STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966519	R 05/24/2017
NAME OF PROVIDER OR SUPPLIER **INDIGO PALMS AT MAITLAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **740 NORTH WYMORE ROAD** **MAITLAND, FL 32751**	

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

0000 - Initial Comments

A revisit to a complaint investigation (2017003496) was conducted on , , and . Indigo Palms at Maitland, license #10704, had deficiencies at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

DEFICIENCY REMAINED UNCORRECTED

Based on record reviews and interviews the facility did not ensure the health assessment form 1823 was complete for 5 of 26 sampled residents (#3, #17, #30 and #37).

Findings:

1. Record review for resident #3 revealed a health assessment form 1823 that was dated . The question that pertained to whether he required 24-hour nursing or , , care was not answered.

On at 1:00 pm, the resident care coordinator confirmed the finding.

2. Record review for Resident #17 revealed a Resident Health Assessment form (1823) that was completed by the health care provider on . The health care provider did not document the type of assistance the resident required with his medications. That section was left blank.

On at 2:10 PM the resident care coordinator confirmed the finding.

3. Resident record review for resident #30 revealed a health assessment report 1823 dated that did not indicate the type of assistance needed with self-administration of medications, that portion of the assessment was blank.

4. Resident record review for resident #37 revealed a health assessment report 1823 dated that did not indicate the type of assistance needed with , , that portion of the assessment was blank.

In an interview on at 1 PM with staff V who stated the revised health assessments were not available.

Class III

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

DEFICIENCY REMAINED UNCORRECTED

Based on observations, record reviews, and interviews, the facility failed to ensure 5 of 26 residents (#1, #20, #25, #36, and #37) received their medications as prescribed by a healthcare provider.

Findings:

1. During an interview with resident #1 on at 11:22 am, she said the facility continued to run out of her medications.

Record review for resident #1 revealed a health assessment form 1823 dated that indicated she had a diagnoses of and (.)

Review of the 2017 Medication Observation Record (MOR) for resident #1 revealed an entry for 30 milligrams (mg,) take 1 tablet by mouth every 6 hours and it was scheduled for 12:00 am, 6:00 am, 12:00 pm, and 6:00 pm. The initials for the 12:00 am doses on , and were circled and documentation on the back of the MOR indicated that the medication was not in the cart and was not given.

An entry for 50 mg, take 1 tablet by mouth daily that was scheduled for 8:00 am, the initials for the , , and doses were circled and documentation on the back of the MOR indicated that the medication was not in the cart and was not given.

An entry for , , / , 1 vial via every 4 hours around the clock that was scheduled for 12 am, 4 am, 8 am, 12 pm, 4 pm, and 8 pm. The initials for the 8 am and 12 pm doses on were circled. The initials for the 12 am, 6 am, 8am, 12 pm, and 4 pm doses on were circled. The initials for the 12 am, 6 am, and 8 am doses on were circled. Documentation on the back of the MOR indicated that the medication was not in the cart and was not given.

During an interview with the resident care coordinator on at 8:42 am, she confirmed the findings on the MOR and said the and were probably in a different cycle package because it didn't make sense that it would be given the day before and the day after and the staff member probably didn't know the medication was in a different cycle package. She said the facility process was that staff were supposed to write a communication form when a medication was unavailable but in this case, the staff member didn't follow protocol. She said she guessed that the was unavailable and that it had to be reordered.

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2. Review of the record for resident #25 revealed a Health Assessment (1823) updated on documenting diagnoses of and . He required assistance with self-administration of medications.

A review of the Medication Observation Record (MOR) for 2017 revealed 2 eye drops among his medications. 0.2% OP Sol, 1 drop in each eye every 8 hours- On 6am it was noted on back of the MOR as "waiting on refill." On the front of MOR the date was circled for not giving the med at 6am and again on at 6 am. The 2 pm & 10 pm doses were initialed as being given on and . , 0.005% sol, 1 drop in each eye at bedtime. It was noted on back of MOR on at 8 pm and at 8 pm as "waiting on refill." The front of MOR shows bedtime doses circled as not given on , and .

In an interview with the interim nursing director on at 12:40 pm, she confirmed the documentation on the MOR and said it would not make sense for the medications to be on order, then available, then on order again on the same dates. She said more re-education was required.

3. The MOR dated 2017 for resident #20 listed 5-325 mg one tablet twice daily @ 8 AM & 5 PM and had staff initials on @ AM, @ 8 AM & 5 PM and @ 8 AM. The back page of the MOR indicated that the medication was not available /awaiting refill. The health assessment report dated indicated he needed assistance with self-administration of medications.

4. Resident #36 lived in the memory care unit. The health assessment report 1823 dated listed diagnoses of high , and . She needed assistance with self-administration of medications. A healthcare provider's order dated indicated the family requested mouth gel and an order was needed. The MOR dated 2017 listed dry mouth gel apply to and , after meals @ 8 AM , 2 PM & 8 PM and had staff initials circled on 5/7 and 6/8 for all dosages, and 5/8 @ 8 AM & 12 PM. The back page the MOR indicated that on 5/7 and 5/8 for all dosages the gel was not applied because it as was not available/awaiting refill.

5. According to the health assessment, report 1823 dated resident #37 needed assistance with self-administration of medications. He lived in the memory care unit. A healthcare provider's order dated indicated tears one drop to each eye every 4 hours. The MOR dated 2017 listed

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tears one drop to each eye every 4 hours at 9 AM, 12 PM, 4 PM and 8 PM. The MOR had staff initials circled on at 4 PM and 8 PM, for all dosages and 8 AM and 12 PM. The back page of the MOR indicated that eye drops were not given because the medication was not available/awaiting delivery on : @ 4 & 8 PM , @ 8 &12 PM , @ 8 AM &12 PM, @ 8 AM, 12 & 8 PM , @ 8 AM , 12 & 8 PM, 4 & 8 PM, @ 12 PM, and @ 8 AM & 12 PM.

Individual record review revealed no notations that the healthcare provider or resident's responsible party were made aware the residents did not have the medications as ordered.

In an interview on at 1:45 PM with staff N, a licensed Practical nurse and staff M who said, after asking each other, that the residents' sons did not bring the medications.

Class III

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

DEFICIENCY REMAINED UNCORRECTED

Based on medication pass observations and interview the facility failed to ensure the unlicensed staff who assisted 2 of 4 sampled residents (#24 and #29) with self-administration of medications followed the correct procedure.

Findings:

1. Observations made during a medication pass for resident #24 on at 7:45 am revealed staff M, an unlicensed caregiver, approached the medication cart that was located in the nurse's station. Staff M removed the medication containers from the cart and compared the labels to the Medication Observation Record (MOR). Staff M placed the pills in a plastic bag, crushed the pills, and then placed them in applesauce. Staff M took the medication and the medication containers to resident #24, who was sitting in the day . Staff M read the medication labels to resident #24. Staff M placed the applesauce that contained the medication onto a spoon and handed the spoon to resident #24, who ate the applesauce without assistance.

Staff M did not prepare the medication in the presence of resident #24, as required.

During an interview with the resident care coordinator on at 8:45 am, she said staff M did not prepare the medications in the presence of resident #24 because the lock on the medication cart was

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broken and the staff were unable to take the cart out of the nurse's station to take it to the resident.

2. Observations on [redacted] 1:30 PM in the memory care unit noted that staff M took the individual pill from the cart, signed the Medication Observation Record (MOR), took water and the pill to resident #29. The resident sat in a wheelchair in the dining [redacted]. He was [redacted] and attempted to feed himself. She told him "I have your 2 o'clock medication".

She attempted to have the resident hold the cup with the pill and he was unable to, the resident was sleepy/sluggish. She took the cup, brought it to the resident's mouth, and gently tilted his head back as she tried to put the pill in his mouth. He did not take it, so she tried again. She observed him swallow the pill and then she was finished.

In an interview on [redacted] at 2:30 PM with staff V, a licensed Practical nurse who said staff M needed more training.

Class III