STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968805	R 04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE BONITA SPRINGS	**11400 LONGFELLOW LN** **BONITA SPRINGS, FL 34135**

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

0000 - Initial Comments

An unannounced revisit survey was conducted on at American House Bonita Springs, an assisted living facility (license #12672) in Bonita Springs, Florida.

This was a follow-up to the relicensure and Limited Nursing Services survey completed on .

The following is a description of the deficiencies found at the time of the visit.

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

Based on record review and interview, the facility failed to have documentation of the health care provider notification of resident refusal of medication and/or medication omissions/errors for 8 (Resident #5, #11, #15, #16, #17, #18, #19, and #20) out of 8 residents sampled.

The findings included:

Review of the , 2017 Medication Administration Record (MAR) computer records, on , revealed:

1. Resident #11 failed to have documentation to demonstrate that Trisiba Flextouch 34 Units ( ) was administered at 7:30 a.m. on 4/7 and . Lacked documentation that 4 Units ( ) was administered at 7:30 a.m. on 4/7 and ; 11:30 a.m. on 4/7 and and 4:30 p.m. on 4/4, 4/7, and . In addition, 4 Units ( ) was not administered on 4/6 at 4:30 p.m. with documentation stating "resident was out of apartment and did not show up to nurses office for injection" and on at 4:30 p.m. with documentation stating "refused."

2. Resident #15 failed to have documentation to demonstrate that Levofloxcin 780mg ( ) was administered for 10 days per physician order (only 8 doses were documented through at 9:00 a.m. (eight days). On 10mg was not administered at 9:00 p.m. with documentation stating "awaiting order." , 50 mg was not administered at 9:00 a.m. on 4/4 and with documentation stating "refused" and 150mg ( ) was not administered on , , with documentation
stating "awaiting order," "only one time dose" and "called the pharmacy already." On and the medication was recorded as given.

When questioned at 10:30 a.m. on , with the Corporate Director of Wellness (CDW) present, Licensed Practical Nurse (LPN) Staff A stated, "That was a one time dose.

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3. Resident #16 failed to have documentation to demonstrate [illegible] (Parkinson's treatment) was administered at 3:00 p.m. on 4/1, 4/3, 4/8, and and at 6:00 p.m. on . In addition , 81mg was not administered at 9:00 p.m. on with documentation stating "awaiting order" and , 15mg (,) was not administered at 9:00 p.m. on with documentation stating "called the pharmacy already and daughter notified."

Interview of LPN Staff A, Medication Technician Staff B and Medication Technician Staff C at 12:00 p.m. on revealed that "awaiting order" meant the medication did not arrive from pharmacy.

4. Resident #17 did not receive Polyethyline , 3350 17gm on at 9:00 a.m. with documentation stating, "resident said she don't need it today." Did not receive 5mg ( ) at 5:00 p.m. on 4/1, 4/3 and with documentation stating "refusal", "not in" and "awaiting order."

5. Resident #19 failed to have documentation that Lubricant Eye Drops, 1 drop both eyes, was administered on at 5:00 p.m. and that , 1000mcg/ml 1ml was administered as scheduled on at 9:00 a.m. A hard (paper) copy of a MOR (Medication Observation Record) shows , 1000mcg/ml 1ml was administered on 4/8 and . This represents conflicting documentation and creating a potential for error (additional doses).

6. Resident #5 failed to have documentation that , 100mg was administered at 2:00 p.m. on 4/1, 4/7 and . In addition, the resident did not receive this medication at 2:00 p.m. on with documentation stating "oof (out of facility)."

7. Resident #18 failed to have documentation that , Fum 25mg (,) was administered at 3:00 p.m. on and and at 8:00 p.m. on ; that 50mg (for) was administered at bedtime on ; that 100mg was administered at 2:00 p.m. on 4/4 and and that , 15mg was administered at bedtime on .

8. Resident #20 failed to have documentation that Metroprolol Tart 25mg was administered at 2:00 p.m. on 4/4 and . In addition, Selsun Blue Natural 3% was ordered to be applied to scalp twice a week on Sunday and Wednesday, but was administered 3 times a week to include Saturday 4/1, Saturday 4/8 and Saturday .

Review of the medical record progress notes, for Resident #5, #11, #15, #16, #17, #18, #19, and #20, revealed no documentation regarding the foregoing omissions, refusals and errors being reported to the

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resident's healthcare provider.

The facility policy states, "The licensed nurse will contact the physician and responsible party for resident refusal of medications."

On at 10:30 a.m., the Corporate Director of Wellness (CDW) stated that a Medication Administration Record (MAR) computer program was implemented "around " and he thought contact of the physician and responsible party was a part of the program for refusal and missed doses of medication. The CDW contacted the computer programmer, at this time, and was advised that it was not included in the program. Further discussion revealed that no audits of this new MAR computer program were conducted at any time and the CDW was unaware of any omissions, refusals or errors. It was also discussed that duplicate hard (paper) copies of MOR's (Medication Observation Records) were still being completed for some medications and these documents presented conflicting information and presented the potential for errors.

Upon interview on at 2:15 p.m., the Administrator and CDW acknowledged that the medication administration records sampled contained missed dosages without documentation of a reason for the omission. They also acknowledged that the medication administration records contained refusals, omissions and medication errors that were not reported to the resident's healthcare provider. Some of these omissions involved significant medications such as , , and . In addition, it was agreed that some missed doses were the result of a failure to reorder medications in a timely manner. It was also agreed that pharmacy monthly restocking of medications did not allow for a 1 or 2 day backup of medications, in lieu of the potential for wasted (dropped, contaminated, etc.) medications.

The surveyor observed this restocking on at 12:00 p.m. and noted that most of the medication containers were empty prior to restocking. The CDW acknowledged that this restocking date correlated with some of the medication omissions.

Class III

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

Based on record review and interview, the facility failed to ensure medications were re-ordered timely to prevent missed dosages for 3 (Resident #15, #16, and #17) out of 8 residents sampled.

The findings included:

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Review of the , 2017 Medication Administration Record (MAR) computer records, on , revealed:

1. Resident #15 On 10mg was not administered at 9:00 p.m. with documentation stating "awaiting order", and 150mg ( ) was not administered on , , with documentation stating "awaiting order", "only one time dose" and "called the pharmacy already".

2. Resident #16 had documentation to demonstrate , 81 mg was not administered at 9:00 p.m. on with documentation stating "awaiting order" and , 150mg (,) was not administered at 9:00 p.m. on with documentation stating "called the pharmacy already and daughter notified."

3. Resident #17 did not receive 5mg ( ) at 5:00 p.m. on 4/1, 4/3 and with documentation stating "refusal", "not in" and "awaiting order."

4. Interview of LPN Staff A, Medication Technician Staff B and Medication Technician Staff C at 12:00 p.m. on revealed that "awaiting order" meant the medication did not arrive from pharmacy.

On at 10:30 a.m. the Corporate Director of Wellness (CDW) stated that a Medication Administration Record (MAR) computer program was implemented "around ." The CDW revealed that no audits of this new MAR computer program were conducted at any time and the CDW was unaware of any omissions for missing medications.

Upon interview on at 2:15 p.m., the Administrator and CDW acknowledged that the medication administration records sampled contained missed dosages without documentation of a reason for the omission. Some of these omissions involved significant medications such as , , , and . It was agreed that some missed doses were the result of a failure to reorder medications in a timely manner. It was also agreed that pharmacy monthly restocking of medications did not allow for a 1 or 2 day backup of medications, in lieu of the potential for wasted (dropped, contaminated, etc.) medications.

The surveyor observed this restocking on at 12:00 p.m. and noted that most of the medication containers were empty prior to restocking. The CDW acknowledged that this restocking date correlated with some of the medication omissions.

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0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review, observation, and interview, the facility failed to ensure that the facility quality assurance program developed plans of action to correct deficiencies cited during a relicensure survey conducted on and . These deficiencies involved failure to ensure healthcare provider notification regarding resident refusals of medication and failure to reorder medications in a timely manner resulting in omissions and errors.

The findings included:

Review of the , 2017 Medication Administration Records on , revealed that the facility failed to have documentation of the healthcare provider being notified of resident refusal of medication and/or medication omissions/errors for 8 (Resident #5, #11, #15, #16, #17, #18, #19, and #20) out of 8 residents sampled.

The facility policy states, "The licensed nurse will contact the physician and responsible party for resident refusal of medications."

On at 10:30 a.m., the Corporate Director of Wellness (CDW) stated that a Medication Administration Record (MAR) computer program was implemented "around " and he thought contact of the physician and responsible party was a part of the program for refusal and missed doses of medication. The CDW contacted the computer programmer at this time, and was advised that it was not included in the program. Further discussion revealed that no audits of this new MAR computer program were conducted at any time and the CDW was unaware of any omissions, refusals or errors relating to medication administration. It was also discussed that duplicate hard (paper) copies of MOR's (Medication Observation Records) were still being completed for some medications and these documents presented conflicting information and presented the potential for errors.

The CDW recognized that the facility must maintain daily medication administration records for each resident who receives assistance with self-administration of medications or medication administration. The medication record must include the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The medication record must be immediately updated each time the medication is offered or administered.

Upon interview on at 2:15 p.m., the Administrator and CDW acknowledged that the medication administration records sampled contained missed dosages without documentation of a reason for the omission. They also acknowledged that the medication administration records contained refusals,

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omissions and medication errors that were not reported to the resident's healthcare provider and not identified by the facility quality assurance program. Some of these omissions involved significant medications such as , , and . In addition, it was agreed that some missed doses were the result of a failure to reorder medications in a timely manner. It was also identified that the pharmacy monthly restocking of medications did not allow for a 1 or 2 day backup of medications, in lieu of the potential for wasted (dropped, contaminated, etc.) medications.

The surveyor observed this restocking on at 12:00 p.m., and noted that most of the medication containers were empty prior to restocking. The CDW acknowledged that this restocking date correlated with some of the medication omissions.

Class III