STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966519	R 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

Revisit for complaint # 2016014670 was conducted on 8/20/17 through 8/22/2017. In addition, complaint investigations # 2017005559, and #2017006956 and revisits for complaint investigations #2017003496, # 201613957, #2017002603 and #2017003875 were conducted on the same dates.

Indigo Palms at Maitland Assisted Living Facility, license #10704, had deficiencies related to the revisit for #2016014670 at the time of the visit

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

DEFICIENCY REMAINED UNCORRECTED

Based on record reviews and interviews the facility failed to ensure the health assessment form 1823 was complete and accurate for 5 of 16 sampled residents (#1, #20, #37, #41, and #47).

Findings:

1. Review of a health assessment form 1823 for resident #20 dated revealed the section regarding the type of diet he required was not answered.

2. Review of a health assessment form 1823 for resident #37 dated revealed the section regarding how much assistance he required with ˬ ˬ was not answered.

3. Review of a health assessment form 1823 for resident #41 dated revealed the question as to whether she required assistance with her medications was not answered.

During an interview with the interim resident care coordinator on at 12 pm, she confirmed the findings.

4. Resident #47's record review revealed form 1823 Health Assessment dated did not indicate the type of medication assistance required by the resident. The question as to whether she required assistance with her medications was not answered.

On at 1 PM, an interview with the Interim care Coordinator who confirmed the finding.

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5. Review of the record for resident #1 revealed a Health Assessment form 1823 dated . The section for type of assistance required with medications was left blank.

In an interview with the Interim Resident Care Coordinator on at 12:28 PM, she confirmed the findings and offered no explanation as to why the form was incomplete.

Class III

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

Based on observations, record review and interviews the facility failed to ensure it provided appropriate care and services and failed to follow healthcare provider orders for medications for 1 of 16 sampled residents (#32).

Findings:

Resident record review for resident #32 revealed a health assessment report dated that listed diagnoses of , , Parkinson's , high , , and , . He needed assistance with self- administration of medications.

The , 2017 Medication Observation Record (MOR) listed , 300 milligram take 3 times daily at 8 AM, 2 PM and 8 PM and had staff initials circled from 7/1 at 9AM to at 2pm and to at 8 AM and 2 PM. The back page of the MOR from 7/1 at 8AM to at 8 PM documented the medication was not given, "waiting on pharmacy". Order dated indicated , 300 milligram take 3 times daily, Order dated indicated 400 mg take one tablet every 8 hours.

The , MOR listed , 400 mg take one tablet every 8 hours at 6 AM , 2 PM and 10 PM and had staff initials circled form 7/1 6AM to at 2 PM , then indicated discontinued on . The back page of the MOR from 7/1 at 8AM to at 8 PM documented the medication was not given, "not in cycle pack" and refused mon at 2 PM.
The review revealed no notations that documented the healthcare provider or significant party were notified the resident did not have the medication available. There were no notations why the medications were not available.

Observations during a medication pass on at 9:30 AM, staff PP an unlicensed caregiver assisted resident #32 with his medications, she handed him 0.05 % with a prescription label dated that indicated use 2 sprays daily. The resident used 1 spray to each nostril. When the Agency representative informed the staff to read the label; must use 2 sprays to each nostril. The staff replied

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he always used 1 spray to each nostril. The resident said, "I did not know 2 if that is what it needs to be them will do 2". Prescription label dated . . indicated . . . 255 milligrams mix 17 grams with 8 ounces of water and drink Mon Tues Wednesday. When the staff assisted the resident with the Miramax, she gave 4 ounces water only. She said the cup was approximately 4 ounces only. That was what she had available.

In an interview with the Interim Resident Care Coordinator on at 1 PM, who stated the staff needed further training. As for the medications, there was a change in pharmacy and the resident needed a new prescription.

Class III

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

DEFICIENCY REMAINED UNCORRECTED

Based on observations, record reviews, and interview, the facility failed to ensure the unlicensed staff (KK and PP) who provided assistance with self-administration of medications followed the correct procedure for 2 of 5 sampled residents during the medication passes (#32 and #35).

Findings:

1. Observations made during a medication pass for resident #35 on at 5:40 am revealed that staff KK, an unlicensed caregiver, took the medication package to resident #35. Staff KK told resident #35 that she was giving her 6 am medication. In the presence of the resident, staff KK placed the medication into a cup and handed it to the resident. Resident #35 took the medication without assistance.

Staff KK did not read the prescription label in the presence of the resident, as required. When questioned following the medication pass, staff KK said she forgot to read the label.

Record review for resident #35 revealed a health assessment form 1823 that was dated on . . . . The form indicated that resident #35 required assistance with self-administration of her medications.

2. Observations during a medication pass on at 9:30 AM staff PP, a caregiver, assisted resident #32 with his medications, she handed him 0.05 % with a prescription label dated . . . . that indicated use 2 sprays daily. The resident used 1 spray to each nostril. When the Agency

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representative informed the staff to read the label; must use 2 sprays to each nostril. The staff replied he always used 1 spray to each nostril. The resident said, "I did not know is 2 if that is what it needs to be them will do 2". Prescription label dated indicated 255 milligrams mix 17 grams with 8 ounces of water and drink Mon, Tues and Wednesday. When the staff assisted the resident with the Miramax, she gave 4 ounces water only. She said the cup was approximately 4 ounces only. That was what she had available. She did not read the label to the resident.

Resident record review for resident #32 revealed a health assessment report dated that listed diagnoses of , , Parkinson's , high , , and , . He needed assistance with self- administration of medications.

In an interview with the Interim Resident Care Coordinator on at 1 PM, who stated the staff needed further training.

Class III