STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966519	08/22/2017
NAME OF PROVIDER OR SUPPLIER **INDIGO PALMS AT MAITLAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **740 NORTH WYMORE ROAD** **MAITLAND, FL 32751**	

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

0000 - Initial Comments

Complaint investigation #2017005559 was conducted on through . In addition, complaint investigations # 2017006956 and #2017007917 and revisits for complaint investigations #2017003496, # 2016014670, # 201613957, #2017002603 and #2017003875 were conducted on the same dates.

Indigo Palms at Maitland Assisted Living Facility, license #10704, had deficiencies related to #2017005559 at the time of the visit.

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

Based on resident record review and interview, the facility failed to maintain accurate Medication Observation Records (MORs) for 3 of 16 sampled residents (#1, #17 & #37).

Findings:

1. Record review for resident #1 revealed a diagnosis of , and .

Review of the Medication Observation Record (MOR) for resident #1 for 2017 revealed several dates with no indication as to whether the resident received medication or not. 100 milligrams capsule was not marked as given on the MOR on at 2 PM. 1000000 cream on at 2 PM & 8 PM and at 2 PM there was no documentation on the MOR that the medication was given. / Solution on at 8 AM & 12 PM, at 8 AM, at 8 PM and at 4 PM, the MOR was blank. 0.3% Op Solution on at 8 AM, the MOR was also blank. No documentation was written on the back of the MOR for 7/1, 7/2, .

In an interview with the Interim Resident Care Coordinator at 12:28 PM on , she confirmed the lack of documentation and offered no explanation as to why the MOR was blank.

2. Review of the MORs for resident #17 revealed there were blanks spaces and there was no documentation to confirm whether the resident received his medications. Some examples are:

5 milligrams (mg) 2 once daily, 20 mg, low 81 mg , POT 100 mg once daily, Handihaler cap Inhale the contents of 1 capsule via Handihaler using two separate

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inhalations by mouth every morning, 50 mg one three time daily, Probiotic Formula cap one twice a day, were all left blank at 8 AM on and 50 mg one three time daily was left blank at 2 PM on / and 50 mg one three time daily, Probiotic Formula cap one twice a day, were all left blank at 5 PM on and 5 mg one at bedtime was left blank at 8 PM on and .

On at 1 PM, the Interim Resident Care Coordinator confirmed the spaces were left blank and she did not have an explanation

3. Review of the 2017 MOR for resident #37 revealed an entry for 12% lotion, apply on arms and legs after shower two times per week on Wednesday and Saturday. The medication was not signed as applied on , and . There was no documentation to indicate why the MOR was not signed. Review of a health assessment form 1823 that was dated on indicated that resident #37 required assistance with self-administration of his medications.

Class III

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

Based on observations, interview and record review the facility failed to ensure that Over the Counter (OTC) medication containers were properly labeled for 1 of 16 sampled residents (#48).

Findings:

On at 8:55 am, staff L identified resident #48 and said he received OTC medications. Review of his OTC medications that were stored in a medication cart revealed there were bottles of D3 capsules and tablets. Neither bottle was labeled with the name of resident #48, as required.

The 2017 Medication Observation Record (MOR) for resident #48 contained entries for D3 200 International Units, 1 capsule by mouth daily at 8 am and , 1 tablet by mouth daily at 8 AM.

On at 9 am, staff N confirmed the OTC bottles were not properly labeled.

Class III

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0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on Florida Health Finder website review and interview, the facility failed to notify the Agency (AHCA) of a change in administrator within 10 days of the change.

Findings:

Review of the facility locator on FloridaHealthFinder.gov was conducted on for the name of the current administrator.

Upon arrival at the facility on at 2:00 PM, Staff OO said the administrator was someone different from the name on the website.

During the entrance conference on at 4:40 PM with the regional manager, the facility business manager and the Interim Resident Care Coordinator stated Staff MM had been the new administrator for about one month. They stated the previous administrator had left "around ." When asked if this was reported to AHCA, they stated yes.

In an interview with the new administrator, Staff MM, on at 3:50 PM, he stated he began his employment as administrator at the facility on . He stated he did file the appropriate paperwork with AHCA at the time. He returned at 4:06 PM and stated he just learned the paperwork was never filed by the Risk Management office. However, he was faxing it to AHCA immediately. He confirmed that the change of administrator notification to AHCA did not take place with 10 days as required.

Class III