STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964835	**06/20/2017**
NAME OF PROVIDER OR SUPPLIER **HARMONY PLACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **11937 NW 31ST STREET** **CORAL SPRINGS, FL 33065**	

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

0000 - Initial Comments

An unannounced standard biennial survey was conducted on at Harmony Place Assisted Living Facility, License 9289. There were deficiencies found at the time of the survey.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, interview, and record review, the facility failed to determine the appropriateness of continued residency, for 1 of 6 sampled residents (Resident #1).

Findings include:

In an interview on at 11:25 AM, Staff B and C, stated that they were home health aides and that they were not licensed staff.

In an observation of a medication pass on at 5:05 PM, Resident #1 was laying in her bed and Staff B raised the bed to place Resident #1 in an upright position. In an observation at this time, Staff C crushed 3 medications (Calcarb 600, Carb-Lev , and Rantitidine 150 MG) and placed the crushed medication into a bowl of applesauce. Staff C took a spoonful of the applesauce with crushed medication and attempted to place the spoon into Resident #1's right hand, while Staff B was trying to lift up Resident #1's right arm. Staff B stated, "She (resident #1) cannot move the hand. It's a arm". Staff C then took the spoonful of applesauce with crushed mediation and pushed the spoonful of medication through resident #1's slightly opened mouth. Staff C repeatedly placed spoonfuls of applesauce with medication into resident #1's mouth until there was no remaining applesauce. Staff C then signed the medication observation record for resident #1.

A review of resident #1's file on documented that the most recent 1823 health assessment was dated and that the box was checked for "needs assistance with self-administration of medications".

Class III

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

Based on observation, interview and record review, the facility failed to maintain an updated written record of significant changes pertaining to medication administration, for 1 out of 6 sampled residents (resident #1).

Findings include:

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In an interview on at 11:25 AM, Staff B and C, stated that they were home health aides and that they were not licensed staff.

In an observation of a medication pass on at 5:05 PM, Resident #1 was laying in her bed and Staff B raised the bed to place Resident #1 in an upright position. In an observation at this time, Staff C crushed 3 medications (Calcarb 600, Carb-Lev , and Rantitidine 150 MG) and placed the crushed medication into a bowl of applesauce. Staff C took a spoonful of the applesauce with crushed medication and attempted to place the spoon into Resident #1's right hand, while Staff B was trying to lift up Resident #1's right arm. Staff B stated, "She (resident #1) cannot move the hand. It's a arm". Staff C then took the spoonful of applesauce with crushed mediation and pushed the spoonful of medication through resident #1's slightly opened mouth. Staff C repeatedly placed spoonfuls of applesauce with medication into resident #1's mouth until there was no remaining applesauce. Staff C then signed the medication observation record for resident #1.

A review of resident #1's file on documented that the most recent 1823 health assessment was dated and that the box was checked for "needs assistance with self-administration of medications".

Class III

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

Based on record review, interview, and observations, the facility failed to follow the correct procedures when assisting a resident with self-administered medications, for 1 out of 6 sampled residents (Resident #4).

Findings include:

A review of the prescription label and medication observation record for resident #4 on , documented that resident #4 had a 5:00 PM dosage of Polyethylene 3350 (powder) with directions of "Dissolve 17 GM (grams) in 8 oz (ounces) of water/juice and drink".

In an interview with the Administrator on at 5:40 PM, she stated that there was no measurement instrument in the medication cart for resident #4's . In an observation at this time, the Administrator used her phone to look up the conversion for 17 GM to teaspoons. The Administrator told Staff B and C that 17 Grams was equivalent to 4.5 teaspoons.

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In an interview with Staff B on at 5:40 PM, she stated that she uses one scoop from a blue scoop-measuring instrument that was in a kitchen cabinet. In an observation of the blue measuring scoop at this time, there were two measurements, one for 1 teaspoon and the other for 1 tablespoon.

In an interview with Staff C on at 5:45 PM, she stated that she did not know how many teaspoons are in 17 grams and that she did not know how to measure 8 ounces of liquid.

In an observation of a medication pass on at 5:45 PM, Staff C used a silverware teaspoon to measure an unknown amount of the Miralax powder for Resident #4. At this time, the agency asked why Staff C was using a silverware teaspoon, instead of a measurement scoop provided by the pharmacy, and the Administrator stated that the powder was already out of the container and could not go back into the original medication container. Staff C then mixed an unknown amount of powder into a Styrofoam cup with water. Staff C did not measure the amount of water in the cup.

In an observation of a medication pass on at 5:50 PM for resident # 4's , Staff C told resident #5 that she had her medication in the cup and that it was a medication used for digestion. Staff C did not state the name of the medication at this time. Staff C handed the cup with water and to resident #4. Resident # 4 stated that she never knew about this mediation because she only takes one red pill at night. Resident #4 stated that the medication must be for her and not for her. Resident #4 stated that she did not take medication mixed with water earlier that day and that she only takes pills. Staff B stated that she put the medication into resident #4's orange juice the morning of . Resident #4 stated that Staff B did not inform her that there was medication in her orange juice that morning.

A review of Resident #4's medication observation record on , documented that the 8:00 AM dosage on of Polyethethylene 3350 (Powder) was signed by Staff B.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview and record review, the facility failed to provide medication administration by a licensed staff member, for 1 of 6 sampled residents (Resident #1).

Findings include:

In an interview on at 11:25 AM, Staff B and C, stated that they were home health aides and that they were not licensed staff.

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In an observation of a medication pass on at 5:05 PM, Resident #1 was laying in her bed and Staff B raised the bed to place Resident #1 in an upright position. In an observation at this time, Staff C crushed 3 medications (Calcarb 600, Carb-Lev , and Rantitidine 150 MG) and placed the crushed medication into a bowl of applesauce. Staff C took a spoonful of the applesauce with crushed medication and attempted to place the spoon into Resident #1's right hand, while Staff B was trying to lift up Resident #1's right arm. Staff B stated, "She (resident #1) cannot move the hand. It's a arm". Staff C then took the spoonful of applesauce with crushed mediation and pushed the spoonful of medication through resident #1's slightly opened mouth. Staff C repeatedly placed spoonfuls of applesauce with medication into resident #1's mouth until there was no remaining applesauce. Staff C then signed the medication observation record for resident #1.

A record review of Staff C's employee file on , revealed that she completed 4 hours of "Assisting the Elderly with Medication Administration" on .

A review of resident #1's file on documented that the most recent 1823 health assessment was dated and that the box was checked for "needs assistance with self-administration of medications".

Class III

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

Based on observation, interview and record review, the facility failed to maintain an accurate Medication Observation Record (MOR), for 4 of 6 sampled residents (residents #1, 2, 3 & 4).

Findings include:

a) A review of the medication observation record on did not document whether resident #1 took her Calc-Carb 600 medication at 5:00 PM, as there were no initials in the corresponding box and there were no notes regarding why the box was not initialed.

b) A review of the medication observation record on did not document whether resident #2 took his Natural Balance Tears eye drop medication or his 325 MG on at 5:00 PM, as there were no initials in the corresponding boxes and there were no notes regarding why the boxes were not initialed.

c) A review of the medication observation record on did not document whether resident #3 took

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her -Timolo eye drop medication on at 5:00 PM, as there were no initials in the corresponding box and there were no notes regarding why the box was not initialed.

d) A review of the medication observation record on did not document whether resident #4 took her Polyethylene Gycol medication on at 5:00 PM, as there were no initials in the corresponding box and there were no notes regarding why the box was not initialed.

e) In an interview with the administrator on at 12:20 PM, she stated that the medications for Resident #1 must have been given because medications are given on time by staff and that the staff working the previous day must have forgotten to write it down. In an interview at this time, the administrator stated, "I can just say it was taken from a pack, not that it was actually given".

In an observation of resident #1's medication on at 12:20 PM, the 5:00 PM dosage of medication for was no longer in the bubble packaging, as the paper backing was punched out. The 5:00 PM bubble packaging dosage for resident #1 included three pills: Calcarb 600, Carb-Lev and Ranitdine 150 MG.

In an observation of Resident #6's medication on at 1:05 PM, a pill was stuck in the bubble packaging for the 8:00 AM dosage on .

A review of the medication observation record on documented that resident #6 received and took their 8:00 AM dose of on , as there were initials in the corresponding box.

Class III

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

Based on observation and interview, the facility failed to dispose expired and discontinued medications for 1 of 6 sampled residents (resident #3).

Findings include:

In an observation of the facility's medication cart on at 1:00 PM, there was a prescription bottle for - eye drops for resident #3 with an expiration of . In an observation of the medication cart at this time, there was a bottle of Robafen- Syrup for resident #3.

In an interview with the administrator on at 1:15 PM, she stated that the manager told her there was a new bottle of - eye drops for resident #3, but the administrator was unable to

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find the new bottle in the medication cart. In an interview at this time, the administrator stated that resident #3's Robafem- syrup was not being used and that the medication was discontinued on resident #3's chart.

In an observation on at 1:40 PM, the new bottle of - was in the purse of resident #3. In an interview at this time, resident #3 stated that she administers her own eye drops.

Class III

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

Based on observation, interview and record review, the facility failed to ensure medication was refilled in a timely manner for 1 of 6 sampled residents (Resident #5).

Findings include:

In an interview with Resident #5 on at 2:20 PM, he stated that he recieved a PRN (pro re nata) - , pill at 7:00 AM on for pain. In an interview at this time, he stated that the morning dose was his last pill and that he needed another pill for the pain he was currently experiencing but that the facility had ran out of this medication.

A review of the facility's controlled medication log on , documented that Resident #5 had 6 - , pills remaining on .

In an observation on at 2:30 PM, the administrator asked multiple times whether resident #5 wanted to take a different PRN medication for pain, since there was no more of the - , . The administrator gave resident #5 a 50 MG tablet at this time. In an observation at this time, she provided Staff B with the used medication bubble pack of -Acetaminohen to call the pharmacy for a refill.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on observation, interview and record review, the facility failed to meet the training requirements for unlicensed staff who provide assistance with self-administration of medication for 1 of 4 sampled staff (Staff C).

Findings include:

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In an interview on at 11:25 AM, C stated that she was a home health aide and that she was not licensed staff.

In an observation of medication passes on at 5:15 PM and 5:35 PM, staff C provided assistance with self-administration of medications to Residents # 2 and 4, respectfully.

A record review of Staff C's employee file on , revealed that she completed 4 hours of "Assisting the Elderly with Medication Administration" on .

In an interview with the training company that provided Staff C's training on at 12:15 PM, she stated that the "Assisting the Elderly with Medication Administration" training was not provided by a licensed nurse or pharmacist and that the facilitator was a home health aide/certified nursing assistant.

Class III

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on interview, observation and record review, the assisted living facility failed to have signed attestations for 4 of 4 sampled staff (administrator, Staff B, C, & D).

Findings include:

In observations on , the administrator, Staff B, C, and D provided direct care and services to residents through medication passes and assistance with activities of daily living.

A review of employee files on for the administrator, staff B, C and D, did not contain signed attestations.

In an interview with the administrator on at 6:15 PM, she stated that she did not know about the attestation requirement for all employees.

Unclassified.