STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967657	**09/05/2017**
NAME OF PROVIDER OR SUPPLIER **INN AT WATER'S EDGE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **10 GROVE AVENUE WEST** **LAKE WALES, FL 33853**	

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

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on record review and staff interview, the facility failed to ensure the LNS (Limited Nursing Services) Supervisor had a background screen in her employee file for 1 (LNS Supervisor) of 5 staff files reviewed.

The findings included:

On at 1:00 p.m., review of the LNS book revealed there was no Background Screen for the LNS Supervisor.

In an interview on at 6:05 p.m. the Administrator stated, "She's getting it."

Unclassified

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SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

Assisted Living Facility

Two unannounced complaint investigations, (CCR# 2017006844 & CCR# 2017007689), were conducted on , in conjunction with an unannounced biennial state licensure survey with limited nursing services (LNS).

The Inn at Water's Edge, Assisted Living Facility, had deficiencies at the time of the visit.

(License #11669)

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

Based on observation, record review, and interview, the facility failed to ensure trained staff, trained in assistance with self-administration of medication, observed residents take their medication for 1 (Resident #2) of 5 residents interviewed.

The findings included:

On at 12:15 p.m., a medication cup with a white pill in it was observed on a dresser in Resident #2's .

Record review of Resident #2's Health Assessment dated , revealed Resident #2 required assistance with self-administration of medication.

Assistance with self-administration of medication requires trained staff to observe the resident take their medication.

On at 12:15 p.m. Resident #2 stated, "They bring it to me several times a day. It was from this morning."

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

Class III

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

Based on observation, record review, and interview, the facility failed to ensure the medication label matched the Medication Observation Record (MOR) and the Healthcare Provider's Order for 1 (Resident #16) of 2 residents reviewed.

The findings included:

On at Staff A was observed preparing to assist Resident #16 with self-administration of medication.

A review of the medication label, the Medication Observation Record, and the Healthcare Provider's Order revealed the following:

The medication label read, " 0.2 mg (milligram) one tab by mouth, three times daily."

The Medication Observation Record read, " (, TTS 2) patch weekly. 0.2 milligram/24 hours."

The Healthcare Provider's Order written read, " 0.2 mg. One tab by mouth, three times daily."

On at 1:30 p.m. the Director of Nursing stated, "It was my fault. I took off the wrong order. I selected the patch from the drop-down."

Class III

N278 - LNS - Records - 58A-5.031(3) FAC

Based on record review and staff interview, the facility failed to maintain a list of all residents receiving LNS (Limited Nursing Services) that included the type of services being provided, for all residents receiving LNS Services.

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

The findings included:

On . . . , the Executive Director was requested to provide a list of Residents receiving Limited Nursing Services.

Review of the list provided by the Executive Director revealed the LNS list did not include the reason why the residents were receiving LNS services.

In an interview on . . . . at 10:30 a.m. the Administrator stated, "Do we have to have that on there?"

Class III