STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965183	03/03/2017
NAME OF PROVIDER OR SUPPLIER **REGAL PALMS**	STREET ADDRESS, CITY, STATE, ZIP CODE **300 LAKE AVE N.E** **LARGO, FL 33771**	

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

0000 - Initial Comments

Assisted Living Facility

A complaint investigation, (CCR# 2017002152), was conducted at Regal Palms on . Regal Palm had deficient practice at the time of the investigation.

(License # 9570)

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

Based on interviews and records review, the facility failed to assure the accuracy of medication administration by relying on incomplete and inaccurate electronic medication information and subjecting residents to potential medication errors, as a result. 1 of 4 sampled residents had incorrect medication information on record.

Findings included:

In an interview at 10:40am on , Staff B stated, "The facility has a new pharmacy computer dispensary system and it has had a lot of glitches. Things are really messed up and the new system does not have all the medications and prescriptions in it. The Medication Observation Record (MOR or eMAR) has been showing wrong medications or medications seem to be missing for a lot of residents. When medications are missing from the MOR (or eMAR), Med Techs or nurses wouldn't know if a medication was supposed to be given until the resident asked for it."

In an interview at 12:30pm on , the Resident Care Coordinator stated, "The facility has had major difficulties with the corporate pharmacy, which is located out of state. Since early , of 2017, the company headquarters mandated that they use a new electronic medication administration (eMAR) system. The biggest problem with the new system is that their corporate headquarters wants the corporate pharmacy to do the data input for all the medication orders. Prior to the new system, the facility nurses would input the resident's medications into the system and they had more control over it. They are seeing many mistakes, delayed orders, omissions and duplicate orders, and orders getting changed by the pharmacy for cost saving purposes. It is very frustrating for everyone - staff and residents alike, and the issue has not been resolved yet."

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At 2:00pm, the facility's third party pharmacy consultant stated, "The facility hired the consulting company to do periodic medication audits, and medication cart audits. Over the past few years there have only been a few minor problems, but since the new eMAR system has been in place, and the pharmacy does the order entry, there have been so many problems. The nurses at this facility used to enter medications into the system and they still have the ability to do so, but the pharmacy is charged with entering the orders in. There have been delays of up to 5 days in getting the medication orders into the eMAR system. When this happens, the medication may already be on the cart, but the eMAR still doesn't show that the medication is supposed to be given to the resident. This creates among the LPNs and Med Techs that are trying to assist with medications. The problem seems to be on the data entry end of it."

A records review conducted at 3:00pm on revealed that the facility's eMAR for , 2017 for Resident #4 did not match up with the medications the doctor ordered (see Photo1 attached). While all of the ordered medications were listed on the eMAR, there were several errors and duplications. Out of 18 different medications, the following incorrect data was listed on the MAR: duplications of , , glucose monitoring, 2 high , medications, a medication and an aerosol inhaler for a lung . A nasal spray used for lung was listed 3 times, to be used "twice a day" and a syrup to be given "as needed every 4 hours" was listed under 2 different names "Geri- " and " SA syrup", with the same exact instructions for the same diagnosis and appearing to be two different medications.

At 3:20pm on , the Administrator acknowledged that they had a problem with the new corporate pharmacy system of data entry into the eMAR system and that they had been trying to work it out and have not been successful yet.

Class III