STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966519	**04/05/2017**
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
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

Complaint Investigation #2017003496 was conducted on and . Indigo Palms at Maitland, License #10704, had deficiencies at the time of the visit.

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

Based on record reviews and interviews, the facility did not ensure the health assessment form 1823 was complete for 1 of 3 sampled residents (#3).

Findings:

Resident #3's record revealed a health assessment form 1823 dated . The questions that pertained to whether he required 24-hour nursing or , , care and whether he required assistance with his medications were blank.

During a phone interview with the director of nursing on at 3 PM, she confirmed the findings.

Class III

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

Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 3 residents (#4 & 5) received their medications as prescribed by a healthcare provider, and failed to notify a healthcare provider when 2 of 3 residents (#4 & 5) were not given their medications.

Findings:

1. Resident #4's record revealed a health assessment form 1823 dated that reflected he had diagnoses of and , and he required assistance with self-administration of his medications.

Review of his 2017 Medication Observation Record (MOR) revealed an entry for 2.5 milligrams (mg.) by mouth daily. It was not signed as given on and .

His record contained a health care provider order dated for 2.5 mg. daily. The order indicated that his International Ratio (INR) was 1.31. His INR on was 1.12 and on it was 1.03. "The normal range for a healthy person not using is 0.8-1.2, and for people on , an INR of 2.0-3.0 is usually targeted...." (wikipedia.org).

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There was no documented evidence in his record to indicate a health care provider was notified when he did not receive his 2.5 mg. on and .

During an interview with resident #4 on at 7:04 PM, he said he did not know if he received his on and .

2. Observations made during a medication pass for resident #5 on at 4:10 PM revealed his 2017 MOR had an entry for , Extended Release 15 mg., 1 tablet by mouth every 12 hours, and was scheduled at 9 AM and 8 PM.

The staff initials were circled on for the 9 AM dose, from through , and on for the 8 PM dose.

It was not signed as given from through for the 9 AM dose and on for the 8 PM dose.

Documentation on the back of the MOR reflected that the medication was unavailable from through .

Observations made of his medication packages on at 7:15 PM revealed , Extended Release 15 mg. tablets was not available. Staff A was present and confirmed she did not have the medication, and thought the medication had been discontinued.

There was no documented evidence in the resident's record to indicate the medication was discontinued and no evidence to indicate a healthcare provider was notified when he did not receive the medication.

Review of a progress note dated and signed by a healthcare provider reflected that resident #5 had a diagnoses of , , and . It reflected that he reported an increase in his pain.

During an interview with resident #5 on at 7:45 PM, he said he did not know he was not given his , . He said the staff did not tell him what medications he received when they brought his medicine to him. He said he just trusted that he received all of his medications. He said he experienced an increase amount of pain in his hips over the last 2 weeks, and could barely walk, and he did not understand why his pain was worse. He said he spoke with his healthcare provider about the increase in his pain and said she told him the pain medication he was prescribed should have helped his pain.

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During an interview with the director of nursing on at 8:55 PM, she confirmed the findings.

Class II

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

Based on medication pass observations and interview, the facility failed to ensure the unlicensed staff who assisted 1 of 1 sampled residents with self-administration of medications followed the correct procedure (#5).

Findings:

Observations made during a medication pass for resident #5 on at 4:10 PM revealed staff A, an unlicensed caregiver, removed the medication containers from the medication cart and compared the label to the Medication Observation Record (MOR). She placed two pills in a souffle cup. She crushed two different pills and placed them in a separate souffle cup. She placed the medication containers back in the medication cart. She took the souffle cups to resident #5, who was in his , and handed him the cups. He took the two pills with water and he placed the crushed medication in applesauce and said it was easier for him to take them that way.

Staff A did not prepare the medication in the presence of resident #5, and did not read the label in the resident's presence, as required.

During an interview with the director of nursing on at 8:45 PM, she did not provide an explanation.

Class III

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

Based on observations, record reviews and interviews, the facility failed to maintain an updated Medication Observation Record (MOR) for 1 of 3 sampled residents who required assistance with self-administration of medications (#5).

Findings:

Observations made during a medication pass for resident #5 on at 4:10 PM revealed staff A gave him four pills. Review of his 2017 MOR revealed the pills were 1 tablet of 25 milligrams (mg.), 1 tablet of 1 mg., and 2 tablets of 20 milliequivalents.

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The 2017 MOR reflected that he was also to receive 900 mg. at 5 pm. When questioned why the was not given during the medication pass, staff A said the medication was given at 9 PM and the MOR was never updated to reflect the time change. The medication was signed as given every day at 5 PM for the entire month of 2017.

During an interview with the director of nursing on at 8:45 PM, she confirmed the finding.

Class III

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

Based on observations, record reviews and interviews, the facility failed to ensure 2 of 3 residents received their medications as prescribed by a healthcare provider (#4 & 5), and failed to notify a healthcare provider when 2 of 3 residents were not given their medications (#4 & 5). Based on the above non-complaince and history of non-compliance the facility shall be required to employ the consultant services of a licensed pharmacist.

Findings:

1. Resident #4's record revealed a health assessment form 1823 dated that reflected he had a diagnoses of and and he required assistance with self-administration of his medications.

Review of his 2017 Medication Observation Record (MOR) revealed an entry for 2.5 milligrams (mg.) by mouth daily. It was not signed as given on and .

His record contained a health care provider order dated for 2.5 mg daily. The order indicated that his International Ratio (INR) was 1.31. His INR on was 1.12 and on it was 1.03. "The normal range for a healthy person not using is 0.8-1.2, and for people on , an INR of 2.0-3.0 is usually targeted...." (wikipedia.org).

There was no documented evidence in his record to indicate a health care provider was notified when he did not receive his 2.5 mg. on and .

During an interview with resident #4 on at 7:04 PM, he said he did not know if he received his on and .

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2. Observations made during a medication pass for resident #5 on at 4:10 PM revealed his 2017 MOR had an entry for , Extended Release 15 mg., 1 tablet by mouth every 12 hours, scheduled at 9 AM and 8 PM.

The staff initials were circled on for the 9 AM dose and on through and for the 8 PM dose.

It was not signed as given from through for the 9 AM dose, and on for the 8 PM dose.

Documentation on the back of the MOR reflected that the medication was unavailable from through .

Observations made of his medication packages on at 7:15 PM did not reveal any , Extended Release 15 mg. tablets available. Staff A was present and confirmed she did not have the medication, and thought the medication had been discontinued.

There was no documented evidence in the resident's record to indicate the medication was discontinued, and no evidence to indicate a healthcare provider was notified when he did not receive the medication.

Review of a progress note, dated and signed by a healthcare provider, reflected that resident #5 had a diagnoses of , , and . It reflected that he reported an increase in his pain.

On at 7:45 PM, resident #5 said he did not know he was not given his , . He said the staff did not tell him what medications he received when they brought his medicine to him. He said he just trusted that he received all of his medications. He said he experienced an increase amount of pain in his hips over the last 2 weeks, could barely walk, and did not understand why his pain was worse. He said he spoke with his healthcare provider about the increase in his pain, and said she told him the pain medication he was prescribed should have helped his pain.

On at 8:55 PM, the director of nursing confirmed the findings.

Class III