STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965659	R 02/27/2017
NAME OF PROVIDER OR SUPPLIER **EMERALD GARDENS INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **2159 MCMULLEN BOOTH ROAD** **CLEARWATER, FL 33759**	

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

0000 - Initial Comments

Assisted Living Facility

A revisit to biennial state licensure survey was conducted at Emerald Gardens Inc. on . Emerald Gardens Inc., Assisted Living Facility, had an uncorrected deficiency at the time of the visit.

(License # 9997)

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation, interview, and record review, the facility failed to ensure that medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times for one (front office) of two observed refrigerators. Additionally, the facility failed to ensure that medications that were expired or abandoned were disposed of within 30 days of being determined abandoned or expired for one (Resident #4's medication) of three medications observed in the refrigerator.

Findings included:

On at 9:30 AM, the surveyor observed an office by the front entrance of the facility on the first floor of the facility. The office was observed to have the door open and no staff were near or in the office. There was a refrigerator in the office. The refrigerator was not locked and was opened by the surveyor. The surveyor observed that medications were kept in the refrigerator alongside food items and that the medications were not contained in a locked box and were out on the refrigerator shelf. One resident was observed walking past the open door to the office during this time.

In an interview on at 9:45 AM, the Administrator stated that the door to the office was not always locked. The Administrator confirmed that the refrigerator was not locked and that there were medications kept in the refrigerator. At this time, the Administrator removed the medications from the refrigerator and the Administrator confirmed that the refrigerator contained a box of eye drops , , , and , suppositories. The box of , was observed to have Resident #4's name on the label and the discard after date on the label was . The Administrator stated that the , was old and that Resident #4 was no longer in the facility and had , . The Administrator then threw the expired medication into a trashcan nearby. The Administrator stated that

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the refrigerator was not locked because they had lost the key to the refrigerator lock or the lock was broken. The Administrator stated that they were trying to contact a locksmith to fix the refrigerator lock. The Administrator stated that they recently cleaned out another refrigerator in the facility, but that they did not look in this refrigerator.

In an interview on at 9:55 AM, Staff A, a medication technician, stated that she was not aware that there was medication kept in the refrigerator. Staff A stated that medications were normally sent back to the pharmacy when they were expired or discontinued, or when the resident leaves the facility.

On , a review of the facility's admission and discharge log revealed that Resident #4 had been discharged from the facility on .

On , a review of the facility's policy for medication storage revealed that centrally stored medications were supposed to be kept in a locked storage cabinet and that medications should only be accessible to the staff that assist with the self-administration of medication.

Class III