STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965317	R 03/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYOU GARDENS	**1585 CURLEW RD.** **DUNEDIN, FL 34698**

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

0000 - Initial Comments

Assisted Living Facility

A revisit to a complaint investigation, (CCR# 2017000338), was conducted from through at Bayou Gardens Assisted Living Facility, (License # 9712) The facility was found to have uncorrected deficiencies at the time of the visit.

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

Based on record review and interview, the facility failed to maintain Medical Observation Records (MORs) which were updated and accurate and free from omissions and errors for 5 of 5 Residents (#1, #3, #10, #11, and #12).

Findings included:

During an observation on at 10:05am found 27 Resident MORs flagged by Med Tech Supervisor.

An interview conducted with Med Tech Supervisor on at 10:10am that the flagged MORs are because "all of these are discrepancies that pharmacy needs to clarify when they come later this afternoon; some are missing medications and some Residents are missing MORs."

A MOR review conducted on for Resident #1 revealed that on two scheduled medications due at 02:00pm was not documented as observed as taken.

A MOR review conducted on for Resident #3 revealed that there was no documentation for twice per day , checks for (both am & pm), (both am & pm, and, (am only). The MOR also revealed that 08:00am medications had not been documented as observed as given. The Med Tech stated "I forgot to sign these out".

A MOR review conducted on for Resident #10 revealed that, there was no documentation for an ordered to be taken every 12 hours for seven days. The omitted documentation was on (8am & 8pm), (8am & 8pm), and, 8am only - which was the last scheduled dose; also another medicine signed out as already observed as taken on @7am.

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A MOR review conducted on . . . . . for Resident #11 revealed that there was no documentation for twice per day , checks for (am only), (am only), and, (am only).

A MOR review conducted on . . . . . for Resident #12 found page two of . . . . , 2017 MORs missing vital Resident information: name, , date-of-birth, , and health care provider name and contact information.

An interview with the Administrator at 11am revealed that herself and Staff A supervise the med tech , who she identified as the med tech supervisor, and she didn't know about the pharmacy discrepancies.

Class III

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

Based on observation, interview, and record review the facility failed to ensure that two of two Residents (#1 and #9) received medications as directed by the physician.

Findings included:

A medication pass observation conducted on at 10:15am revealed that Resident #1 received all meds that were ordered to be taken at 08:00am, at 10:15am. The Med Tech Supervisor stated in an interview that, "this was the first time I was able to offer her meds to her [and] she is the only Resident that has not received their 8am medication." The Med Tech Supervisor also did not document the med observation on the Medication Observation Record (MOR) after observing Resident #1 take the medications.

A review of the MOR conducted on . . . . . at 10:21am revealed that the MORs for Resident #1 had already been documented for the 08:00am medications. Med Tech stated that, "I attempted earlier to give [Resident #1] her medication but she wasn't available."

A MOR review conducted on . . . . . revealed that Resident #9 did not receive a scheduled twice per day eye drop medication as ordered related to "not delivered" (from pharmacy) for the period: . . . . . through . . . . . .

At 11 am on . . . . . in an interview with the Administrator , during a review of Resident # 1 and 9's

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medication sheets with the surveyor, she stated she does not know why the times weren't changed for the medication. She acknowledges that they are all the same times as , 's med sheets and the times should have been changed in response to the citation from the previous survey.

Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on observation, interview, and record review the facility failed to ensure that two of two Residents (#1 and #9) received medications as directed by the physician. Based on the above stated uncorrected deficiency (relative to complaint CCR 2017000338 which was a revisit from a Change in Ownership survey on), the facility shall be required to employ the consultant services of a licensed pharmacist or a registered nurse.

Findings included:

A med pass observation conducted on at 10:15am revealed that Resident #1 received, all meds (ordered for 08:00am) at 10:15am. Med tech stated that, "this was the first time I was able to offer her meds to her [and] she is the only Resident that has not received their 8am medication." The Med Tech also did not document the med observation on the Medication Observation Record (MOR) after observing Resident #1 take the medications.

A review MOR conducted on at 10:21am revealed that the MORs for Resident #1 had already been signed as observed for the 08:00am medications. Med Tech stated that, "I attempted earlier to give her [referring to Resident #1] her medication but she wasn't available."

A MOR review conducted on revealed that Resident #9 did not receive a scheduled twice per day eye drop medication as ordered related to (according to the back of the MOR) "not delivered" (from pharmacy) for the period: through (copy attached).

Based on the above stated uncorrected deficiency (relative to complaint CCR 2017000338 which was a revisit from a Change in Ownership survey on), the facility shall be required to employ the consultant services of a licensed pharmacist or a registered nurse.

The consultant shall at a minimum, provide onsite quarterly consultation until the inspection team from

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the Agency determines that such consultation services are no longer required.

This serves as a written notification of the requirement for the above described consultation services.

Unclassed