STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966519	02/06/2017
NAME OF PROVIDER OR SUPPLIER **INDIGO PALMS AT MAITLAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **740 NORTH WYMORE ROAD** **MAITLAND, FL 32751**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A complaint investigation CCR# 201613957 was conducted on to . Indigo Palms at Maitland license # 10704 had deficiencies at the time of the visit.

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

Based on record review and interviews the facility failed to provide care and services appropriate to the needs of residents accepted for admission to the facility and did not make sure healthcare provider orders for medications were followed for 7 of 7 sampled residents (#1, #2, #3, #5, #6, #7, and #8) and failed to ensure medications were given free from errors (3).

Findings:

1. Review of the 2017 Medication Observation Record (MOR) for resident #1 revealed an entry for 5% patch (generic for ,) apply 1 patch to left , every day, on for 12 hours and off for 12 hours and was initialed and circled on 2/1 with no documented explanation and was blank from 2/1 through 2/5.
During an interview with staff A, an unlicensed staff, on at 9:30 AM, she said the facility did not have the patches.
During an interview with resident #1 on at 10:04 AM, she said she did not receive her patch and said, "I found out just yesterday the insurance wouldn't pay for it, it's been a month."
Record review for resident #1 revealed a health care provider order dated that read ' patch 5% apply to left , on for 12 hours then remove.'
Review of her 2016 and 2017 MORs revealed an entry for 5% patch, apply 1 patch daily to left , , on for 12 hours and off for 12 hours scheduled to be applied at 9 AM, and was blank on , , , through , 1/4 through 1/7, 1/9 through . The initials were circled with no documented explanation on 12/7, , , through , 1/8. The initials were circled on , 1/1, 1/2 with an entry on the back of the MOR that read 'not available.'
Review of her record revealed no evidence a health care provider discontinued the medication.
During an interview with the health and wellness director on at 1:37 PM regarding the findings, she said, "I don't have a clue."

Review of the 2016, 2017, 2017 MORs for resident #1 revealed entries for D , take 1 tablet by mouth twice daily scheduled at 9 AM and 9 PM and was blank on , , , for the 9 AM dose and on , , , through , , for the 9 PM dose

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160 HFA, use 1 puff by mouth two times a day scheduled at 9 AM and 9 PM and was blank on , , , for the 9 PM dose

, 40 milligrams (mg,) take 1 tablet by mouth twice daily scheduled at 9 AM and 9 PM and was blank on , , 1/6, for the 9 PM dose

50 mg, take 2 tablets by mouth twice daily scheduled at 9 AM and 9 PM and was blank on 1/9, , for the 9 AM dose and on , , , 1/7, for the 9 PM dose. The initials for the 9 AM dose on 1/8 and the 9 PM dose on 1/9 were circled with no documented explanation.

, 200 mg, take 1 tablet by mouth three times a day scheduled at 9 AM, 1 PM, 9 PM and was blank on 12/8, , 1/9, , , through for the 1 PM dose and on through , , for the 9 PM dose

, 800 mg by mouth three times daily with a 100 mg tablet scheduled for 9 AM, 1 PM, 9 PM and was blank on 12/8, for the 1 PM dose and on 12/8, , , , , for the 9 PM dose. The initials were circled with no documented explanation on 12/7, 12/9 for the 9 AM dose and on 12/7, 12/9 for the 1 PM dose and 12/7, 12/9 for the 9 PM dose.

, 100 mg by mouth three times daily with 800 mg tablet and was scheduled for 9 AM, 1 PM, 9 PM and was blank on 12/8 for the 1 PM dose and on through for the 9 PM dose.

0.4-0.3%, 1 drop both eyes three times a day scheduled at 9 AM, 1 PM, 5 PM, 9 PM and was blank on for all doses, and for the 5 PM and 9 PM doses, for the 5 PM dose, for the 9 PM dose. The initials were circled with no documented explanation on and for the 5 PM and 9 PM doses.

0.05%, 1 drop both eyes two times a day scheduled at 9 AM and 9 PM and was blank on for the 9 AM dose and on , , , , , for the 9 PM dose.

1%, 1 drop in right eye four times a day was scheduled at 9 AM, 1 PM, 5 PM, 9 PM and was blank on for the 9 PM dose, for all the doses, for the 5 PM dose, and for all doses, for the 9 AM and 1 PM dose, for the 9 AM, 1 PM, 9 PM dose.

5mg/gram, apply 1 application at bedtime to both eyes scheduled at 9 PM and was blank on , , .

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, 0.3%, 1 drop two times a day scheduled for 9 AM and 5 PM and was blank on , , for the 9 AM dose and , , , for the 5 PM dose. The initials were circled with no documented explanation on through for the 5 PM dose.

0.5%, 1 drop in right eye two times a day scheduled for 9 AM and 5 PM and was blank on for the 9 AM dose and on , , , for the 5 PM dose.

0.5%, 1 drop to right eye once daily scheduled for 9 AM and was blank on , , , .

0.005%, 1 drop to each eye at dinner scheduled at 5 PM and was blank on , , , .

10 mg, 1 tablet by mouth at bedtime was blank on , , and the initials were circled with no documented explanation on 12/4 through 12/9, and .

, 15 mg, take 2 capsules (30 mg) by mouth at bedtime and was blank on , , , through and the initials were circled with no documented explanation on 12/3 through 12/9, , through , through .

30 mg, take 1 tablet by mouth every 6 hours scheduled at 12 AM, 6 AM, 12 PM, 6 PM and was blank on , through for the 12 PM dose and on , for the 6 PM dose.

50 mg, take 1 tab by mouth every day scheduled for 9 AM and was blank on , , , and the initials were circled with no documented explanation on and .

2 mg, take 1 tab by mouth twice daily scheduled for 9 AM and 9 PM and was blank on , for the 9 AM dose and on through for the 9 PM dose. The initials were circled with no documented explanation on , .

, , / , give 1 vial via every 4 hours around the clock and was scheduled at 12 AM, 5 AM, 9 AM, 1 PM, 4 PM, 8 PM and was blank on 2/1 through 2/4 for the 9 AM and 1 PM doses.

Record review for resident #1 revealed a health care provider order dated that read ' 325 mg, 1 tablet by mouth twice daily for 3 months.' There was no evidence of a health care provider order to continue the after 3 months.

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Review of her 2016 MOR revealed the was signed as given from 12/1 through at 9 AM and from 12/1 through at 9 PM.

Record review for resident #1 revealed a resident care note dated that read ' , was not held on and .'

Review of her 2016 MOR revealed an entry for , 81 mg, chew 1 tablet by mouth every day and was signed as given on 12/9 and .

Review of her record revealed a health care provider order dated that read 'stop , until Thursday 15th .'

Record review for resident #1 revealed a health care provider order dated that read 'stop , on .'

Review of her 2017 MOR revealed an entry for , 81 mg, chew 1 tablet by mouth every day and was signed as given from 2/1 through 2/5.

Review of her record revealed no evidence of a health care provider order to restart the , .

Review of the 2017 MOR for resident #1 revealed an entry dated for (generic for ,) 0.5% eye drops, instill 1 drop in left eye two times a day until the 29th, and then stop. It was signed as given from 2/1 through 2/5.

Review of her record revealed no evidence of a health care provider order to continue the medication after .

2. During an interview with resident #8 on at 2:20 PM, she said, "I went to self-medicating because I knew I was getting the wrong medications at the wrong time," and "They were also running out of my medicine."

Review of her 2016 and 2017 MORs revealed an entry for / , mg, 1 tablet by mouth twice daily scheduled at 6 AM and 8 PM and was blank without a documented explanation on , , for the 8 PM dose and on 1/5 for the 6 AM dose.

3. During an interview with resident #6 on at 2:37 PM, she said the facility ran out of her in and she did not have the medication for 2-3 days.

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Review of her 2016 MOR revealed an entry for ( ) 12.5 mg, 1 tablet by mouth twice daily scheduled at 9 AM and 9 PM. The initials were circled on through for the 9 AM dose and on through for the 9 PM dose. The back of the MOR read 'med not available' on and .

Review of the 2017 MOR for resident #6 revealed entries for 500 micrograms, 1 tablet by mouth daily and the initials were circled with no documented explanation on 2/4, 2/5.

20 mg, 1 tablet by mouth daily and the initials were circled on 2/4, 2/5, 2/6 with a note on the back of the MOR that read 'med is unavailable.'

Review of the available medication containers for resident #6 revealed her and were not in the medication cart.

During an interview with staff A on at 11:45 AM, she confirmed the resident did not have and Famotadine and said, "I requested a refill a couple of days ago but they haven't arrived yet.

During an interview with the health and wellness director on at 1:37 PM, she confirmed all the findings and offered no explanation.

4. Resident #5 had a health assessment report 1823 dated that listed diagnoses of high , , , and chronic pain and assistance was needed with self-administration of medications. A local hospital emergency , dated indicated a diagnosis of and a prescription dated indicated 500 mg one tablet 4 times daily for 7 days (a total of 28 doses). The , 2017 MOR listed the to be given at 8 AM, 12 PM 4 PM and 8 PM and was started on at 4PM. The review revealed the MOR was blank on at 4 PM and 8 PM, and on at 12 PM, the resident did get 28 doses of the - .

The 2016 MOR listed 0.1 mg daily for , (first number), , greater than 160 or diastolic (second number) , greater than 100 and was blank to . A record was not available. There was no written documentation to confirm the resident's , was taken by a nurse and judgment made as to whether or not the medication was needed.

Order dated indicated 400 mg one 3 times daily and 6 refills were ordered. The

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2016 MOR listed 300 mg twice daily. A healthcare provider order to change the medication dosage from 3 times daily to 2 times daily was not available.

5 mg daily t 8AM, was blank on , had staff initials circled on , , , and and had a period (.) from to /1.

Vesicare 10 mg twice daily at 9 AM and 9PM was blank on 12/5, , and had staff initials circled and was blank on 12/5 , & PM; had a line drawn across from to . Entries on the back page of the MOR indicated that AM & PM, Vesicare was not available.

The MOR listed 0.1 mg daily for (first number), , greater than 160 or diastolic (second number) , greater than 100 and was blank from to .

( ) 400 mg 3 times daily at 9 AM, 12PM and 5 pm had staff initials on , at 9AM; there was a period (.) on 01/ 04 to in AM; an arrow from 1/8 to in AM. The 12 PM dose was blank on and had staff circled on and an arrow from 1/8 to . The 5 PM dose had a period on and was blank on and .

20 mg daily at bedtime was blank on , , , and

The MOR listed 0.1 mg daily for (first number) , greater than 160 or diastolic (second number) , greater than 100.

The medication review on at 11 AM noted a prescription label dated for 7.5 mg one daily. The 2017 MOR indicated 7.5 mg as needed. The bubble pack dated was intact no pills had been used. A healthcare provider's order for the change in the use of the medication was not available.

In an interview on at 2PM, with the director of nursing, a Licensed Practical Nurse (LPN), who stated that the facility was an assisted living facility and , were not taken daily. When and if resident #5 complained of not feeling well, his , would be taken. Then the would be given.

In an interview on at 9:45 AM with an LPN who stated she was new hire. She said if resident was out of medication, the doctor would be called for a prescription and the pharmacy would be called to

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request that the medication be delivered immediately (stat). If there is, less than a 7 day supply the staff is to talk to the pharmacy tech and re -order the medication(s). Seems a problem at the Assisted living (AL) building, the memory care unit (MCU) was good, only nurses pass in MCU

Resident #5 stated during an interview on at 9:25 AM that "For a long time I've had issues with getting my medicine on time," "I told {name} and she told me to let her know when I needed the medicine but I can't gauge that because I don't keep the medicine." "Last week I was told there were 4 or 5 medications they didn't have," "{Name} told me they were ordered from the VA but I called the VA and they said the medications were never ordered."

In an interview on at 10 AM with an LPN who stated after showing her the order for resident #5 her interpretation of the order was that the resident's needed to be taken daily and to determine whether or not he needed to take the medication.

In an interview on /17 at 11:30 AM with the unlicensed staff (A) who worked the medication cart where the medications for resident #5 were kept stated after looking over the MOR and stated that the resident did not have , there were no medication "as needed". She checked the overflow storage and said there was no .

5. During an interview on at 10 am with resident #2 and his daughter. He said he ran out of medications, different medications at different times. The facility would tell him the medication was not delivered, hasn't been ordered or the medication ran out. He has been out of medications for 3 to 4 days. Some people at my table complain of medications being out too, sometimes 5 days. He named residents # 5 and #6.

Resident record review for resident #2 revealed a health assessment report 1823 dated listed diagnoses of with valve replacement, high , and and assistance was needed with self-administration.

The 2017 listed 10 mg daily at 10PM and was blank on Pradaxa 150 mg one every 12 hours at 8 AM & 8 PM was blank on at 8 PM. tears one drop to both eye 4 times a day at 8AM, 12 PM , 5 PM & 8 PM and was blank on at 8 AM & 12 PM; at 8 AM & 12 PM; was blank at 12PM and 5 PM, and was blank at 5 and 8 PM .

Order dated indicated give in PM only - not in AM every PM, dispense 90 tablets. Review of the 2017 and MOR revealed that mg in PM was not listed on the MOR.

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The not Review of the resident's medications on at 11:30 AM revealed the medication was not in the medication cart (available).

100 mg take 2 tablets at bedtime at bedtime not available. The staff stated show would check the overflow. She stated after she checked the was not here; need to be ordered.

6. Resident #7 stated during an interview on at 9:08 AM she had problems getting her medications on time. She said it depended on who was on duty. She said the latest time she was supposed to receive her eye drops was at 8:30 PM but the staff have brought them at 10:00 PM. She said "On Saturday and Sunday, it is empty, you don't get anything," "Sometimes you get your medicine and sometimes you don't."

Resident #7 had a health assessment report 1823 dated that listed diagnoses of failure, , high , and to both eyes. She needed assistance with self-administration of medications. The record review a healthcare provider's order dated that indicated 0.004% eye drops 1 drop to each eye at bedtime.

The 2016 MOR listed 0.004% eye drops 1 drop to each eye at bedtime with a start date of . The MOR was blank on 12/3, 12 /7 & 12/8, and , indication the eye drops were not given. There were no notes on back page that explained what the blank spaces indicated. A prescription label dated indicated one drop to both eyes at bedtime.

The , 2017 MOR listed that Donezapil 5 mg daily and indicated was discontinued on and was marked as given on 02/1 and , although it was discontinued on . The MOR also listed Donezapil 10 mg daily and was marked as given on 02/1, 02/2 as well, and through . Prescription label dated indicated Donezapil 10 mg daily.

7. Resident #3 stated in an interview on at 10:35 AM said she ran out of her and and said, "I just had to go without for 4 days."

Resident #3 had a health assessment report 1823 dated that listed diagnoses of VRE/ CDT (-resistant -) and . A fax sent to the healthcare provider on indicated the staff made an error with the residents' IS 30 mg and ( ) 1 mg. Resident #3 was given an extra dosage at 8 AM and an order for the "extra" dosage. There were no adverse reaction noted. The healthcare provider signed the order. Another fax to MD on requested clarification of the IS 30 mg 1 every 6 hours while awake and the

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IS 30 mg 4 times daily as needed for pain.

A fax dated to the healthcare provider requested clarification of IS 30 mg every 6 hours while awake and IS 30 mg 4 times a day as needed for pain and 1 mg ( ) every 6 hours while wake and 1 mg as needed for . The healthcare provider replied to discontinue IS 30 mg every 6 hours while awake and to continue with IS 30 mg 4 times daily and 1 mg every 6 hours as needed for .

The 2017 MOR listed IS 30 mg one twice as needed for pain, although the order dated indicated IS 30 mg 4 times daily.

During an interview with director of nursing on at 2 PM who offered no comment. She stated she had taken the position at approximately 3 months, and personnel changes had been made. She had no explanation for the blanks on the MOR's. She further stated she did not know whether the physician orders were available or not.

Class III

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

Based on 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.

Findings:

During observations on at 9:15 AM, an unlicensed staff member was standing at a medication cart. Continued observation revealed pills in a medicine cup sitting on top of the cart. The unlicensed staff pushed the medication cart around to the other side of the building and stopped in front of the resident #1. She entered the resident's handed the medicine cup with the pills to the resident, who took the medications.

She did not prepare the medication in the presence of the resident, as required.

During an interview with the unlicensed staff member on at 9:20 AM regarding which medications were in the cup, she removed the medication containers from the cart and said the medications were , 200 milligram (mg) 1 tablet, , 800 mg 1 tablet, , 100 mg 1 capsule, with D 1 tablet, , DR 40 mg 1 tablet, 50 mg 1 tablet, 40 mg 1 tablet, ER 20 milliequivalent 1 tablet, 2

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mg 1 tablet, 50 mg 2 tablets.

During observation of a medication pass for resident #1 on at 9:30 AM, the unlicensed staff removed an inhaler from the medication cart and took the inhaler with the Medication Observation Record (MOR) to the bedside of the resident. She handed the inhaler to the resident and said, "Here you go." The resident placed the inhaler in her mouth and took 1 puff.

The unlicensed staff did not read the medication label on the inhaler in the presence of the resident , as required.

During an interview with the health and wellness director on at 1:30 PM regarding the findings, she said, "she was just in the training I gave."

Class III

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

Based on record reviews and interviews the facility did not make every reasonable effort to ensure that a prescription for 3 of 7 sampled residents (#1, #5 and #6) who received assistance with self-administration of medications was filled in a timely manner.

Findings:

1. Review of the 2017 MOR for resident #1 revealed an entry for 5% patch (generic for ,) apply 1 patch to left , every day, on for 12 hours and off for 12 hours and was initialed and circled on 2/1 with no documented explanation and was blank from 2/1 through 2/5.

During an interview with staff A, an unlicensed staff, on at 9:30 AM, she said the facility did not have the patches.

During an interview with resident #1 on at 10:04 AM, she said she did not receive her patch and said, "I found out just yesterday that insurance wouldn't pay for it, it's been a month."

Record review for resident #1 revealed a health care provider order dated that read ' patch 5% apply to left , on for 12 hours then remove.'

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Review of her 2016 and 2017 MORs revealed an entry for 5% patch, apply 1 patch daily to left , on for 12 hours and off for 12 hours scheduled to be applied at 9 AM, and was blank on , , , through , 1/4 through 1/7, 1/9 through . The initials were circled with no documented explanation on 12/7, , , through & . The initials were circled on , and with an entry on the back of the MOR that read 'not available.'

Review of her record revealed no evidence a health care provider discontinued the medication.

During an interview with the health and wellness director on at 1:37 PM regarding the findings, she said, "I don't have a clue."

2. During an interview with resident #6 on at 2:37 PM, she said the facility ran out of her in and she did not have the medication for 2 to 3 days.
Review of her 2016 MOR revealed an entry for ( ) 12.5 milligrams (mg,) 1 tablet by mouth twice daily scheduled at 9 AM and 9 PM. The 9 AM dose on through was initialed and circled and the 9 PM dose on through was initialed and circled. The back of the MOR read 'med not available' on and .
Review of the 2017 MOR for resident #6 revealed entries for 500 micrograms, 1 tablet by mouth daily and the initials were circled with no documented explanation on 2/4 and 2/5.
20 mg, 1 tablet by mouth daily and the initials were circled on 2/4, 2/5, 2/6 with a note on the back of the MOR that read 'med is unavailable.'
Review of the available medication containers for resident #6 revealed her and were not in the medication cart.
During an interview with staff A on at 11:45 AM, she confirmed the resident did not have and and said, "I requested a refill a couple of days ago but they haven't arrived yet.
During an interview with the health and wellness director on at 1:37 PM, she confirmed all the findings and offered no explanation.

3. Resident #5 had a health assessment report 1823 dated that listed diagnoses of high , , , , and chronic pain and assistance was needed with self-administration of medications.

The 2016 MOR listed 5 mg daily at 8AM was not available on , , , and . The notations on the MOR indicated the medication was not available, nurse notified.

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The , 2017 listed , , 5 mg daily at 8 AM had staff initials circled on and ; had an "H"; there was a period (.) from to ; there was a staff initials on 1/8 and an arrow on and , and an "x" on and was blank on . The notations on the back page of the MOR indicated that from to , the medication was not available and the nurse was informed. Thera-M tablets one daily was marked not available from to . Several notations on the back page of the MOR indicated unavailable -notified nurse LPN.

The , MOR listed Thera-M tablets one daily and had a period (.) from to . The entries on the back page of the MOR indicated Their M- unavailable -notified nurse LPN.

Resident #5 stated during an interview on at 9:25 AM that "For a long time I've had issues with getting my medicine on time," "I told {name} and she told me to let her know when I needed the medicine but I can't gauge that because I don't keep the medicine." "Last week I was told there were 4 or 5 medications they didn't have," "{Name} told me they were ordered from the VA but I called the VA and they said the medications were never ordered."

In an interview on at 9:45 AM LPN who stated she was a new hire. She said if the resident was out of medication; a prescription is requested from the doctor, then call the pharmacy and request the medication to be delivered immediately (stat). If there is less than 7 day's supply, the staff is to talk to pharmacy tech and re -order the medication(s).

In an interview with staff D, who assisted residents with self-administration of medications said that she made a list of medications that were due to be refilled 7 days in advance, and then handed the list to a nurse. The nurses contacted tech pharmacies as they facility did not want everybody calling and re-ordering, to avoid . The facility used 3 pharmacies mostly, but they all did not provide automatic refills, some medications were and some were not.

In an interview with staff A, who assisted residents with self- administration of medications stated medications that were due to be refilled 7 days in advance she would let the nurse know. The nurse would re-order the medication.

In an interview with the director of nursing on at 2 PM who stated the staff should be ordering medication 7 days before the medication was finished. Any staff (nurses and unlicensed staff) were both able to re-order medications. She added that there must be a misunderstanding as she thought any staff could order /re-ordered medications.

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(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

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

Based on record review and interview the facility did not ensure the resident record included a completed health assessment every 3 years or after a significant change for 1 of 7 sampled residents (2).

Findings:

Resident record review for resident #2 revealed a health assessment report dated . The review revealed an up dated health assessment was not available.

During an interview on at 2 PM with the director of nursing, who said she had been working on getting the assessment updated, but did not have an assessment for resident #2.

Class III