STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966948	**03/28/2017**
NAME OF PROVIDER OR SUPPLIER **CARINGTON MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **3215 EAST JAMES LEE BLVD** **CRESTVIEW, FL 32539**	

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

0000 - Initial Comments

An unannounced abbreviated licensure survey with Limited Nursing Services was conducted on 27- , 2017 at the Carington Manor assisted living facility, licensure number 11068. There were deficiencies found at the time of the survey.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review and interview the facility failed to ensure the residents lived in a safe environment for 2 of 15 sampled residents (#12 and 13) by failing to ensure medications were secured and by failing to report missing to the police and the Department of Children's and Families Services.

The findings are:

On at approximately 11:53AM an interview was being conducted with the facility administrator. During this interview the facility administrator revealed at the end of 2016 and early , of 2017 the facility had a resident aide who they suspected of stealing residents' medications. This was a non licensed staff who assisted residents with self administration of medications, (sampled staff D). The administrator was asked if she reported this to the police and to the Department of Children's and Families Services for , of residents. She stated, "No, I did not". The administrator was asked to explain what happened and how they handled the situation. She stated on approximately Friday , the day Licensed Practical Nurse/medication nurse, (sampled staff C), discovered sampled resident #12 had six pills of the pain medication 5-325 milligrams (mg) missing. Sampled staff C reported the missing medication to the assistant administrator. The administrator was not working that day. On sampled staff C discovered sampled resident #12, had eleven more pills of the medication, missing. She stated the resident never requested any of these medications for pain. The administrator stated sampled staff C, the assistant administrator, and herself developed a plan and counted all the other residents' medications to ensure no other medications were missing. They continued to count these medications on a daily basis. Prior to the missing medications the facility staff did not have a reconciliation system in place to ensure medications were secure. They obtained a refill from the physician for sampled resident #12's . On they discovered thirteen pills of the pain medication, , for sampled resident #13 were missing. During this time the administrator stated they were continuing their investigation by reviewing staff schedules, reviewing the videos, counting medications and reviewing records. They continued to investigate. On they discovered sampled resident's #12 whole pack of thirty pills were missing. She stated by this time thru their investigation they suspected sampled staff D,

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a resident aide, who assisted resident's with self administration of medications and who worked the 6AM-6PM shift, of taking the medications. The administrator stated she, the facility owner, sampled staff C, and the assistant administrator spoke to sampled staff D concerning the missing medications. The administrator stated sampled staff D denied the allegations. The administrator required the sampled staff D to complete a drug test. The administrator stated the drug test was negative, but was told it did not test for . She stated the staff resigned on . The administrator stated they have not had any problems since sampled staff D resigned. The administrator was asked how they ensured there were no continued issues she stated the nurses continued to count the residents' thru . The administrator was asked how the facility ensures the residents' are safe and secure. She stated when the are received the assistant administrator counts the medications but then after the initial count these medications are not counted to ensure they are not being diverted. The administrator was asked if the residents' physicians and families were notified of the missing medications and she stated sampled resident #12's physician was contacted for a refill of the , but at no other time was the physician or families notified. She stated neither resident was without their medications. An interview was conducted on at approximately 1:21 PM with sampled staff C, the medication nurse, and with the assistant administrator at 2:38 PM which concurred with the administrator's interview concerning the circumstances of the residents' missing medications.

Class III

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

Based on observations, record review and staff interviews the facility nursing staff failed to administer medications in accordance with the physician's orders for 1 of 2 sampled residents observed during medication pass (#9).

The findings are:

On at approximately 10:19AM a medication administration observation was conducted with sampled staff C, the licensed practical nurse (LPN), and day medication nurse. Sampled staff C prepared and administered the medication 500 milligrams plus D 200 milligrams (mg) one tablet for sampled resident #9. The resident received this medication once daily. Record review revealed physician orders on contained in the Resident Health Assessment for Assisted Living Facilities 1823 (and received by the facility on) for the resident to recieve 500 plus D tablet 500-125 milligrams one tablet with food daily. An interview and record review were conducted with sampled staff C on at 2:39PM. The nurse stated she did not realize the newest 1823 dated had an order for 500mg with D 125 mg once daily. She was asked which orders she should be following and she stated this latest Resident Health Assessment for Assisted

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Living Facilities 1823 of . Interview with the administrator on at approximately 9:20AM revealed the facility staff has contacted the resident's physician, since the medication pass, who stated she wanted the resident on the 500 with D 125 mg. The administrator confirmed the physician's orders were not being followed.

Class III

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

Based on observations, record reviews and interviews the facility failed to ensure resident's medications were securely stored for 4 of 15 sampled residents (#12, #13, #15, and #17) by failing to ensure there was an appropriate reconciliation of residents medications.

The findings are:

On at approximately 11:53AM an interview was being conducted with the facility administrator. During this interview the facility administrator revealed at the end of 2016 and early of 2017 the facility had a resident aide who they suspected of stealing residents' medications. This was a non licensed staff who assisted residents with self administration of medications, (sampled staff D). The administrator was asked if she reported this to the police and to the Department of Children's and Families Services for of residents. She stated, "No, I did not". The administrator was asked to explain what happened and how they handled the situation. She stated on approximately Friday , the day Licensed Practical Nurse/medication nurse, (sampled staff C), discovered sampled resident #12 had six pills of the pain medication 5-325 milligrams (mg) missing. Sampled staff C reported the missing medication to the assistant administrator. The administrator was not working that day. On sampled staff C discovered sampled resident #12, had eleven more pills of the medication, missing. She stated the resident never requested any of these medications for pain. The administrator stated sampled staff C, the assistant administrator, and herself developed a plan and counted all the other residents medications to ensure no other medications were missing. They continued to count these medications on a daily basis. Prior to the missing medications the facility staff did not have a reconciliation system in place to ensure medications were secure. They obtained a refill from the physician for sampled resident #12's . On , they discovered thirteen pills of the pain medication, , for sampled resident #13 were missing. During this time the administrator stated they were continuing their investigation by reviewing staff schedules, reviewing the videos, counting medications and reviewing records. They continued to investigate. On they discovered sampled resident's #12 whole pack of thirty pills was missing. She stated by this time, thru their investigation, they suspected sampled staff D, a resident aide, who assisted resident's with self administration of medications and who worked the

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6AM-6PM shift, of taking the medications. The administrator stated she, the facility owner, sampled staff C, and the assistant administrator spoke to sampled staff D concerning the missing medications. The administrator stated sampled staff D denied the allegations. The administrator required the sampled staff D to complete a drug test. The administrator stated the drug test was negative, but was told it did not test for . She stated the staff resigned on . The administrator stated they have not had any problems since sampled staff D resigned. The administrator was asked how they ensured there were no continued issues, and she stated the nurses continued to count the residents' thru . The administrator was asked how the facility ensures the residents' are safe and secure. She stated when the are received the assistant administrator counts the medications but then after the initial count these medications are not counted to ensure they are not being diverted. An interview was conducted on at approximately 1:20PM with sampled staff C, the medication nurse and with the assistant administrator at 2:38 PM which concurred with the administrator's interview concerning the circumstances of the residents' missing medications.

Interview on at 1:25PM with the administrator and sampled staff C, the medication nurse, revealed that they did not count the residents' every shift. They count them when they arrive from the pharmacy and log them into a book with the date they were received. Then every Tuesday all medications are reviewed by the assistant administrator just to see if any residents need medication refills; but the staff do not actually confirm the correct count. They were asked about the location of the video camera and they indicated there was one outside the medication the common area which was directed into the medication a window, but does not allow full view of anyone in the medication all times. They both stated they do not maintain a log of the residents' in which they use to count the , even daily, to ensure they are correct and secure. They both stated they had not had any problems until recently and they only counted the for a couple of weeks till the suspected staff resigned.

On beginning at approximately 1:30PM a random count of the residents medications was conducted with sampled staff D. Observations revealed each of the residents' medications are stored in individual plastic boxes identified with the resident's name. These boxes are stored in a large locked metal cabinet in the locked medication .

The random count was started with sampled staff C, the medication nurse. Review of the medications at 1:48PM of sampled resident #17 revealed the resident with the controlled medication , . Sampled staff C tried to reconcile the resident's medication by reviewing the resident's medication observation record (MOR), the calendar, and the bottle of medication. She thought the resident should have fifteen pills left in a bottle of thirty but she actually had thirty five pills. She stated she does not know why there are more than there should be.

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Observation of the controlled medication for sampled resident #15 was done. The medication nurse tried to reconcil the count of this medication. She stated the drug card arrived on and she could not be sure of the count because she does not know when the medication was started.

Review of the medications for sampled resident #12 revealed she was taking controlled medication . Interview and observation with sampled staff C revealed the received date for the new card of medication, , was , but she was unable to provide an accurate count because she did not know when the patient received the first dose from the card.

The medication nurse stated she could not provide an accurate count of the residents' medication because in many cases she was unsure of when the new bottles or packs of medications were opened and being dispensed. She stated, "this system is obviously not working."

Class III