STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910275	**02/06/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN RETIREMENT HM	**507 S.E. 1ST AVENUE WILLISTON, FL 32696**

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

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

Based on record review and interview, the facility failed to ensure telephone orders were obtained and recorded by licensed staff members and written/signed physician's orders were obtained by the facility within 10 working days of receipt of the physician's order for 1 of 3 residents (Resident #1).

Findings:

On at 7:39 AM, Resident #1 was observed being assisted by a facility Medication Technician during assistance with self-administration. The Medication Technician was observed to remind Resident #1 of a physician's order change that had reduced his medication from 30 units to 20 units.

During an interview on at 7:39 AM, the Medication Technician assisting Resident #1 with medications stated that Resident #1's physician had changed Resident #1's management medication from 30 units to 20 units "last week."

On , a record review of Resident #1's Medication Observation Record Medication List (presented to the surveyor as current on) revealed a documented entry that Resident #1 was prescribed 70-30 100 unit/milliliter vial, 30 units , every day.

On , further record review of Resident #1's current physician's orders prescriptions revealed a signed physician's order (dated) that documented 1. discontinue and 2. Sliding Scale Ante Cibum (before eating) Hora Somni (within the hour) for sugar 150-200: Give 4 Units, 201-250: Give 6 units, 251-300: Give 8 Units, 301-350: Give 10 Units, 351-400: Give 12 Units, 400 +: Give 15 Units and Call me.

On , a record review of Resident #1's clinical record failed to reveal a written/signed physician's order to reduce Resident #1's management medication from 30 units to 20 units.

During an interview on at 8:25 AM, the facility Manager confirmed Resident #1's physician's order related to / sugar had been changed on . She stated that the Advanced Registered Nurse Practitioner had told her to reduce Resident #1's management medication through telephone text message on .

During an interview on at 9:22 AM, the facility Advanced Registered Nurse Practitioner confirmed that Resident #1's management medication had been reduced from 30 units to 20 units on due to dropped sugar readings.

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On , a record review of Resident #1's Medication Observation Record Medication List (presented to the surveyor as current on) revealed a documented entry that Resident #1 was prescribed Hydrocondone , 325 milligrams - 1 milligram by mouth every 8 hours as needed (start date).

On , a record review of Resident #1's clinical record failed to reveal documentation the facility had obtained a written/signed physician's order for the prescribed Hydrocondone , 325 milligrams - 1 milligram by mouth every 8 hours as needed (start date).

During an interview on at 11:57 AM, the facility Manager stated that Resident #1 had been prescribed Hydrocondone , 325 milligrams - 1 milligram by mouth every 8 hours as needed (start date) by his dentist. She stated that she could not locate a written/signed physician's order for the Hydrocondone , 325 milligrams - 1 milligram by mouth every 8 hours as needed (start date).

During a follow up interview on at 12:39 PM, the facility Manager confirmed there was no written/signed physician's order for Resident #1's prescribed Hydrocondone , 325 milligrams - 1 milligram by mouth every 8 hours as needed (start date) available for review at the facility.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on interview and record review, the facility failed to ensure menus reflecting therapeutic diets were prepared at least 1 week in advance for 2 of 3 residents (Resident #1, #3) reviewed for therapeutic diets.

Findings:

On , a record review of Resident #1's Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823), dated , revealed documentation Resident #1 was to receive a Low Fat/Low diet. A record review of Resident #3's Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823), dated , revealed documentation Resident #3 was to receive a Low Fat/Low diet and a / diet.

On , a record review of the facility menu (dated) failed to reveal meal menu items specified for a Low Fat/Low diet and a / diet. Record review of the facility

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menu (dated) revealed documentation the planned menu items for the noon meal were: 8 ounces Macaroni and Cheese, tomato stew sauce, ½ cup green beans, 1 slice bread and butter, 1 pear, lemonade, coffee, tea.

During an interview on at 11:15 AM, the facility Administrator stated that residents on special diets received the same meal menu items as residents who were not on special diets. He stated that the facility limited the meal items provided to residents on specialized diets if there , or sugar level was too high. He confirmed the facility had received no guidance from the Registered Dietician related to menu meal items that should be provided to residents who were on special diets.

During an interview on at 11:27 AM, the facility Manager stated she had not received guidance from the Registered Dietician related to residents with specialized diets or specialized diet meal menu items. She stated that she attempted to steam the vegetables and serve chicken, tuna and beef to the residents.

Class III

0000 - Initial Comments

A complaint investigation (CCR#2017001319) was conducted at Good Samaritan Retirement Home (License #25) on . Good Samaritan Retirement Home had deficiencies at the time of the investigation.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure the Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823) was completed to document the level of assistance needed with medication administration for 1 of 3 residents (Resident #1).

Findings:

On , a record review of Resident #1's Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823), dated , revealed no documentation had been entered on Page 4 Section B. "Does the individual need help with taking his or her medications (meds)?" or in the sections "Needs Assistance with Self-Administration of Medications", "Needs Medication Administration" and "Able to Administer" without "Assistance."

During an interview on at 11:30 AM, the facility manager confirmed Resident #1's Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823), dated , contained no

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documentation on Page 4 Section B. "Does the individual need help with taking his or her medications (meds)?" or in the sections "Needs Assistance with Self-Administration of Medications", "Needs Medication Administration" and "Able to Administer" without "Assistance."

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on record review and interview, the facility failed to ensure medication that was drawn from a vial for administration to a resident was administered by a licensed staff member for 1 of 3 residents (Resident #1).

Findings:

On , a record review of Resident #1's Medication Observation Record Medication List (presented to the surveyor as current on) revealed Resident #1 was prescribed 70-30 100 unit/milliliter vial, 30 units , every day.

During an interview on at 8:25 AM, the facility Manager stated that she had sometimes drawn the medication with the syringe from the vial for Resident #1 to help him get the proper amount of medication. She confirmed that she was not a licensed nurse.

During an interview on at 9:52 AM, the Registered Nurse with the Ombudsman program confirmed that on at least one visit to the facility she had witnessed a facility staff member, who was not a licensed nurse, draw the from the vial for administration to Resident #1.

Class III

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

Based on record review and interview, the facility failed to ensure 1 of 3 resident's (Resident #1) Medication Observation Record had been immediately updated to document a physician's order change, and 2 of 3 residents' (Resident #1, #2) Medication Observation Records accurately documented physician's orders.

Findings:

On , a record review of Resident #1's Medication Observation Record Medication List (presented to the surveyor as current on) revealed a documented entry that Resident #1 was

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prescribed 70-30 100 unit/milliliter vial, 30 units , every day.

On , further record review of Resident #1's current physician's orders prescriptions revealed a signed physician's order (dated) that documented 1. discontinue and 2. Sliding Scale Ante Cibum (before eating) Hora Somni (within the hour) for sugar 150-200: Give 4 Units, 201-250: Give 6 units, 251-300: Give 8 Units, 301-350: Give 10 Units, 351-400: Give 12 Units, 400 +: Give 15 Units and Call me.

During an interview on at 8:25 AM, the facility Manager confirmed Resident #1's physician's order related to / sugar had been changed on .

During an interview on beginning at 11:34 AM, during record review of Resident #1's Medication Observation Record, the facility Manager confirmed that Resident #1's Medication Observation Record had not been immediately updated to document the physician's order change.

On , a record review of Resident #1's Medication Observation Record Medication List (presented to the surveyor as current on) revealed a documented entry that Resident #1 was prescribed 1000 milligrams 1 tablet by mouth every 1 day.

On , a record review of the patient prescription sheet filed in Resident #1's clinical record revealed a signed physician's order for Resident #1 to take 1000 milligrams by mouth twice a day.

During an interview on beginning at 11:34 AM, during record review of Resident #1's Medication Observation Record and physician's orders, the facility Manager stated that the physician's order documented on Resident #1's Medication Observation Record was inaccurate.

On , a record review of Resident #2's Medication Observation Record Medication List (presented to the surveyor as current on) revealed a documented entry that Resident #2 was prescribed , 400 milligrams 1 tablet by mouth qd (daily).

On , a record review of the patient prescription sheet filed in Resident #2's clinical record revealed a signed physician's order for Resident #2 to take , 400 milligrams by mouth twice a day.

During an interview on beginning at 11:34 AM, during record review of Resident #2's Medication Observation Record and physician's orders, the facility Manager stated that the physician's

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order documented on Resident #2's Medication Observation Record was inaccurate.

Class III