STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966084	06/22/2017
NAME OF PROVIDER OR SUPPLIER **TITUSVILLE TOWERS**	STREET ADDRESS, CITY, STATE, ZIP CODE **405 INDIAN RIVER AVENUE** **TITUSVILLE, FL 32796**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A re-licensure survey with Extended Congregate Care in conjunction with complaint #2017004114 was conducted on . Titusville Towers, license #10346, had deficiencies related to both surveys at the time of the visit.

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

Based on resident record review and interview, the facility failed to have written records that the licensed provider and legal representatives/family were notified of a significant change for 3 of 5 sampled residents (#1, #6 & #8).

Findings:

1. Resident #6's record review revealed an AHCA 1823 Health Assessment form dated of admission into Hospice care (a significant change). Further review, revealed there was no documentation or written records in the progress notes that the physician and legal representatives/family was notified about the significant change.

On at 4:30 PM, an interview with the Manager who confirmed the finding, also stating that she thought that getting a new 1823 Health Assessment was sufficient for a significant change.

2. Review of the weight record for resident #1 revealed that on , his weight was 165 pounds and on , his weight was 179.8 pounds, a 14.8 pound weight gain in 11 days.

His weight record contained a printed warning when his weight was documented on . The warning included a comparison of his weight gain between and .

His record did not contain any documentation to indicate that a health care provider was notified when he had a significant weight change, as required.

During an interview with the facility manager on at 2:30 pm, she said she did not know if a health care provider was notified and she confirmed there was no documentation to indicate that a health care provider was notified.

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3. Record review for Resident #8 revealed she was enrolled in hospice care on . Further record review revealed there was no documentation to confirm the family and health care provider were contact to notify them of the changes in her health condition that resulted in the need for hospice services.

On at 4:50 PM, the facility's manager said if it was not in the notes if the family and health care provider were notified.

Class III

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

Based on observations, record reviews, and interview, the facility failed to ensure that the unlicensed staff who assisted 1 of 2 sampled residents (#3) with self-administration of medications followed the correct procedure.

Findings:

Observations made during the medication pass for resident #3 on at 12:02 pm revealed that staff B, an unlicensed staff member, removed the medication package from the medication cart. Staff B asked resident #3 to come to the medication cart then staff B popped the pill into a souffle cup. Staff B handed the medication and a cup to resident #3. Staff B and resident #3 walked to a water fountain where resident #3 placed water in the cup and then took the medication without assistance.

Staff B did not read the medication label in the presence of resident #3, as required.

Record review for resident #3 revealed a health assessment form 1823 that was dated on . The form indicated that resident #3 required assistance with self-administration of his medications.

During an interview with the facility manager on at 2:23 pm, she did not provide an explanation.

Class III

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

Based on Electronic Medication Observation Record (MOR) review and interview, the facility failed to maintain an accurate MORs for 7 of 25 sampled residents (#8, #14, #21, #22, #23, #24 and #25).

Findings:

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Review of the and Electronic MORs for Resident #8, #14, #21, #22, 23, #24 and #25 revealed there was a "9" in the spaces with staff initials for some of the days. Review of the Legend on the MORs revealed the "9" meant "Other/see progress note" There was nothing on the progress notes to confirm whether the residents received their medications. The following are examples:

Review resident 8 MORS revealed the following:
HCl 25 milligram (MG) at bedtime at 8 PM on 5/5, 5/7, 5/8, , , , , , , , 6/3, 6/4, 6/6, 6/8,

AER 160-4 2 puffs twice a day at 8 PM on 5/2, 5/4, 5/5, 5/6, 5/8, 5/9, , , , , through and through , 6/1, 6/3, 6/4, 6/5, 6/6 and 6/9.

, , /SOL inhale via four times daily at 3 PM on 5/2, 5/4, 5/6, 5/7, 5/9, , , , , through , , , , , 6/1, 6/3, 6/4.
At 4 PM on 6/1, 6/3, 6/4, 6/8, 6/9, , /, , .

At 8 PM on 5/2, 5/4 through 5/7, 5/9, , , , and , , 6/1, 6/3, 6/4, 6/8, 6/9, , , /, , , .

On at 6:20 PM Staff F was asked if it was her initials on at 8 PM for the HCl 25 MG, she said it was her initials. She was asked what the "9" meant in the spaces where here initials were on the MOR for the residents and she said she did not know what the "9" meant.

2. Review of the 2017 MOR for resident #14 revealed an entry for cream 12%, apply to both hands , and it was scheduled daily at 8 pm. The number 9 was documented for the doses on through , through , , , and through .

3. Review of the 2017 MOR for resident #21 revealed an entry for , 5 milligrams (mg) by mouth every 8 hours for muscle spasms and it was scheduled daily at 12 am, 8 am, and 4 pm. The number 9 was documented for the 4 pm dose on and the 4 pm dose on .

4. Review of the 2017 MOR for resident #22 revealed an entry for 10 mg by mouth in the evening for and it was scheduled daily at 8 pm. The number 9 was documented for the doses on , , , , , , , , and .

5. Review of the 2017 MOR for resident #23 revealed an entry for Suspension 40

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mg/5 milliliters (ml,) give 2.5 ml by mouth at bedtime for ( ) and it was scheduled daily at 8 pm. The number 9 was documented for the dose on .

6. Review of the 2017 MOR for resident #24 revealed an entry for , 30 mg by mouth at bedtime for , and it was scheduled daily at 8 pm. The number 9 was documented for the dose on , , , , and .

7. Review of the 2017 MOR for resident #25 revealed an entry for 100 mg by mouth two times a day for an until and it was scheduled at 8 am and 8 pm. The number 9 was documented for the 8 pm dose on and the 8 pm dose on .

Class III

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

Based on record review and interview the facility failed to make every reasonable effort to ensure that a prescription for 10 of 25 residents (#1, #6, #7, #8, #14, #21, #22, #23, #24, and #25) who received assistance with self-administration of their medications was filled in a timely manner. Which caused the facility to borrow medication from another resident for 2 of 25 residents (#1 and #6) who did not have medications available. The facility failed to ensure centrally stored medications were properly labeled for 2 of 2 sampled residents (#19 and #20) who received .

Findings:

1. During an interview with resident #1 on at 11:21 AM, he said every once in a while the facility ran out of his medication but the staff was good about borrowing the medication from another resident so he did not miss any doses. He said he was currently out of one of his , medications.

Record review for resident #1 revealed a health assessment form 1823 that was dated on . The form indicated that he required assistance with self-administration of his medications.

Review of the 2017 MOR for resident #1 revealed that all of his medications were signed as given on and .

Review of his medication containers revealed that he did not have , 50 milligrams (mg) tablets available. The MOR indicated that he was to receive , 50 mg by mouth two times a day for high , .

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During an interview with staff C on at 3:15 pm, she said resident #1 was out of his since and the staff had to borrow the medication from another resident who also received .

On at 5:10 pm, the facility manager provided a medication container for resident #18 and said the staff used that container to borrow the for resident #1. The prescription label indicated that the medication in the container was 50 mg tablets.

On at 6:30 pm, the facility manager said she did not know the staff borrowed medications from the residents and she did not know the resident's medications were unavailable.

Review of the facility's electronic Medication Observation Records (MOR) revealed a list of chart codes. The chart indicated that the number 11 meant that the medication was not available.

Review of the 2017 MOR for resident #1 revealed an entry for 50 mg by mouth two times a day for high and it was scheduled daily at 8 am and 8 pm. The number 11 was documented for the 8 pm dose on , the 8 am dose on , and the 8 pm dose on .

2. Review of the 2017 MOR for resident #14 revealed an entry for Cream 12%, apply to both hands and it was scheduled daily at 8 pm. The number 11 was documented for the dose on and .

3. Review of the 2017 MOR for resident #21 revealed an entry for 5 mg by mouth every 8 hours for muscle spasms and it was scheduled daily at 12 am, 8 am, and 4 pm. The number 11 was documented for the 12 am and 4 pm doses on and the 12 am dose on .

4. Review of the 2017 MOR for resident #22 revealed an entry for 10 mg by mouth in the evening for and it was scheduled daily at 8 pm. The number 11 was documented for the doses on , , , , , , and .

5. Review of the 2017 MOR for resident #23 revealed an entry for Suspension 40 mg/5 milliliters (ml,) give 2.5 ml by mouth at bedtime for ( ) and it was scheduled daily at 8 pm. The number 11 was documented for the dose on .

6. Review of the 2017 MOR for resident #24 revealed an entry for 70 mg by mouth one time a day every Monday for and it was scheduled at 6 am. The number 11 was documented for the doses on , , and .

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7. Review of the 2017 MOR for resident #25 revealed an entry for 10 mg by mouth three times a day for , and it was scheduled daily at 9 am, 1 pm, and 5 pm. The number 11 was documented for the 5 pm dose on .

8. Review of a Ziploc bag located in the top drawer of a facility medication cart revealed that the bag contained a pen that did not contain a prescription label. A yellow sticky note that was attached to the bag contained hand written information that included the name of resident #19, the name of the pen, and the directions for its use.

On at 6:50 pm, staff C said the original prescription label for the was on a box that was located in a facility refrigerator.

On at 7 pm, staff G said the original pen containers that contained the proper prescription labels were in a refrigerator and not on the medication carts because more than one pen came in the container and the had to remain in the refrigerator. Review of the medication containers located in the facility's medication refrigerator revealed the properly labeled containers were present for the pens for residents #19 and #20.

9. On at 5 PM, it was stated by unlicensed caregiver (staff G) working on the 2nd shift 3 PM-11 PM that she borrowed medication , 400mg prescribed to take 1 capsule orally for anticonvulsant in the morning & evening for Tuesday, to give resident #6 from another resident.

Furthermore, resident #6 had no knowledge that her , 400mg was out.

On at 11:10 AM, an interview with resident #6 who confirmed that she had no concerns with her medications being provided timely or never missed any medications & did not have any issues with her medications being filled on time.
Furthermore, resident #6 had no knowledge that her , 400mg was out.

Review of the MORs for and for Resident #7 and #8 revealed there were "11's" in the spaces on some days. Review of the Legend on the MOR revealed the "11's" meant Med Not Available. Some examples of the days the Medications were not available are as follows:

10. Resident #7 said on at 10:30 AM, she said she ran out of her medication one day in the month of . She said she could not remember what day and what medication it was.

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Resident #7's eye drops 1 drop in each eye for times daily at 4 PM on and At 8 PM on , and the medication was not available.

11. Resident #8 said on at 10:45 AM that on last Friday ( ) she ran out of her inhaler and did not get it until . She said the facility was having a problem with the pharmacy they were using.

Resident #8's AER 160-4.5 two puffs two times daily at 8 PM on 5/7, , (for ,) 88 Micrograms (mcg) 1 in the morning at 6 AM on Capsule extended release 10 MEQ (ER) at 8 AM on , 40 mg 1 daily for at 8 AM on through HCl 25 milligram (MG) at bedtime for at 8 PM on 5/6, 5/7, , , , , , , , , , the medications were not available for the listed dates.

Review of the MOR revealed Staff E initials were on the MOR on 6/6 and 6/8 at 8 PM for HCl with a "9" in the spaces. On , a staff had initialed the MOR to indicate the medication was given. On at 6:20 PM Staff E reviewed the MOR and was asked what the "9's" meant that were in the spaces. She said she was not sure. She was asked what the "11's" meant and she said she did not know. Staff E was asked to review the MOR for also. She was shown that the HCl was marked as unavailable ("11") by her on , she placed and "9" in the space on she placed an "11" in the space. Staff E said she did not know "because this was not one of the medications that we would borrow." She was asked at the time if they were borrowing? Staff E then answered "no maybe an , or something." The agency staff asked again are you borrowing , ? Staff E then answered, "No we are not borrowing , ."

Record review for Resident #7 and #8 revealed they both required assistance with the self-administration of medications. There was no documentation to confirm that the facility had make every reasonable effort to ensure that prescriptions for residents were refilled in a timely manner.

12. Observations on at 7 PM revealed there were 3 Solution Pens in a Ziploc bag in the medication cart that were not in their proper prescription labeled container. Staff E said at the time that the pens belonged to Resident #20 and the prescription container with the residents other pens were in refrigerator

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Class III

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observations and interviews, the facility failed to properly label Over the Counter (OTC) medications that were centrally stored.

Finding:

Observations on 7:15 PM on . . . in a . . . . to where the medication carts were kept revealed there was a large variety of bottles of OTC medications that included , stool softeners and , on the shelves.
Further observations of the bottles revealed some of them had numbers on the top of the lids and some of them did not. There were no bottles observed that were labeled with the resident's name as required.

On . . . at 7:30 PM, the facility's manager said the medications belonged to different residents of the facility who had the type of the insurance that would furnished them over the counter medications monthly. She said the resident's would sit with the social workers monthly and order their medications. She said they would then store them all together, so that when a resident would run out, the staff would take their medications from the stock. She said the numbers on top of the lid were the resident's . . .

The facility manager confirmed the OTC's medication bottles only had the of the residents and that some of the bottles did not have . . . . . that would identity who the medication belonged to.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observation, staff schedule review and interview the facility failed to maintain and accurate and up to date staff schedule.

Findings:

Review of the staff schedule for . . . 2017 revealed a nurse was scheduled to be in the facility the week of -23.
When asked to speak with this nurse, the staff said she was on vacation.

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In an interview with the facility manager on at 6:20 PM, she confirmed that the nurse was on vacation and she had not corrected the schedule to reflect the change.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review, Electronic Medication Observation Record (MOR) and interview the facility did not obtain a health care providers order for 1 of 25 sampled residents to self-administer her medications (#8).

Findings:

Record review for Resident #8 revealed a Health Assessment Form (1823) that was dated . The health care provider noted she required assistance with the self-administration of her medications.

On at 10:45 AM, resident #8 said the staff assisted her with the self-administration of her medications.
Review of the Electronic MOR for revealed it noted , AER 160-4.5 two puff daily at 8 AM and 8 PM the MOR noted in the spaces on through at 8 AM "U-SA." At 8 PM the MOR noted in the space on 6/9 through "U-SA". For , , /SOL inhale via every 6 hours as needed. The MOR noted "U-SA" from 6/9 through no time.

Further review of the MOR revealed the Legend noted, "U-SA meant "Unsupervised self-administration. Further record review revealed there was no health care providers order available for review for the resident to self-administer her medications.

On at 3:50 PM, staff I a Certified Nursing Assistant (CNA) that assisted in the office stated Resident #8 did self-administer the above medications because her family member said to let her self administer the medication, Staff I checked the Resident's record and said there was no order for her to self-administer.

Class III