STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953664	**05/30/2017**
NAME OF PROVIDER OR SUPPLIER **MIDWAY MANOR RETIREMENT RESIDENCE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1754 ENSLEY AVENUE** **CLEARWATER, FL 33756**	

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

0000 - Initial Comments

Assisted Living Facility

Three complaint investigations, (CCR# 2017002656, CCR# 2017002777, and CCR# 2017003594) were conducted at Midway Manor ALF on . Midway Manor ALF had deficiencies at the time of the visit.

(License # 8632)

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

Based on observation, interview and record review, the facility failed to (1) provide medications at the prescribed time for one (#7) of five sampled residents; (2) provide two prescribed medications, and notify or obtain approval (verbal or written) from resident's health care provider for changes to frequency for one prescribed medications given to one (#10) of five sampled residents for medication review, and; (3) ensure that one (#13) of five sampled resident received a total of eight daily prescribed nigh medications.

Findings included:

1)
During medication assistance observation with Staff B, conducted on at 04:40 p.m., it was observed that medication bubble packaging, for Resident #7, was missing the dosage scheduled and labeled for Tuesday, , 2017 at 05:00 p.m. Staff B was unable to locate dosages of scheduled medication. Staff B also was unable to locate Resident #7 ' s powdered mixed medication.
Review of the Medical Observation Report (MOR) revealed that resident was supposed to receive the missing medications daily at 05:00 p.m.

During interview with the Facility Director, on at 06: 25 p.m., she stated that another unidentified staff removed the tablets for the wrong day; she also located the powdered mix. The Facility Director gave Resident #7 the medication dosages for self-administration by mouth. The Facility Director confirmed that the medication dosages were given after the one-hour grace period that a resident should receive their medication dosages.

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2)
At Approximately 05:15 on . . . . . , while conducting a medication assistance observation with Staff B, Resident #10 stated that the Assistant Administrator denied her scheduled 02:00 p.m. pain medication. Review of the MOR revealed that resident was to receive the pain medication scheduled for, and documented as given at a six-hour frequency for a total of six days. Further review of the MOR revealed that the medication was to be given every eight hours.
Review of the physician orders dated confirmed that Resident #10 was to receive the medication every eight hours.
During interview with the Facility Director, on at 07:02 p.m., she confirmed that the facility has been giving at eight in the morning and at two in the afternoon; which conflict with physician orders and MOR instructions to take.

At Approximately 05:15 on , while conducting a medication assistance observation with Staff B, Resident #10 stated that the facility failed to provide her with scheduled nasal spray and oral inhaler since her arrival to the facility.

At 05:36 p.m., after searching, Staff B stated that she was unable to locate Resident #7 ' s Disk inhaler or nasal spray.

Review of the MOR revealed that staff has documented the nasal spray and the disk inhaler as administered twice daily from through .

During interview joint with Staff C and The Facility Director, conducted on at 06:56 p.m., Staff C stated that she has not given Resident #10 any nasal spray, or a disk-shaped inhaler. Staff C confirmed that her initials on Resident #10 ' s MOR indicated that the nostril spray and inhaler (disk) was given from 05// through . Staff confirmed that she has not given the inhaler (disk) or the nasal spray to Resident #10 since resident ' s arrival.

3)
On . . . . . , at approximately 09:15 p.m., during the eight o ' clock medication pass, Resident #13 expressed that he did not get his medications and that staff was unable to locate the bubbled pack of his medication. Staff B and C was observed searching for the medication packaging.
Review of the MOR and physician orders revealed that the missing medication package contained one prescribed medication, scheduled daily for six in the evening; and seven prescribed medications scheduled for eight at night daily.

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SUMMARY STATEMENT OF DEFICIENCIES
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On , at approximately 10:00 p.m., Staff B and C confirmed that they were unable to locate the bubble-packaged medications that belonged to Resident #13. Staff B and C confirmed that Resident #13 did not receive the scheduled night (8:00 p.m.) medications. Staff B and C notified the Administrator of missing medications.
n , at 12:04 a.m., the Facility Director and Administrator confirmed that that Resident #13 did not receive his evening and night medications that were in the bubble pack. The physician and pharmacy has been notified and Resident #13 ' s medication will be delivered to the facility tomorrow morning at 7a.m.

Class III

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

Based on interview, and record review, the facility failed to accurately document missed dosages of prescribed medications in the medication observation record (MOR) for one (Resident #10) of five sampled residents for medication review.

Findings included:

At approximately 05:15 on , while conducting a medication assistance observation with Staff B, Resident #10 stated that the facility failed to provide her with scheduled nasal spray and oral inhaler since her arrival to the facility.

On at 05:36 p.m., Staff B stated that she was unable to locate Resident #7 ' s Disk inhaler or nasal spray after searching the medication cart.

Review of the MOR revealed that staff documented the nasal spray and the disk inhaler as administered twice daily from through .

During interview joint with Staff C and The Facility Director, conducted on at 06:56 p.m., Staff C stated that she has not given Resident #10 any nasal spray, or a disk-shaped inhaler. Staff C confirmed that her initials on Resident #10 ' s MOR indicated that the nostril spray and inhaler (disk) was given from 05// through . Staff confirmed that she has not given the inhaler (disk) or the nasal spray to Resident #10 since resident ' s arrival.

Class III

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