STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964934	**05/22/2017**
NAME OF PROVIDER OR SUPPLIER **CABOT RESERVE ON THE GREEN**	STREET ADDRESS, CITY, STATE, ZIP CODE **4450 8TH STREET** **SARASOTA, FL 34232**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR# 2017004841 was completed on at Cabot Reserve on the Green, an Assisted Living Facility (license # 9381) located in Sarasota, Florida.

The complaint contained 2 allegations, of which both were substantiated with a deficiency.

The following is description of the deficiencies.

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

Based on record review and resident family interview the facility failed to notify Resident #3's family of a significant change that resulted in the resident going to the hospital.

The findings included:

Review of a fax in Resident #3's record revealed the fax arrived from the ARNP on at 3:50 p.m. to send Resident #3 to a local hospital for 24 hour observation, " [diagnosis] [arrow up-increased] INR greater than 7."

A review of records from the local hospital found Resident #3 was an inpatient from , 2017 through , 2017 and with an admission diagnosis of an elevated INR.

During an interview on at 2:00 p.m., Resident #3's family member said when she had been visiting a few weeks ago she noticed Resident #3 had . She said staff told her they had noticed it and immediate lab work had been ordered. Resident 3's family member said she was never notified by the facility or physician that Resident #3 was sent to the hospital and was there from , 2017 through , 2017.

Class III

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

Based on record review and staff interviews, the facility failed to properly document and dispense medication per provider order for 3 (Residents' #1, #2 and #3) of 3 residents who received assistance with self-administration of medication. This failure contributed to increased and hospitalization of Resident #3 related to critical laboratory values and need for medical intervention.

The findings included:

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1. Review of Resident 3's record showed a physician's order dated to hold on and start 2 mg. by mouth daily on .

On , the facility received a new physician's order to change to 3 mg. by mouth every day and repeat /INR (Prothrombin/international normalized ratio- a measurement of clotting time) in 5 days. The order showed someone faxed this order to pharmacy on at 3:39 p.m. but it was not initialed or signed.

On , another physician's order was hand written by a Licensed Practical Nurse (LPN) to increase ( ) to 3 mg. and redraw lab work on . This was signed off by the physician on .

Review of the , 2017 Medication Observation Record (MOR) showed the dose was not increased from 2 mg. to 3 mg. per physician's orders. Instead, Resident #3 received both doses (5 mg. total) of between through -approximately 13 doses.

On , a physician order form was faxed to the doctor which included: " ... Resident [#3] has an order for 2 mg at 4 pm and another 3 mg at 8 am. He is experiencing a lot of . Please advise. Nurse made call to hold the 2 mg for a cpl [couple] days. Please advise if it should be d/c [discontinued] or dosing can be adjusted." The return order on the same day at 3:04 p.m. by the Advanced Registered Nurse Practitioner (ARNP) said to discontinue all previous orders and hold the on and , and to restart the 3.5 mg. 1 tablet by mouth every day on ; /INR to be redrawn on .

Another fax arrived from the ARNP on at 3:50 p.m. to send Resident #3 to a local hospital for 24 hour observation, " [diagnosis] [arrow up-increased] INR greater than 7."

Review of the unsigned resident progress notes found the following: " ...Requested a stat [immediate] /INR draw which came back greater than 7. Told the ARNP, whom then exclaimed to me that it was obviously our fault for not D/C [discontinuing] the old order ...He was sent to the hospital. Family was being notified by physician."

During an interview on at 2:00 p.m., Resident #3's family member said when she had been visiting a few weeks ago she noticed Resident #3 had . She said staff told her they had noticed it and immediate lab work had been ordered. Resident 3's family member said she was never notified by the facility or physician that Resident #3 was sent to the hospital and was there from , 2017

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through , 2017. Resident #3's family member said the staff at the facility told her the nurse from the Doctor's group had changed the order, and in that order the doctor's nurse didn't discontinue the original order and he ended up getting too much. Resident 3's family member said she asked why someone didn't notice this and the response was, "the med techs at night don't see what medications the med techs give during the day."

In an interview on at 2:50 p.m. with the Administrator (ADM) and Resident Care Manager (RCM) Staff A, the RCM said she thought there had to be a discontinue order from the physician to discontinue any medications. RCM Staff A suggested the pharmacy should have caught it. The ADM said a nurse would and/or should know that when a change or increase order comes in for , it negates the previous order. The ADM said someone should have been in contact with the physician to clarify the orders.

No documentation in the record showed anyone had contacted the physician to clarify the orders.

A review of records from the local hospital found Resident #3 was an inpatient from , 2017 through , 2017 and with an admission diagnosis of an elevated INR. Hospital lab reports listed a therapeutic range of 2.0 - 3.0 for INR results, and 22.0 - 39.5 for . Review of the hospital lab values on at 7:04 p.m. revealed an INR of 8.54 and a of 98.5. Lab values for at 5:00 a.m. revealed an INR of 6.15 and a of 70.2. Hospital reports noted Resident #3 was being treated with K and by day 3, on at 5:16 a.m., they were able to decrease INR to 1.43 and to 15.6.

2. Review of the 1823 Health Assessment dated for Resident #2 included orders for 2.5 mg. and 3.0 mg. every other day, alternating days between the two. A review of the MOR showed 2.5 mg. and 3.0 mg. were given together on , , 2017, , , 2017, and on , , 2017.
During an interview on at 12:58 p.m., the ADM admitted it looked like it was being given wrong in , . There was no documentation the physician was notified.

3. Record review for Resident #1 showed a physician's order dated for 2.5 mg. on Monday, Wednesday and Friday, and 5 mg. on Saturday, Sunday, Tuesday and Thursday.

A review of the Medication Observation Record (MOR) for , 2017 showed Resident #1 did not receive the from , , 2017 through , , 2017.

During an interview on at 12:30 p.m., the Administrator (ADM) verified the areas on the MOR were blank and was unsure why.

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In an interview on . . . . at 12:31 p.m., Resident Care Manager (RCM) Staff A reviewed the record and said maybe the pharmacy didn't deliver it. She said the only thing she could think of was the medication wasn't at the facility or someone took a verbal (order) to hold.

On . . . . at 12:37 p.m., the ADM and RCM Staff A agreed they were unable to find any documentation of why the medication wasn't given per order or that the doctor was notified.

Class II