STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910367	05/02/2017
NAME OF PROVIDER OR SUPPLIER **CRESTHAVEN EAST**	STREET ADDRESS, CITY, STATE, ZIP CODE **5100 CRESTHAVEN BLVD.** **HAVERHILL, FL 33415**	

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

0000 - Initial Comments

An unannounced licensure complaint surveys, CCR# 2017001755, #2017002153, and 2017002471, was conducted on . . . . at Cresthaven East, License #4769. The facility had deficiencies identified at the time of the survey.
Deficient practice identified at CCR#2017001755.

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

Based on observation, staff interview and record review, the facility failed to maintain an accurate medication record for 1 of 3 residents whose Medication Record was reviewed (Resident #10).

The findings included:

On at 9:43 AM, this surveyor observed the Med Tech for Cart D (Staff A) provide medication assistance to Resident #10. Staff A sanitized her hands and removed the resident's medication bottles from the locked medication cart. Staff A compared the Medication Record with the medication label, but did not catch a discrepancy between the medication label on the prescription bottle of , , 5 mg, and the dosage information documented on the current monthly Medication Record (, 2017). The Medication Record is to contain the same information from the physician orders as what is printed on the medication label placed on the medication containers. These Medication Records are used to document when a medication is provided to the resident. The , 2017 Medication Record for Resident #10 documented , 5 mg was to be provided once daily. The medication label instructed , 5 mg to be provided twice daily. Staff A took the medications in it's original container into the resident's apartment, removed medication from the bottle, and placed into small, plastic medication cup.
Staff A provided the , . . to Resident #10 and observed the resident swallow the pill.
Staff A initialed the Medication Record next to the , documenting the medication was given.

When the discrepancy between the label on the bottle of , and the dosage information on the Medication Record was brought to Staff A's attention, she stated she was not aware of the difference and did not know which was correct. She stated she would let the nurse know of the discrepancy.

A review of the Medication Record for , 2017 revealed , dosage was documented at 5 mg twice daily, which was provided as ordered.

On . . . . . , at approximately 1:00 PM, the Director of Nursing submitted a Medication Error Form showing the , dosage error documented on Medication Record received from pharmacy was reported to physician and pharmacy on . . . . . at 10:30 AM. The error was corrected on the

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Medication Record, and the pharmacy was notified to correct error on their documentation.

Class III

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

Based on observation, staff interview, and record review, Staff A failed to secure medications for 1 of 2 residents whose medication assistance was observed (Resident #10).

The findings included:

On at 9:43 AM, this surveyor observed the Med Tech for Cart D (Staff A) provide medication assistance to Resident #10. Staff A sanitized her hands and removed the resident's medication bottles from the locked medication cart. Staff A compared the MOR with the medication label, and she took the medications in their original containers into the resident's apartment. Staff A removed medication from 12 containers and placed the medication into a small, plastic medication cup. At this time, Staff A walked out of the apartment, without explaining her need to leave, and left all the unsecured medication bottles, the unsecured/uncovered pills sitting in the small medication cup, and 4 pages of Resident #10's Medication Record sitting on the resident's table (photo evidence obtained).
Staff A was out of the Resident's apartment for 4 minutes before returning.
At the time of return, Staff A proceeded to take the Resident's and record the results.
Staff A then handed the cup of pills to the resident, informing her of each medication.
She observed the resident swallow the pills, and initialed the Medication Record for each 9 AM medication, even though she had not verified all the medications after leaving them unattended for 4 minutes.

On at 2:45 PM. the Director of Nursing (DON) was notified that Staff A had left the medication unsecured during Med Pass Observation. The DON acknowledged medication is not to be left unattended and unsecured at any time, even in the presence of AHCA surveyor. The Administrator was also informed of the finding during exit conference at 3:15 PM.

Class III