STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968462	**04/18/2017**
NAME OF PROVIDER OR SUPPLIER **SPRING HILL ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **8239 CESSNA DR,** **SPRING HILL, FL 34606**	

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

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

Based on observation, record review and interview, the facility failed to provide a prescribed medication for 1 of 5 residents (Resident #5).

Findings:

1.) During Medication Passage observation on at 12:30 PM with the Medication Technician assigned to Homes #4, 5, 6, she had an empty box for the on the medication cart.

During an interview with Resident #5 on at 12:40 PM, he stated he thought the might be in the he did not know. The medication was not given to the resident.

Review of the Medication Observation Record (MOR) for revealed no doctor's order for bedside medications for this resident.

An interview with the Medication Technician assigned to Homes #4, 5, 6 on at 12:40 PM confirmed she had no to provide to Resident #5. She stated this was a missed medication and was recorded as such in the MOR. She stated she had not been told if the administration of the had been changed for this resident but it was not documented. No was provided. She stated medications which can be kept at the resident's bedside are noted by the Physician on the MOR in the orders. She stated "I am circling my initials on the MAR/MOR to indicate he did not receive the medication on at noon."

An interview was conducted with the Director on at approximately 2:00 PM to notify of the missing medication. She noted she was already aware. She stated the doctor felt it was fine for the to be kept at the bedside but they did not communicate that to all of the staff.

A Physician's Order dated , was faxed to the facility for the to be kept at the bedside of Resident #5. No further information was provided.

Class III

L242 - LMH - Responsibilities of Facility - 429.075(2) FS; 58A-5.029(3) FAC

Based on record review and interview, the facility failed to ensure mental health resident records were maintained as required and upheld the facility's responsibilities as outlined in the Community Living Support Plans for 3 of 3 limited mental health residents (Residents #6, 7 and 11).

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Findings:

On , a record review of the terms of the Community Living Support Plans for mental health Residents #6, 7 and 11, showed each included an outlined section of the facility responsibilities. A review of this section of the Community Living Support Plan in each case included the facility shall: Advise the Provider of significant behavior changes in Provider's clients who are Spring Hill Assisted Living Residents; participate in the development of the resident's community living support plan; facilitate resident's participation in the development of their community living support plan. During the record review, a comparison of the three resident Community Living Support Plans revealed that each support plan read identically, with no evidence that the support plans were written to meet individual goals, or needs of the mental health residents. No facility maintained observation logs were evidenced in any of the three resident records reviewed to support the facility's responsibility to report behavior changes to the mental health providers.

An interview was conducted with the Resident Administrator (Staff D) on at 10:10 AM. During the interview, she confirmed the facility did not have any observation logs, which recorded resident behaviors, activities, etc. She stated the mental health provider; Advanced Nurse Practitioner (ARNP) (referenced by name) was presently recovering from an accident and has been unable to be active in participation with the residents. She further stated that the facility would facilitate a meeting soon with the mental health providers to tighten up the Community Support Plans with more specific activities to meet the individual needs of the mental health residents. She also stated the facility would develop a form to record and log observations and behavioral changes observed during the support plan activities.

An interview was conducted with the Administrator/Owner on at 10:30 AM regarding the concerns with the facility not documenting the limited mental health activities and behaviors, activities, and the Community Support Plans. He confirmed he would have a meeting with the mental health providers and facility staff to make adjustments and improvements to the Community Support Plans and develop a tool to document behaviors and activities of the limited mental health residents.

On , a review of Resident #6's record revealed he receives mental health services. He has a Community Support Plan signed by resident , and ARNP on . Resident #6's admission to the facility was, , and he received his mental health assessment on .

An interview was conducted with Resident #6 on at 12:15 PM. During the interview, when

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asked, about his Community Support Plan, he stated, "This is the first I have ever heard about a Community Support Plan, I am not familiar with what that means." When asked if he recalled receiving any mental health services he confirmed he sees a psychologist (he referenced by name) once a week or so. He stated we sometimes talk about me during those conversations and also current issues, or anything else under the sun. He concluded the interview with stating the psychologist is a "good guy", when asked if he had ever seen or talked to , Advanced Registered Nurse Practitioner, who was referenced by name, he stated he was not familiar with her.

On , a review of Resident #7's record revealed he receives mental health services. He has a Community Support Plan signed by resident , and , ARNP on . Resident #7-admission date to the facility was , and he received his mental health assessment on .

An interview was conducted with Resident #7 on at 12:25 PM concerning his Community Support Plan. Resident #7 denied receiving any mental health services from the facility. He stated he is familiar with the psychologist who talks with residents but stated he does not talk with me on a regular basis.

On , a review of Resident #11's record revealed she receives mental health services. She has a Community Support Plan signed by the Resident Administrator. Resident #11 is new to the facility. She has had her assessment and the plan as of .

An interview was conducted with the Psychologist with Elder Care Services on at 9:45 AM. He stated he sees all of the residents with Mental Health issues. He stated he sees Resident # 11 biweekly.

Class III

0000 - Initial Comments

An unannounced Biennial Survey with Limited Mental Health (LMH) was conducted on through at Spring Hill Assisted Living Facility (facility license number 12359). Deficient practice was identified at the time of the survey.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review and interview, the facility failed to protect the privacy of residents and secure the kit containing the Medication Observation Records (MORs) for residents in 1 of 6 homes (Home #3); based on observation and interview, the facility failed to ensure privacy of 1 of 1 residents

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(Resident #11), during assistance with self-administration of medication; and, based on observation and interview, the facility failed to ensure the privacy of 65 of 65 residents by having a dry erase board with residents' names and care needs in a location that was observable by other residents, staff and facility visitors.

Findings:

1.) During an observation tour of Home #3 with the Medication Technician, Staff A, on at 10:00 AM, the Emergency Kit located on top of the Medication cart in Home #3 was not locked. The cart is parked in the great multi use the center of the home. 12 syringes, a sugar kit and 50 30-G lancets were located in the kit along with the Medication Administration Observation (MOR) Log for . Throughout the course of every day the staff are nearby but not actually in each home. So the above items had no employee supervision.

During an interview on at 10:00 AM with the Medication Technician, Staff A, she confirmed she leaves the above items in the kit and unlocked on a regular basis. She stated she does this intentionally for the convenience of the Home Health Nurses, even though the home is frequently without staff and the residents have easy access to the kit. She confirmed the MOR was private health information for all of the residents.

2.) During the Medication Passage Observation on at 12:30 PM with the assigned Medication Technician, she gave Resident #11 the glucometer. The resident tested herself using the stick procedure with the drop of at the dining with 2 other residents at the small table. It was lunch time and the test was conducted after all the residents were seated at their tables in the small . Her score was loudly announced by staff, 176, while the residents of the home were seated for lunch. The resident was then given her injectable pen from the medication cart. She proceeded to pull up her dress exposing her thigh and gave herself the injection in full view of the other residents. She was not asked if she wanted to go somewhere else to undergo this medical procedure. The other residents were not asked if they wanted to watch the procedure.

During an interview with Resident #11 on at 2:00 PM, she stated that is what they have been doing every day. She was not aware of any other options.

3.) An observation was made on at 11:00 AM, of a large dry erase board and two smaller dry erase boards mounted on the wall located outside the Administrator's Office. These dry erase boards displayed residents' personal information concerning their personal care needs. The notes referenced the individual residents' by name. The dry erase boards were located on a wall very visible to anyone

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coming into the office area. This office area is frequented by not only facility staff, but also residents, couriers, physicians, and others coming in and out from outside the facility. (Photographic Evidence attached).

During an interview with the Administrator on at 11:55 AM, he stated he agreed the dry erase board could be moved to a less conspicuous location, where only care staff could view the information and not anyone walking into the office.

A facility policy for health information privacy was provided on . It states the staff must secure the medications book. The Policy states "Effective ". There is also a policy now for resident privacy during medical treatments, which calls for shielding both the resident receiving the treatment as well as other residents in close proximity.

Class III

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

Based on observation, record review and interview, the facility failed to maintain a secured centrally located location for medications, abandoned/expired medications, and failed to secure medications for 1 of 1 residents (Resident #2) who medications were kept unsecured by the resident's bedside.

Findings:

1.) An observation of the centrally located medication refrigerator, on at 11:00 AM, found no locks and the residents walking past it, unsupervised, going from one area in the main building to another.

Inside the refrigerator:
Lantus 2 boxes 100 units Prefilled pens (abandoned)
2 400 mg vials and syringes, one of the vials was expired , (abandoned)
100 ml in 4 boxes
100 ml in 2 boxes
Lantus 5 units 12 boxes of vials
Eyedrops 4 boxes
1 box
100 ml 1 box (resident never in facility)

Observation Tour with the Medication Technician, Staff A, on at 10:30 AM, revealed 3

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inhalers and 4 vials of solution sitting on top of Resident #2's bedside table, visible from the doorway. The resident's bed was made and he was out of the building at this time.

An interview with the Medication Technician, Staff A, on at 10:35 AM and the Director and Owner at 11:05 AM, confirmed they had the above listed medications in an unsecured refrigerator in an unsecured closet, in an open kitchen, with resident access. Further they confirmed the left by the empty bedside of Resident # 2. They confirmed the Lantus, and were abandoned by residents gone more than 30 days from the facility. They confirmed the had a prescription label for a resident not on the Admission Log or other documentation. Further, the Director stated she had tried to get the medications disposed of but the pharmacist refused to take them. No further action or information was provided.

2.) During an observation tour of Home #3 with the Medication Technician, Staff A, on at 10:00 AM, the Emergency Kit located on top of the medication cart in Home #3 was observed to be not locked. The cart is parked in the great multi use the center of the home. 12 syringes, a sugar kit and 50 30-G lancets were located in the kit along with the Medication Administration/Observation Log for .

During an interview on at 10:00 AM with the Medication Technician, Staff A, she confirmed she leaves the above items in the kit and unlocked on a regular basis. She stated she does this intentionally for the convenience of the Home Health Nurses, even though the home is frequently without staff and the residents have easy access to the kit.

Class III