STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968706	**12/18/2017**
NAME OF PROVIDER OR SUPPLIER **ENCORE AT AVALON PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **13798 CYGNUS DR** **ORLANDO, FL 32828**	

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

0000 - Initial Comments

A complaint investigation (2017011223) was conducted on , 2017. Encore at Avalon Park, license #12618, had deficiencies at the time of the investigation.

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

Based on record reviews and interview, the facility failed to ensure the health assessment form 1823 was accurate for 3 of 3 sampled residents (#1, #2, and #3).

Findings:

1. Record review for resident #1 revealed a health assessment form 1823 dated on that indicated she required medication administration.

2. Record review for resident #2 revealed a health assessment form 1823 dated on that indicated she required medication administration.

3. Record review for resident #3 revealed a health assessment form 1823 dated on that indicated she would self-administer her medications.

During an interview with the administrator on at 3:09 pm, she said residents #1, #2, and #3 required assistance with self-administration of their medications and all of the health assessment forms were incorrect.

The records for residents #1, #2, and #3 contained no documented evidence to indicate the facility obtained the correct information from the health care providers.

Class III

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

Based on observations, record reviews, and interviews, the facility failed to perform quality controls for 1 of 2 residents (#1) who received glucose testing, failed to notify a health care provider when 1 of 2 residents (#1) refused and failed to notify a health care provider when a resident (#1) made a statement of self-harm.

Findings:

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1. Observations made of a medication pass for resident #1 on at 12 pm revealed staff B, a nurse, unlocked the medication cart. She removed glucose-testing supplies from the cart, cleaned the glucose machine with , sanitized her hands, and then took the supplies to the resident in her . Staff B donned gloves, placed a testing strip into a glucose machine, prepped the left pinky finger of resident #1 with an , used a lancet to stick the finger, and then placed a droplet onto the testing strip. The results were 165.

Staff B dialed a pen to 7 units, prepped the left upper arm of resident #1 with , and then she injected the . She removed her gloves, discarded them into the garbage, and placed the lancet and needle into a sharps container. She cleaned the glucose machine with .

Review of the testing strip vial revealed control values of 45-75 for low and 166-224 for high.

On at 12:12 pm, staff B confirmed the control values on the vial and said she did not know whether controls were done on the glucose machine.

On at 12:30 pm, the administrator said quality controls were not done on the machine.

The purpose of the control solution testing is to make sure the meter and test strips are working properly. Control testing should be performed when using the meter for the first time and when using a new bottle of test strips (Medline.com).

2. Review of the , 2017 Medication Observation Record (MOR) for resident #1 revealed an entry that indicated on , she refused her Lantus . Review of her record revealed no documentation to indicate the health care provider was notified when she refused the .

On at 4:35 pm, the business office manager confirmed the findings.

3. Record review for resident #1 revealed a progress note dated on at 1:03 pm that indicated during 1 am rounds, she stated to the caregiver that she wanted to kill herself. On the 7am-3pm shift, she stated that she was depressed because her family was not there and she would not harm herself. The staff would continue to monitor. The information was passed on to the first floor nurse and it would be passed on to the next shift to monitor.

The record for resident #1 contained no documented evidence to indicate a health care provider was notified when she made the statement that she wanted to kill herself.

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On at 4:40 pm, the business officer manager confirmed the findings.

Class III

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

Based on observations, record review, and interview, the facility failed to ensure the unlicensed staff who assisted a resident (#2) with self-administered medications followed the correct procedure.

Findings:

Observations made during a medication pass for resident #2 on at 11:11 am revealed staff A, an unlicensed caregiver, unlocked the medication cart and removed the medication package from the cart. She compared the prescription label to the Medication Observation Record (MOR.) While standing at the cart, she popped the pill into a cup, put applesauce into a separate medication cup, and then she poured the pill into the applesauce. She took the medication to resident #2, who was in her . The resident spooned the mixture into her mouth without assistance. Staff A signed the MOR.

Staff A did not read the prescription label to the resident and did not prepare the medication in the presence of the resident, as required.

On at 11:18 am, staff A confirmed the findings.

Class III

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

Based on record reviews and interview, the facility failed to ensure the Medication Observation Record (MOR) was updated for 1 of 3 sampled residents (#2) who required assistance with self-administered medications.

Findings:

1. Review of the 2017 MOR for resident #2 revealed an entry for 500 milligram (mg) extra strength tablet, give 1 tablet by mouth three times a day at 6am, 2pm, and 5pm for chronic pain. The 6am doses on and were not signed as given.

Max-Freeze Gel, apply to left calf, neck, and left shoulder daily at 6am for chronic pain. The dose on was not signed as applied.

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2. Review of the 2017 MOR for resident #2 revealed an entry for , 2.5 mg tablet, give 1 tablet by mouth twice a day and was scheduled at 8am and 5pm. The 5pm dose on was not signed as given.

Ferrex 150 mg capsule, give 1 capsule by mouth twice a day for Chronic Kidney and was scheduled at 8am and 5pm. The 5 pm dose on was not signed as given.

25 mg tablets give 1 tablet by mouth four times a day for and was scheduled at 8am, 12pm, 5pm, and 8pm. The 5 pm dose on was not signed as given.

On at 4:32 pm, the business office manager confirmed the findings.

Class III

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

Based on record reviews and interview, the facility failed to make every reasonable effort to ensure a prescription was filled in a timely manner for 1 of 3 sampled residents (#2) who received assistance with self-administered medications.

Findings:

Record review for resident #2 revealed a health assessment form 1823 dated on that indicated she had a diagnosis of Dyslipidemia and she required medication administration.

Review of the 2017 Medication Observation Record (MOR) for resident #2 revealed an entry for 10 milligram (mg) tablets, give 1 tablet by mouth at bedtime. Documentation on the MOR indicated the medication was not given from 12/1 through because the facility was waiting on a refill.

The record for resident #2 revealed no documentation to indicate the facility made every reasonable effort to ensure the medication was filled in a timely manner, as required.

On at 4:32 pm, the business office manager confirmed the findings.

Class III

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0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record reviews and interview, the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience and allowed unlicensed staff to perform glucose testing and administer for 1 of 2 sampled residents (#1).

Findings:

Record review for resident #1 revealed a health assessment form 1823, dated on that indicated she had a diagnosis of and she required medication administration.

Review of the 2017 Medication Observation Record (MOR) for resident #1 revealed entries for the following:

Accu-check by finger stick four times a day.

, inject 5 units before each meal.

The staffing initials key on the bottom of the MOR indicated that on , the initials of the staff who checked the glucose and who gave the 6pm dose of to resident #1 were those of staff C, an unlicensed caregiver.

On at 12:30 pm, the administrator confirmed the findings and said she thought at that time that the unlicensed caregivers were allowed to assist with glucose monitoring and administration.

Class III