STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942870	R 04/07/2017
NAME OF PROVIDER OR SUPPLIER **PARK PLACE ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **541 PARK STREET** **DUNEDIN, FL 34698**	

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

0000 - Initial Comments

Assisted Living Facility

On a revisit to a biennial survey was conducted in conjunction with a revisit to a complaint survey, CCR# 201601477, and a new complaint survey, (CCR# 2017002566). Uncorrected and new deficiencies were identified at the time of the visit.

(license #8284)

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

Based on observation, interview and record review, the facility failed to (1) provide medications at the prescribed time to one resident (#11) of five sampled residents for medication observation, and; (2) failed to provide scheduled medication for two residents (#11 and #14) of five sampled residents for medication observation.

Findings included:

1.
A review of medication label revealed that packaged individual tablets dated " Thu , , Noon " and " Fri , , Noon " remained attached to the packaging issued by the pharmacy (photographic evidence obtained).

A record review conducted on , at 02:00 p.m., revealed that Resident #11 had routinely scheduled medication at Noon. The Administrator ' s initial on the MOR indicated that the medication was given on and .

During an interview with the Administrator, on , at 02:03 p.m., she confirmed that she documented on the MOR that the medication was given for and . The Administrator acknowledged that the medications were still in the sealed packaging issued by the pharmacy, and medication not given to Resident #11 on . The Administrator stated there was not physician orders to hold the medication; it was just a mistake.

On , at 02:05 p.m., the Administrator instructed Staff D to assist Resident #11 with medication

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self-Administration. The Administrator stated that she did not document or notified the resident ' s physician that medication was not given on and acknowledge that was given two hours late on , , 2017.

2.
A review of the medication labeled instructions revealed that Resident #14 had one routine medication scheduled for " three times a day "

During an interview with the Administrator, on , at 02:38 p.m. she stated that Resident #14 does not have a MOR for her medications. She stated that she used the labels on the medication as the guidance to give Resident #14 her medicine. Administrator stated that #14 does not have a 12:00 p.m. medication. The administrator was not aware of the printed instruction for " 3 times a day " for one of Resident #14 ' medication.

On , at 03:49 p.m., the Administrator stated that she received the MOR from the pharmacy for Resident #14, and she added her initial on the MOR for all medication, except 12:00 p.m. medications, from to . Administrator acknowledged the inaccuracy of her initials, as Staff C provided Resident Milrdred #14 ' medication during some medication pass. The Administrator stated that she did not give Resident #14 that specific medications during the noon medication pass because she did not have a MOR that instructed her to provide the medication in the afternoon. The administrator confirmed that Resident #14 was admitted into the facility on .

Class III

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

Based on observation, interview and record review, the facility failed to maintaining a daily Medication Observation Record (MOR) for residents who received assistance with self-administration for two Residents(#5 and #14) of five sampled residents.

Findings included:

During record review conducted on , at 02:38 p.m., no MOR was found for Residents #14 and Resident #5.
During interview with the Administrator, on , at 02:38 p.m. she stated that neither Resident #14 nor Resident #5 had MORs at the facility. Administrator confirmed that Resident # #14 and Resident #5 have received assistance with medication self-administration without an existing MOR to document on.

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Administrator confirmed that Resident (#14) was admitted into the facility on , and Resident #5 was admitted on .
On , at 03:49 p.m., the Administrator stated that she received the MOR from the pharmacy for Resident #14, and she added her initial on the MOR for all medication, except 12:00 p.m. medications, from to . Administrator did not furnish a MOR for Resident #5.

Class III

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

Based on observation, interview and record review, the facility failed to, (1) notify or obtain approval (verbal or written) from resident's health care provider for medication not provided to three residents (#11, #14, and #15) of five sampled residents for medication observation, and; (2) maintain or provide physician orders for 15 of 15 medications provided to one resident (#14) of five sampled residents for medication observation.

Findings included:
1.
While conducting observation of assistance with self-administration by the Administrator on , at 12:26 p.m., it was noted that Resident #15 ' s medication labeled " Sun , , NOON. "
On , at 12:27p.m., Resident #15 self-administered medications provided by the Administrator.

During an interview with the Administrator on , at 12:28 p.m., The Administrator stated that she discarded medication that was labeled for , , 2017 and , , 2017 because Resident #15 was supposed to be fasting for her surgery. Administrator stated that there was no physician orders to hold or discard the resident ' s medication.

A record review for Resident #15 revealed there was no physician orders or any form of documentation in Resident #15 ' s chart that authorized hold or disposal of the medication.

A record review conducted on , at 02:00 p.m., revealed that Resident #11 had routinely scheduled medication at Noon. The Administrator ' s initial on the MOR indicated that the medication was given on and .

A review of medication label revealed that packaged individual tablets dated " Thu , , Noon " and " Fri , , Noon " remained attached to the packaging issued by the pharmacy (Image taken).

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During an interview with the Administrator, on , at 02:03 p.m., she confirmed that the medications were still in the sealed packaging issued by the pharmacy. The Administrator confirmed that there was no physician order, or any documentation that authorized holding the medication. The administrator stated that it was just a mistake.

A record review for Resident #14 confirmed there was no physician orders authorizing the holding of the medication, or any documentation of physician notified of missed dosages.

2.
Review of the medication labeled instructions revealed that Resident #14 had one routine medication scheduled for " three times a day. "

During an interview with the Administrator, on , at 02:38 p.m. she stated that she used the labels on the medication as the guidance to give Resident #14 her medicine. Administrator stated that #14 does not have a 12:00 p.m. medication. The administrator was not aware of the printed instruction for " 3 times a day " for one of Resident #14 ' medication.

On , at 03:49 p.m., the Administrator stated that she did not give Resident #14 that specific medications during the noon medication pass because she did not have a MOR or physician orders that instructed her to provide the medication in the afternoon. The administrator confirmed that Resident #14 was admitted into the facility on . After making attempt to search for the resident ' s records, the Administrator stated, " whatever, I cannot find it. " She confirmed that she did not have any physician orders for Resident #14.

A record review for Resident #14 revealed there was no physician orders for any of the medication that the facility was providing to Resident #14. Review of the facility's Admission discharge log revealed that Resident #14 was admitted to the facility on .

Class III

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

Based on record review and interview the facility failed to correct a class III deficiency regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary, or both during a biennial survey.

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Findings included:

On , , 2017 the facility had a documented class III deficiency cited under regulation 0052 medication-assistance with self-administration. On , , 2017 a revisit was conducted. The facility failed to ensure the previous cited medicinal regulation (0052) was corrected. In addition the facility was cited for two additional medicinal regulations (0054 & 0056) in regards to medication records, labeling and ordering.

In review of 2 resident records (#11 and #14) the facility failed to ensure their medications were given at the prescribed time frame and as prescribed by the physician.

On , , 2017 an interview was conducted with the administrator, they stated they were following all physicians orders.

Unclassed

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation and interview, the facility failed to maintain or furnish a written work schedule for three (Administrator, Staff C and Staff D) of three employees who worked as direct care staff.

Findings included:

During facility tour conducted on at 09:09 a.m., it was observed that the facility did not have a written schedule posted.

During an interview with the Administrator, on , at 10:26 a.m., she confirmed that the facility does not have a written schedule for the direct care staff. The Administrator began handwriting a schedule for the day, but did not completed one.

During interview with Staff C on at 11:08 a.m., he confirmed that he works during the night shift. Staff C stated that he is not on any direct care-staffing schedule, nor have seen one at the facility.

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Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on record review and interview, the facility failed to ensure that one employee (Staff C) of three sampled employees, who worked alone in the facility maintained and up-to- date First Aid and ( ) training.

Findings included:

Employee record review, conducted on , revealed that Staff C, completed First Aid Training on . Printed on the certification of completion was "recommended renewal: ." There were no documentation of First Aid or certification renewal.

During telephonic interview with staff C, on , at 11:08 p.m., he confirmed that he worked by himself during the night shift.
During interview with the Administrator, on , at 11:15 a.m., she confirmed that she does not have any documentation of recently completed and first aid training by Staff C.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on interview and record review, the administrator of a facility failed to maintain personnel records for each staff member (#C and #D) which contain at a minimum a copy of the employment application, with references furnished, and documentation on verifying freedom from signs or symptoms of a communicable and documentation of compliance with staff training.

Finding included:

An employee record review for Staff C was conducted on . It revealed that there was no application for employment, to include references and work history. There was also no documentation found that verified communicable status or status.

An employee record review for staff D was conducted on . It revealed that there was no

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application for employment, to include references and work history. There was also no documentation found that verified communicable or status.

During interview with the Administrator, conducted on at 3:25 pm., they confirmed Staff C and Staff D did not have an application or documentation of a communicable statement / status.

Class III

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

Based on record review and interview, the facility failed to produce and maintain any documentation for one resident (#14) of seven sampled residents.

Findings included:

Review of the Admission/Discharge log revealed that Resident #14 was admitted to the facility on .

During observation of assistance with self-administration of medication, conducted on , it was observed that the facility stored medication for Resident #14.

During interview with the Administrator, on , at 02:38 p.m. she stated that she used the labels on the medication as the guidance to give Resident #14 her medicine because the facility did not have a MOR for the resident ' s medication. Administrator confirmed that the facility does assist Resident #14 with medication self-administration.

On , at 03:49 p.m., The Administrator searched for Resident #14 ' s records, and was not able to find it. The Administrator stated, " whatever, I cannot find it. "

Class III

0163 - Records - Resident, Penalties for Alteration - 429.49 FS

Based on observation, interview, and record review, the facility failed to ensure the Medical Observation Report (MOR) was completed accurately and free from alteration and falsification by the Administrator.

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The Administrator, in the presence of two surveyors, (1) Inaccurately documented that medications was disposed as a result of medication refusal for one (Resident #15) of five sampled residents for medication observation; (2) Changed Staff C ' s initials, and added her initial to blank spaces on residents ' MORs, and; (3) inaccurately documented that medications were given for two Residents (# 11 and #14) of five sampled residents for medication observation.

Findings included:

1.
While conducting observation of assistance with self-administration by the Administrator on , at 12:26 p.m., it was noted that Resident #15 ' s medication labeled " Sun , , NOON. "
On , at 12:27p.m., Resident #15 self-administered medications provided by the Administrator.

During interview with the Administrator on , at 12:28 p.m., she confirmed that Resident #15 received medication labeled " Sun , , NOON. " The Administrator stated that she discarded medications labeled for , , 2017 and , , 2017 because Resident #15 was supposed to be fasting for her surgery. Administrator confirmed that there was no physician orders to hold or discard the resident ' s medication.

On , at 1:28 p.m., the Administrator was observed documenting on the back of Resident #15 ' s MOR, which indicated that Resident #15 refused and medication was disposed for at 11:45 (hours).

2.
While conducting observation of assistance with self-administration by the Administrator on , at 1:10 p.m., the Administrator was observed documenting in blank " 8:00 AM " section of MOR, and over Staff C ' s initials previously documented during morning medication pass. Administrator stated that she passed one tablet, during the morning medications pass; and she wanted to prove that she was here in the morning. She continued writing her initials over the Staff C existing initial, and adding her initial to blank slots from unmarked dates prior to date of survey.

On , at 1:10 p.m., The Administrator became upset because surveyor was watching and documenting. Administrator again confirmed that she falsely documented the MOR and that asked surveyor if he would like to go to court.

On , at 1:34p.m., the Administrator continued to document in the MOR for all residents to

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including blank MOR spaces from 8pm medication pass on for multiple residents. Administrator stated that she is making corrections by adding her initial to the blank spaces in the MOR.

3.
A record review conducted on , at 02:00 p.m., revealed that Resident #11 had routinely scheduled medication at Noon. The Administrator ' s initial on the MOR indicated that the medication was given on and . Resident #11 was not part of residents include during of assistance with self-administration of medication conducted on .

A review of medication label revealed that packaged individual tablets dated " Thu , , Noon " and " Fri , , Noon " remained attached to the packaging issued by the pharmacy (Image taken).

During an interview with the Administrator, on , at 02:03 p.m., she confirmed that she documented on the MOR that the medication was given for and while she was making corrections on the MOR for all residents. The Administrator confirmed that the medications were still in the sealed packaging issued by the pharmacy and that Resident #11 did not receive the medications as documented.

4.
A review of the medication labeled instructions revealed that Resident #14 had one routine medication scheduled for " three times a day "

During an interview with the Administrator, on , at 02:38 p.m. she stated that Resident #14 does not have a MOR for her medications. She stated that she used the labels on the medication as the guidance to give Resident #14 the medications. Administrator stated that #14 does not have 12 pm medication. The administrator was not aware of the printed instruction for " 3 times a day " for one of Resident #14 ' medication.

On , at 03:49 p.m., the Administrator stated that she received the MOR from the pharmacy for Resident #14, and she added her initial on the MOR for all medication, except 12:00 p.m. medications, from to . Administrator acknowledged the inaccuracy of her initials, as Staff C provided Resident #14's medication during some medication pass.

Class III