Observations revealed the activity was not done.

During an interview with the administrator on at 5:00 PM, he confirmed the scheduled exercise and range of motion activity was not done. He stated he tried in the past to provide activities for the residents but they did not participate.
4. Resident #5 stated in an interview on . . . . . at 10 AM that there were no activities provided; there was nothing to but watch television.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on medication pass observations and interview, the facility failed to ensure the unlicensed staff who assisted 1 of 1 sampled residents (1) with self-administration of medications followed the correct procedure.

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Findings:

On at 12:30 PM, resident #1 was observed standing to the side of the medication cart. The unlicensed medication technician removed the medication bottles from the medication cart, told resident #1 the name of each pill, and poured each pill into the resident's hand. The resident took each pill separately without assistance. The medication technician signed the medication observation record.

The medication technician did not read the medication label in the presence of the resident, as required.

During an interview with the administrator on at 4:25 PM, regarding the finding, he said, "I've never done that, I didn't know."

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observations, record reviews, and interviews, the facility failed to maintain an updated Medication Observation Record (MOR) for 4 of 6 sampled residents (1, 4, 5and 7) who required assistance with self-administration of medications.

Findings:

1. During observation of the medication pass for resident #1 on at 12:30 PM, the medication technician gave the resident a pill from a prescription labeled bottle that read milligrams (mg) 1 tablet by mouth three times a day as needed.

After the medication pass, the technician signed an entry on the 2016 MOR that read 5-325 mg 3x daily and was scheduled for 8:00 AM, 12:00 PM, 5:00 PM.

Record review for resident #1 revealed a health care provider order dated that read 10 mg-325 mg oral tablet, take 1 pill by mouth three times a day as needed.

During an interview with the administrator on at 4:27 PM regarding the discrepancy of the dose on the MOR, he reviewed the MOR and confirmed the discrepancy and said, "That was my fault, I print them from my computer."

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2. Review of the 2016 and , 2017 MORs for resident #7 revealed an entry for , 160/4.5 mg 2 puffs 2x daily scheduled for 8:00 AM and 5:00 PM and was blank on 12/3 and for the 8:00 AM doses and 12/9, , , , , , , , , , , , , , , , 1/1, , , , , , , , , for the 5:00 PM doses.
An entry for , 400 mg 2 tabs 2x daily scheduled for 8:00 AM and 5:00 PM was blank on , , , , 1/1, , , , for the 5:00 PM doses.
An entry for , , 75 mg daily was scheduled for 8:00 AM and was blank on , , .
An entry for 10 mg 1 tablet daily was scheduled for bedtime and was blank on 12/9, , .

At 4:34 PM, the administrator confirmed the blanks on the MORs and said, "those should have been signed."

3. Resident #5 stated in an interview on at 10 AM there are times when he ran out of medications.
Resident record review for resident # 5 revealed a health assessment report dated listed diagnoses of left food , uncontrolled , , , , , , and , . He needed assistance with self- administration of medication.
The 2016 Medication Observation Record (MOR) listed:
1000 mg twice daily at 8 AM & 5 PM and was blank on in AM and 12/8 & in PM
, 10 mg twice daily at 8 AM & 5 PM and was blank on 12/8 in PM and in AM
20 mg daily was blank on
, 150 mg twice a day @ 8 AM and 5 PM was blank on AM
100 mg @ 8AM was blank on 12/1, , , , and
, 7.5 mg twice a day at 8AM and 5 PM was blank on in AM; 12/8 in PM and was blank on 12/ 9, & in PM
40 mg daily was blank on 12/1 to 12/6 and
Tamulosin 4 mg at bedtime was blank on
The , 2017 MOR listed:
, 300 mg twice daily 8AM & 5 PM and was blank on 1/9 in PM
1000 mg twice daily at 8 AM & 5 PM was blank on in PM
, 10 mg twice daily at 8 AM & 5 PM was blank on and in PM
50 mg at 12 pm and 5 PM and was blank on , .

4. Resident record review for resident #4 revealed a health assessment report dated listed diagnoses of , , high , and right sided He needed assistance with

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self- administration of medications.
Prescription label dated indicated , 5-325 mg one every 4 hours as needed for pain; 12 dispensed, 3 pills used and 9 available.
The , 2017 MOR listed , 5-325 mg one every 4 hours as needed for pain and documented the medication as given on and .
Interview with staff A on at 2:30 PM who stated she was not the only one who gave the resident his medications, she did not know why the MOR and the medications did not add up.
The 2016 MOR listed
Gly/met 2 twice daily with meals at 8 am and 5PM and had a dash (-) on 12/3 AM and PM & AM , 5 mg daily had a dash (-) on
, 81 daily - over the counter -at 8 Am was blank on
The ledger on the bottom of the page indicated "O" out reordered and "H" home pass. There was a ledger to indicate what a dash (-) meant.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on interviews and record reviews, the facility did not make every reasonable effort to ensure that a prescription for 4 of 6 sampled residents (1, 3, 4, and 7); who received assistance with self-administration of medications was filled in a timely manner and failed to obtain an order from a health care provider for a change in directions of a medication for 1 of 6 sampled residents (1).
Findings:
1. During an interview with resident #7 on at 11:15 AM, he said the facility had run out of his medications in the past because the staff did not alert him soon enough for him to reorder his medications from the Veterans Administration (VA.)

Review of his 2016 Medication Observation Record (MOR) revealed an entry for , 400 milligrams (mg) 2 tablets 2x daily and was scheduled at 8:00 AM and 5:00 PM. A zero (0) was documented on 12/2, 12/4 for the 8:00 AM doses and 12/1, 12/2, 12/4, 12/5 for the 5:00 PM doses.

During an interview with the administrator on at 4:19 PM, he confirmed the findings and said, "the zeros mean it's out, we're waiting on the pharmacy."

2. During an interview with resident #1 on at 12:40 PM, she said there were times the facility ran out of her medications. She was unable to provide specific dates.
Review of her 2016 MOR revealed an entry for , 5-325 mg 3x daily and was scheduled at 8:00 AM, 12:00 PM, 5:00 PM. A zero (0) was documented for the 12:00 PM and 5:00 PM

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doses on 12/6 and 12/7 and the 8:00 AM dose on 12/8.
During an interview with the administrator on at 4:19 PM, he confirmed the findings and said, "the zeros mean it's out, we're waiting on the pharmacy."
Review of the 2017 MOR for resident #1 revealed an entry for 5-325 mg 3x daily and was scheduled for 8:00 AM, 12:00 PM, 5:00 PM.
Review of her record revealed a health care provider order dated that read - 10mg-325mg oral tablet, take 1 pill by mouth three times a day as needed.
Continued review revealed no health care provider order to change the medication from as needed to scheduled, as indicated on the MOR.
During an interview with the administrator on at 4:25 PM, he confirmed the medication was given on a scheduled basis and not as needed, and said he gave the staff permission to schedule the medication on the MOR because the resident wanted the medication at the same time every day.

3. Resident #5 stated in an interview on at 10 AM that there are times when he ran out of medications.

Resident record review for resident # 5 revealed a health assessment report dated listed diagnoses of left food , uncontrolled , , , , and . He needed assistance with self- administration of medication.

2016 MOR listed

, 40 mg daily had a "o" on to
150 mg twice a day @ 8 AM and 5 PM had "O" from , and for AM & PM,
100 mg @ 8AM had an "O"
7.5 mg twice a day at 8AM and 5PM had a "O" on 12/7, 12/8 in PM and was blank on 12/9, & in PM
The ledger on the bottom of the page indicated "O" meant the medication was / reordered.
The ledger on the bottom of the page indicated "O" out reordered and "H" home pass. There was ledger to indicate what a dash (-) meant. The review revealed no written evidence what efforts the facility did to ensure the medications were refilled in a timely manner.

4. Resident record review for resident #4 revealed a health assessment report dated listed diagnoses of , , high , and right sided . He needed assistance with

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self- administration of medications.
The 2016 MOR listed
, 5 mg daily had an "o" on
, 81 daily at 8 AM had a "O" on and
The legend on the bottom of the page indicated "O" out reordered and "H" home pass. There was ledger to indicate what a dash (-) meant

The review revealed no written evidence what efforts the facility did to ensure the medications were refilled in a timely manner.
During an interview with the administrator on at 4:19 PM, he confirmed the findings and said, "the zeros mean it's out, we're waiting on the pharmacy."

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on interviews and record reviews, the facility failed to maintain a complete resident record that included a health care provider order for assistance with self-administration of medications for 1 of 6 sampled residents (7.)

Findings:

During an interview with resident #7 on at 11:15 AM, he said the facility had run out of his medications in the past because the staff did not alert him soon enough for him to reorder his medications from the Veterans Administration (VA.)

Record review for resident #7 on revealed a health assessment form 1823 dated that read he did not require assistance with his medications.

There was no evidence a health care provider order was obtained for the facility to assist him with his medications, as required.

During a telephone interview with the administrator on at 1:30 PM, he said resident #7 was able to self-administer his medications but he requested that the staff assist him because he was unable to manage them on his own.

Class III

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