STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966948	R 05/25/2017
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 licensure revisit survey was conducted on , 2017 at Carington Manor assisted living facility, license#11068. This was a revisit to the facilities biennial survey conducted , 2017. There were deficiencies found at the time of the revisit.

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 administration (#2).

The findings are:

Medication administration observation for sampled resident #2 on , beginning at approximately 9:40AM was conducted with the registered nurse (RN), sampled staff A. The RN was observed to place one tablet in a medication cup. She was asked if the resident had eaten breakfast that morning, and stated "yes". Observation of the medication label revealed instructions for the resident to take one tablet by mouth once daily, before breakfast. Observation and review of the resident's medication administration record with the nurse revealed the nursing staff had been documenting administration of this medication at 9:00AM daily from thru . When the surveyor asked about this being given after the resident had eaten, and not per the physician's orders, she stated "oh, it is supposed to be given before her meal; we will need to change this". She then obtained the resident's bottle of nasal spray, and stated she would administer two puffs to each of the resident's nostrils. Review of the prescription label on the nasal spray box revealed the resident was to receive one puff to each nostril. The nurse crushed all the oral medications except for one capsule, which she opened and sprinkled into the medication cup with the crushed oral medications. She mixed all the oral medications with peach yogurt. The nurse took the medications to the resident's bedside, identified the resident, and explained to her about her medications. The resident took all of the oral medications, including the . The nurse then administered the nasal spray, two puffs into each nostril, as she counted out loud "One-two, one-two." She then stated to the resident: " I know you don't like this nasal spray, but it is helping with your ".

Observation of the and the nasal spray medication labels, and review of the physician's orders on at approximately 10:44 AM with this medication nurse and the administrator revealed she had administered these medications incorrectly. The administrator stated they would contact the physician.

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Class III