

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967214	(X3) DATE SURVEY COMPLETED R 12/14/2017
NAME OF PROVIDER OR SUPPLIER TM TENDER CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 9 PONDEROSA LANE PALM COAST, FL 32164	

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

0000 - Initial Comments

An unannounced follow-up visit was conducted on _____ at TM Tender Care (Lic # 11336).
Deficiencies were identified at the time of the visit.

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

Based on record review, observation and staff interview the facility failed to ensure the Medication Observation Record (MOR) was accurate for 2 of 6 sampled residents, Resident #4 and #6.

The findings include:

1. Review of the MOR for Resident #6 found that a line was designated to document how often _____ was given. The label for the package of _____ stated the dose was 75 mg.

The MOR did not include the dosage information or frequency for the _____ for Resident #6.

Further review of MOR for Resident #6 found a medication order for _____ pm (as needed). The MOR did not include instructions for use, frequency, or dosage. The medication was recorded as given two times a day.

An interview was conducted with the Medication Technician (Employee A) on _____ 17 at 2:25 pm. When asked how often Resident #6 received _____, she said twice a day, at 8:00 am and 8:00 pm. She was asked if Resident #6 requested the medication at those times. She explained Resident #6 had been taking it routinely since admission in _____. When asked how many tablets Resident #6 received, Employee A said one tablet each time. Employee A was asked how she knew how many to give, and she said she has always just taken one.

2. During a comparison of the medications on hand with the MOR for Resident #4, the medication _____ 10 mg was observed in the box that contained his medications. There was no documentation on the MOR that Res #4 had received the medication.

An interview was conducted with Employee A on _____ at 2:30 pm. When asked if Resident #4 was ordered the medication _____, she said "yes" he takes it at 1:00 pm everyday. She was asked where on the MOR she recorded the medication.

After review of Resident #4's MOR, she stated it was not listed, it must have been missed when the _____ records were written. When asked who writes the new MOR's, she said she had copied them

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from the records. She was asked how the facility reconciled the MOR's each month, and Employee A explained she usually does them with the Administrator. She said they did not reconcile the MOR's for An interview was conducted with the Administrator on at 3:20 pm. She was asked how the facility reconciled MOR's with the physician orders each month. She said usually she and Employee A do them together. One reads the order, and the other checks to see that it is correct. When asked if the MOR's were reconciled for , she said they did them in and there was no problem. She was asked to review the MOR for Resident #4 for the medication , 10 mg daily. After review she stated the medication was not on the MOR. She was asked if there was a current order for the medication, she stated "yes". She produced the medication for examination. She was asked why the facility was not documenting that Resident #4 received this medication, and she explained it must have been missed when written for Class III 0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC Based on record review, observation and staff interview the facility failed to ensure clarification was received for as needed medication for 1 of 6 sampled residents, Resident #6. The findings include: 1. Review of MOR for Resident #6 found a line for the medication , to be given PRN (as needed). The order did not include instructions for use, frequency or dosage. The medication was recorded as being given two times a day. There was no documentation of what time the medication was given, or a reason. An interview was conducted with the Employee A (an unlicensed staff member who has been trained as a Medication Technician) on at 2:25 pm. When asked how often Resident #6 received , she said it is given twice a day, at 8:00 am and 8:00 pm. She was asked if Resident #6 requested the medication at those times. Employee A said Resident #6 had been taking it routinely since she came to the facility in . When asked how many tablets she received, Employee A said one tablet each time. She was asked how she knew how many to give, and Employee A explained she has always just taken one. Review of Resident #6's physician order for , had no instructions for use, dosage or frequency. At the time of the survey, there was no documentation to indicate the staff had attempted to		

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

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FORM APPROVED

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get clarification on the PRN order. Class III Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS Based on employee record review and interview with the administrator, the facility failed to register the employment status of 3 of 3 sampled employees whose files were reviewed (Employee A, B, C) within the agency's background screening clearinghouse. The findings include: Review of the Agency for Healthcare Administration background screening website on at 3:30 PM revealed the employee roster for the facility was not updated. Employees A, B and C were not listed on the roster as active employees in the facility. An interview was conducted with the Administrator on at 3:40 pm. She confirmed that the roster was not updated. She stated she had issues getting into the system but when asked for documentation of her attempts to reach the Background Screening Unit, she stated she did not have any. Unclassified		