STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966084	R 08/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TITUSVILLE TOWERS	**405 INDIAN RIVER AVENUE** **TITUSVILLE, FL 32796**

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

0000 - Initial Comments

A revisit to a relicensure survey with Extended Congregate Care (ECC) in conjunction with a revisit to a complaint investigation (2017004114) was conducted on , 2017. Titusville Towers, license #10346, had deficiencies during the revisit to the relicensure survey.

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

Based on record reviews, review of medication containers, and interviews, the facility failed to make every reasonable effort to ensure that a prescription for 3 of 12 residents (#8, #21, and #24) was filled in a timely manner.

Findings:

1. Resident #8 required assistance with self-administration of her medications. Review of her 2017 Medication Observation Record (MOR) revealed an entry for 200 milligrams (mg) by mouth every 3 hours as needed for , or .

Review of the medication containers for resident #8 revealed that she did not have the available.

On at 3:55 pm, staff J confirmed resident #8 did not have the medication available.

2. Resident #21 required assistance with self-administration of his medications. Review of his 2017 MOR revealed an entry for 10 mg by mouth at bedtime for .

The number 9 was documented for the dose on and . The charting codes indicated that the number 9 meant "other/see progress notes." There was no additional documentation to explain the number 9.

During an interview with the facility manager on at 3:20 pm, she said the number 9 meant that the medication was unavailable.

3. Resident #24 required assistance with self-administration of her medications. Review of her 2017 MOR revealed an entry for 70 mg by mouth every Monday.

The number 11 was documented for the dose on . The charting codes indicated that the number 11 meant "medication not available."

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SUMMARY STATEMENT OF DEFICIENCIES
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Review of the medication containers for resident #24 revealed that she did not have the medication available.

During an interview with the facility manager on at 2:30 pm, she said residents #8 and #24 did not have their medications because the facility was having pharmacy issues.

On at 3:50 pm, the facility manager said the staff who assisted the residents with their medications were supposed to notify the nurse when a resident needed a refill of medications. She said the staff did not notify the nurse when residents #8 and #24 were out of their medications.

Class III

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

Based on record reviews and interviews, the facility failed to ensure that the resident record for 1 of 5 sampled residents (#25) contained an order from a health care provider to self-administer a medication.

Findings:

Review of the 2017 Medication Observation Record (MOR) for resident #25 revealed an entry for 2% cream, apply to affected area two times a day for . Beginning on , Unsupervised Self-Administration (U-SA) was documented for each dose.

During an interview with staff J on at 11:30 am, she said resident #25 had the cream in his he self-administered the cream.

Review of the record for resident #25 revealed a health assessment form 1823 that was dated on . The form indicated that he required assistance with self-administration of his medications. The record did not contain an order from a health care provider to indicate that he was able to self-administer the cream.

On at 3:45 pm, the facility manager confirmed the record for resident #25 did not contain an order, as required.

Class III