STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966595	04/28/2017
NAME OF PROVIDER OR SUPPLIER **SPRING OAKS**	STREET ADDRESS, CITY, STATE, ZIP CODE **7251 GROVE RD** **BROOKSVILLE, FL 34613**	

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

0000 - Initial Comments

An unannounced complaint survey, CCR #2017004513, was conducted on and at Spring Oaks Assisted Living Facility (facility license number 10763). Deficient practice was identified during survey.

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

Based on record review and interview, the facility failed to ensure that 5 of 5 residents (Resident #1, #2, #3, #4, #5) received the required care and supervision to ensure that prescribed medications were delivered to the facility timely, to ensure that the residents were receiving the prescribed medications as ordered by their physicians. Based on record review and interview, 1 of 5 residents (Resident #1) suffered harm as a result of not receiving her prescribed medication, suffering a massive left middle status post tissue plasminogen activator and .

Findings:

Resident #1

Record review of History & Physical for Resident #1 revealed diagnoses of dominant side right , aphasia, , acute left-sided , in origin.
Record review of charting notes for Resident #1, dated , revealed that the Licensed Practical Nurse (LPN) notified pharmacy that is not available. MD notified of missed dose.
Record review of physician's communication note dated revealed a note to the treating physician that Resident #1 missed 6 doses of .

In an interview on at 12:30 PM with the family member of Resident #1, he said that she went to St. Joseph's hospital. He said she had a and went to the hospital. According to the family member, the certificate stated the resident from natural acute accident and .

Review of Resident #1's Discharge Summary from St. Joseph's Hospital, stated in part:
Admit Date:
Date of :
Admission Diagnosis:
Discharge Diagnoses:

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1. Massive left middle status post tissue plasminogen activator and
2. with anticoagulation, noncompliance.
3. Acute hypoxemic failure status post extubation and progressive decline.
4. Acute
5.
6.
7.
8.
9. Parkinson's

Review of 15-Day Adverse Incident Report, dated , regarding Resident #1, stated in part: Resident was ordered by MD to be on . Resident received last dose on AM. Pharmacy was notified on and was to send out med. On it was noted med was not delivered. Pharmacy was notified and indicated they would refill and send STAT. On a new prescription was obtained from MD and sent to pharmacy. Family picked resident up for LOA on . On family notified community that resident suffered a and was admitted to hospital where she remains at this time. The report continued: B. Corrective or proactive action(s) taken: none, resident expired at hospital. The 15-Day Adverse Incident Report was completed and submitted by the facility Administrator.

During an interview on at 1:32 PM with Resident #1's treating physician, he confirmed that Resident #1 is his patient. He stated he just now became aware of her missing her , that the was not being given to her while at the facility. Surveyor informed him that the facility records show that the facility contacted him on to inform him that the resident missed 6 doses of . He checked his records, and stated his records show he was contacted by the facility on advising that the resident needed a new prescription. The records do not show that the facility informed him that the resident had gone several days without . He stated the resident was last seen by him on . He stated was first time he was contacted after . He stated he was never told the resident was out of the . He does not have any doubt that the resident not receiving may have contributed to the resident's and . If the resident wasn't receiving the , then her wasn't thinned. He stated the resident had a previous embolic episode, the resident had . He sees his patients once a month at the facility.

Resident #2

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In an interview with the LPN and administrator, they said that the Exception report does not show that the medication was given on at 8 PM for Resident #2. They stated the nurse checks the exception report every morning for medication omissions.

During an interview on at 1:32 PM with Resident #2's treating physician, he confirmed that Resident #2 is his patient. He last saw him on . He had no information that the resident did not receive his , on . He sees his patients once a month at the facility.

Resident #3
On , review of Resident #3's Medication Observation Record (MOR) showed that the resident missed the 6:00 AM dosage of , on . Review of the facility medication exception report showed Resident #3 missed the 6:00 AM dosage of , on due to awaiting delivery of the medication from the pharmacy.

In an interview on at 11:28 AM with the Administrator and the Licensed Practical Nurse (LPN), they confirmed that Resident #3 missed dosage of , on .

Resident #4
Record review of the MOR for dates , , , for Resident #4 revealed the resident did not receive the following medications as ordered by the physician: , , , , , . Record review of the Exceptions list revealed the reason the resident did not receive the medication was because of waiting for delivery from pharmacy.
Record review of charting notes dated, , for Resident #4 revealed the resident has been out of several medications for 3-5 days. Staff sent requests for medications to be refilled multiple times. MD and family notified of issue.

During an interview on at 1:32 PM with Resident #4's treating physician, he confirmed that Resident #4 is his patient. He stated he saw her last on . He was not notified that the resident did not receive her , , on and and , on , and . He sees his patients once a month at the facility.

Resident #5
An interview was conducted on at 2:45 PM with the facility LPN. She stated the , capsules were ordered for Resident #5 on . She stated the facility received the first dose of , at noon on .

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An interview was conducted on at 3:00 PM with the Administrator, who stated the was ordered on when Resident #5 was received in the facility from the hospital.

Record review of prescription for Resident #5, dated , revealed an order for 125 mg four times a day for 15 days.

An interview was conducted on at 3:05 PM with the Hospice clinical manager. She stated Resident #5 was on for a ( ) and . She stated Resident #5 was supposed to be on for 15 days, 4 times a day.

Record review of clinician narrative note from Hospice, dated , revealed that prescribed medications still were not at the Springs Oaks facility for Resident #5.

Record review of physician's order for Resident #5, dated , showed vanco recon solution 2.5 ml by mouth , and stop on .

Record review of the facility's Exception Report and Resident #5's MOR revealed Medication Exceptions (missed doses) while waiting for pharmacy delivery on , , , , and .

Class I

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on record review and interview, the facility Administrator failed to ensure that methods were implemented to ensure the timely delivery of prescribed medications for 5 of 5 residents (Resident #1, #2, #3, #4, #5), beginning in 2017 (Resident #5 was ordered on , but did not receive the medication for at least 10 days. Resident #1 stopped receiving prescribed on , and did not receive the prescribed for the remainder of the month of 2017).

Findings:

On at 11:38 AM in an interview with the LPN, she said the med techs can fax for refill. New orders are the nurse's responsibility. When we get new admissions we fax the Resident Health Assessment (AHCA Form 1823) to the pharmacy. Orders are delivered overnight Monday through Saturday. We are having some issues with our pharmacy if there is a medication requiring prior authorization, the pharmacy sends the medication to the doctor we then have to get an emergency filling

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and the facility is charged for it. Lead med techs can fax the orders, but we prefer nurses to do it. To ensure dosages are not missed, once they are profiled in the computer system, the 1823 is faxed, then put the medication in quick Mar and have 24 hours to do that. Once the resident has been profiled, then the 1823 is compared to what the pharmacy has put in the computer.

In an interview on at 1:21 PM with the Med Tech, she said when there are no medication, we fill out a pharmacy order form and fax it to the pharmacy, and they usually have it to us on the same night. We have a problem with the pharmacy not delivering. It happened a few weeks ago, but I can't remember for which resident. She confirmed that a medication , was missed on the evening of . Record review of the exception sheet revealed the medication was missed due to waiting for delivery from pharmacy. She said the , is given for the resident's pain. She said if the medication is not delivered the nurse will follow-up.

Review of 15-Day Adverse Incident Report, dated , regarding Resident #1, stated in part: Resident was ordered by MD to be on , . Resident received last dose on AM. Pharmacy was notified on and was to send out med. On it was noted med was not delivered. Pharmacy was notified and indicated they would refill and send STAT. On a new prescription was obtained from MD and sent to pharmacy. Family picked resident up for LOA on . On family notified community that resident suffered a and was admitted to hospital where she remains at this time. The report continued: B. Corrective or proactive action(s) taken: none, resident expired at hospital. The 15-Day Adverse Incident Report was completed and submitted by the facility Administrator.

Record review of Daily Clinical rounds guideline policy published revealed that Exception and missed medication reports are pulled daily to verify medications are being given per physician orders.

In an interview with the administrator on at 12:21 PM, regarding the documentation reports, she said they don't have a copy of the report or any documentation to support that the Exception Report is used to audit records for missing medication doses.
The Administrator confirmed that residents had not been receiving prescribed medications due to the pharmacy not delivering some of the medications to the facility.

Class II