STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968826	**04/27/2017**
NAME OF PROVIDER OR SUPPLIER **ANGELS SENIOR LIVING IN NEW PORT RICHEY**	STREET ADDRESS, CITY, STATE, ZIP CODE **6716 CONGRESS ST** **NEW PORT RICHEY, FL 34653**	

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

0000 - Initial Comments

Assisted Living Facility

On , , 2017, a biennial re-licensure survey with extended congregate care (ECC) was conducted at Angels Senior Living in New Port Richey. Deficient practice was identified during the survey.

(License # 12688)

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

Based on observation and interview, the facility allowed an unlicensed person to administrate medications for 1 of 4 residents observed.

Findings included:

At 11:45am on , an observation was conducted of Staff A assisting with medication self-administration. Staff A is a Med Tech and is unlicensed to administer medications. Staff A identified Resident #12 and reviewed the resident's medication observation record (MOR) and determined that it was time for Resident #12's medications which included an encapsulated pill and some eye drops. Staff A used hand sanitizer and located the medications on the cart, compared the medication labels to the MOR, popped the encapsulated medication into a small cup of applesauce and, using a plastic spoon, inserted some applesauce with the medication into Resident #12's mouth. Staff A did not explain the medication to Resident #12 or assist the resident with self -administration. Then Staff A asked Resident #12 to tilt (the resident's) head back and instilled the eye drops - one drop into each of the resident's eyes and then, with a tissue, dabbed the resident's eyes. Staff A then documented in the MOR that the medications were given.

When asked, during an interview at 12:30pm, if there were any other residents that Staff A thought needed to have medications administered to them, the Staff A, replied ,"No, (Resident 12) is the only one."

Class III

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

Based on records review and interviews, the facility failed to maintain a daily medication observation record (MOR) for each resident who receives assistnace with self-administration of medications for 1 of 6 resident's records reviewed.

Findings included:

At 3:00pm on , a review of Resident #9's Medication Observation Record (MOR) for of 2017 revealed an order for a cream medication stating " cream to be applied to the area 3 times a day for 14 days and then as needed". According to documentation in the MOR, for the month of 2017, the resident received the medication from to (or 14 days) and then did not receive it again. The documentation in the resident's MOR for the month of , 2017 indicated that the resident was to receive the cream "as needed" but there were no entries that it had been given at all (photographic evidence available). In an interview with Staff A at 2:30pm, Staff A stated that the resident's cream ran out and had been ordered but it had not yet come from the pharmacy. A document that the facility provided, a copy of an order form to the pharmacy dated was reviewed and it showed that an refill order for Resident #9's cream was sent in to the pharmacy nearly a month after the resident's MOR indicated that the resident stopped receiving the medication (photographic evidence available).

At 3:30pm, in an interview with Staff D, a resident care supervisor, stated the order had not been filled because the pharmacy said that it was too soon to order it and that it would not be able to fill the prescription until , 2017. The facility could not provide any other documentation of contacting the pharmacy or the doctor regarding Resident #9's prescription for the cream.

At 4:00pm, in an interview with the Administrator, the Administrator revealed that Staff A and Staff D stated (to the Administrator) that they had been giving the Resident #9 the cream as the resident requested (as needed), but were not documenting it in the MORs for the reason that it was "too often".

Class III

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

Based on observations, interviews and records review, the facility failed to make every reasonable effort

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to ensure that prescriptions for residents who receive assistance with self-administration are filled or refilled in a timely manner for 2 of 10 residents interviewed.

Findings included:

In an interview the morning of , Resident #4 stated that the facility had run out of one of the resident's inhaled medications that was to be used twice a day for a chronic of the lungs. A review of Resident #4's Medication Observation Record (MOR) for , 2017 revealed that Resident #4 had been without the medication " " for nearly 2 weeks (photographic evidence available). Beginning on , Resident # 4's MOR showed that that the medication was not administered due to its unavailability. Twice a day, in the morning and in the evening, from to , the MOR record indicated that the medication was not available.

In an interview with Staff D, a resident care supervisor, at 1:20pm on , Staff D stated that the medication ran out and that the facility was having problems with the pharmacy in filling the prescription. At 1:40pm on , Staff D stated they would need to call the doctor and try to have the medication discontinued because the pharmacy was not able to obtain it. Staff D stated that prior to that, the facility had not called the physician regarding the issue of the medication's unavailability from the pharmacy. At 1:47 Staff D stated that Resident D would have to pay a co-pay of $121 to obtain the medication and that the resident does not have the money. Staff D provided a record copy of a faxed order to the pharmacy for the medication dated , which was 2 days after the medication apparently ran out according to the MOR (photographic evidence available). The facility was unable to provide any other documentation to verify that they had attempted to contact the pharmacy or the doctor regarding Resident #9's .

In an interview with Resident #9 at 2:10pm on , the resident stated that the facility ran out of a medication cream that the doctor had ordered. Resident #9 stated that Staff D told the resident that the facility would not be able to provide the ordered cream for at least a month because the pharmacy said the resident "had used too much". The cream medication was for an irritating condition that the resident was being treated for.

A review of Resident #9's Medication Observation Record (MOR) for of 2017 revealed an order for the cream medication stating " , cream to be applied to the area 3 times a day for 14 days and then as needed". According to documentation in the MOR, for the month of 2017, the resident received the medication from to (or 14 days) and then did not receive it again.

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The documentation in the resident's MOR, for the month of , 2017, indicated that the resident was to receive the cream "as needed" but there were no entries that it had been given at all (photographic evidence available). In an interview with Staff A at 2:30pm, Staff A stated that the resident's cream ran out and had been ordered but it had not yet come from the pharmacy. A document that the facility provided, a copy of an order form to the pharmacy dated was reviewed and it showed that an refill order for Resident #9's cream was sent in to the pharmacy nearly a month after the resident's MOR indicated that the resident stopped receiving the medication (photographic evidence available).

At 3:30pm, in an interview with Staff D, a resident care supervisor, stated the order had not been filled because the pharmacy said that it was too soon to order it and that it would not be able to fill the prescription until , 2017. The facility could not provide any other documentation of contacting the pharmacy or the doctor regarding Resident #9's prescription for the cream.

At 4:00pm, in an interview with the Administrator, the Administrator revealed that Staff A and Staff D stated (to the Administrator) that they had been giving the Resident #9 the cream as the resident requested (as needed), but were not documenting it in the MORs for the reason that it was "too often".

According to the facility's Policy & Procedure for Ordering Medications, reviewed on , the facility "will order the medication from the pharmacy, contact doctors for refills, and do all we can to assure that residents have their medications refilled in a timely manner. " In an interview with the Administrator at 4:30pm on , a timely manner means, "Before the prescription runs out."

Class III