| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11910275** | **12/15/2017** |
| NAME OF PROVIDER OR SUPPLIER<br>**GOOD SAMARITAN RETIREMENT HM** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**507 S.E. 1ST AVENUE WILLISTON, FL 32696** | |

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

**0000 - Initial Comments**

On a monitoring survey was conducted at Good Samaritan Assisted Living Facility at 507 SE 1st Ave, Williston, FL. (License number 25). Deficient practice was identified at time of survey.

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

Based on observation and interview the facility failed to have a signed Resident Health Assessment (AHCA Form 1823) by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner within 60 days before admission to the facility for 1 (#5) of 6 residents.

Findings:

On , Record review of Residents #5's file revealed an incomplete Resident Health Assessment (AHCA Form 1823); only the first 3 pages of the health assessment are on file at the facility. Resident #5's health assessment has not been completed or signed by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner.

On at 5:20 PM, the facility's owner confirmed Resident #5 did not have a signed resident health assessment on file at the facility.

Class III

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

Based on observation and interview the facility failed to document in residents record significant change in the residents health, specific to medication refusals and report it immediately to the health care provider for 5 (Resident #1, #2, #3, #4, and #5) of 6 residents.

Findings:

1. On , record review of Resident #1 Medication Observation record revealed: Medication refusals from through , for the following medications:

, 10 mg ( , ), refused 8 dosages.
, 81 mg ( Health), refused 8 dosages.
Levothroxine 25 mg ( ), refused 8 dosages.
, 20 mg. , 25mg. refused 19 dosages.
75 mg, , 200 mg (Mood stabilization), refused 22 dosages.

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

200 mg (for mood), refused 17 dosages.
0.5 mg ( ), refused 18 dosages.
15 mg (Sleep), refused 10 dosages.
25 mg, refused 12 dosages.

On a record review of residents records revealed no documentation that the resident's primary care physician or family were contacted regarding refusal of above medications.

On at 1:36 PM, interview conducted with first shift staff A, in reference to resident #1 medication refusals, Staff A stated "staff notified the manager and owner of the resident refusing his medication but she only documented the refusal information on the back of the medication record and did not write it on residents observation log that she reported it to management. She states she was not sure if the manager or owner contacted the physician or resident family when resident refused his medication during the earlier dates of . Staff A stated that the doctor visits the facility to provide care and treatment on occasion but she was not sure of the last visit, no documentation is on file related to physician's visits to the facility for the month of and . Regarding the incident on when resident #1 went to the hospital via emergency medical services ( ); staff stated the resident son was called due to resident #1 decline and behavior. The son informed staff to call 911 for medical attention, so they did. Staff A stated, "Resident had not been eating or taking his medication for several days; she states information regarding resident not eating was not documented in the staff communication log which is kept in the administrator office.

On at 3:07 PM, interview conducted with the facilities administrator; he stated, I am new here and unaware of the location of resident files, the communication log book, how change in medication orders are handled and if the physician was notified concerning resident medication refusals.

On at 5:15 PM, interview conducted with the facilities owner; She stated "I have been through three administrators and I don't know where anything is, I have to call my son". She stated the doctor conducts visits to the facility monthly but she does not know when. When ask for any supporting documentation, she stated, "I don't have any because it's not written down". When ask for the location of the observation logbook, she stated, "I have to call and ask my son". When ask for supporting documentation of notification to primary care physician and family in regards to resident's refusals of medication from 12/1- , she stated, "I am not aware of any documentation, I will call and ask my son". She stated all that information should have been written down, but she does not know where and she has to look for it.

2. During a record review conducted on it was revealed, Resident #2 had 25 documented

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(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

refusals of medication from through for 500 mg tablets, take 1 tablet by mouth 2 times a day.

On A record review of residents #2 file reveal no documentation indicating if primary care physician or family were notified regarding medication refusals by Resident #2.

On at 1:45 PM, Staff A stated the only documentation for resident #2's medication refusals for the month of 2017, was made under the nurses medication notes on the back of the residents medication observation record. She stated there is no other documentation regarding those medication refusals. Staff A stated, "the refusals were brought to the attention of the administrator and manager; and she is not sure if they notified the primary care physician or the resident family.

On at 5:25 PM, The facility owner stated she does not know if the primary care physician or family had been contacted about Resident #2, #3, #4, or #5's medication refusals. She stated that she has been through many administrator and has no idea where the documentation is located to verify if contacts were made.

3. On , Record review of Resident #3"s file revealed 14 refusals of medication from through for 100,000, apply to affected area 2 times a day per Medication Observation Record. There were also ten dosages missing from the MOR which required documentation.

Record Review of resident #3 record revealed no indication that the resident primary care physician or family were contacted about resident's refusal of medication.

On at 1:53 PM, interview conducted with Staff A stated concerning resident #3's medication refusals for the month of 2017, She stated the residents refusal of medication was not documented on any other form than the MOR. Staff A stated, "The refusals were brought to the attention of the administrator and manager; and she is not sure if they notified the primary care physician or the resident family.

On at 5:25 PM, The facility owner stated she does not know if the primary care physician or family had been contacted about resident #1 family being contacted prior to today or if the physician was contacted about resident #2, #3, #4, or #5's medication refusals. She stated that she has been through many administrator and has no idea where the documentation is located to verify if contacts were made to notify the doctor or the family as needed.

4. On , Record review of resident #4's medication observation record revealed on he

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refused all his AM medication for the following;

, 75 mg tablet take 1 tablet by mouth once a day for .
20 mg tablet take 1 tablet by mouth once a day for .
Sulf 325 MG tab take 1 tablet by mouth once a day.
2.5 mg tablet take 1 tablet by mouth in the morning for high .
SOD DR 40 mg T take 1 tablet by mouth daily for .
D2 5,000 unit softg take 1 capsule by mouth once a day.
MAPAP 325 Tablet take 1 tablet by mouth twice a day for pain.

On at 2:07 PM, interview conducted with Staff A; she stated as it relates to resident #4's medication refusals for the month of 2017, the refusals were documented under the nurses medication notes on the back of the residents medication record. She stated, "The refusal of medication was not placed on any other form regarding the refusals. Staff stated, "The refusals were brought to the attention of the administrator and manager; and she is not sure if they notified the primary care physician or the resident family.

On at 5:25 PM, The facility owner stated she does not know if the primary care physician or family had been contacted about Resident #2, #3, #4, or #5's medication refusals. She stated that she has been through many administrator and has no idea where the documentation is located to verify if contacts were made to notify the doctor or the family as needed.

5. On , Record review of resident #5's medication observation record revealed medication refusals from through . Documentation shows resident refused his 8:00 AM dose of 180 mg tablets, take 1 tablet by mouth daily. Resident refused his 8:00 AM dose of 600 mg tablets, take 1 tablet by mouth 3 times daily; no documentation displayed for the 12:00 PM dose, section observed to be blank. Refusals documented for residents 8:00 PM dose of , 25mg tablet, take 1 tablet by mouth twice daily (12/1- ). Review of residents file revealed no doctors' orders, and no observation notes on file.

On at 11:13 AM, interview conducted with office manager of doctors office. She stated that no one from the facility as of today had notified the office that resident #5 had been refusing his medications since , 2017. She stated that is a concern and she would notify the doctor immediately and she would contact the facility as to the doctor's response on the concern.

On at 2:16 PM, interview with Staff A stated as it relates to resident #5's medication refusals for the month of 2017, refusal documentation was made under the nurses medication notes on

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the back of the residents medication record. She stated, "the refusal of medication was not placed on any other form regarding the refusals. Staff stated, "the refusals were brought to the attention of the administrator and manager; and she is not sure if they notified the primary care physician or the resident family.

On at 5:25 PM, The facility owner stated she does not know if the primary care physician or family had been contacted about Resident #2, #3, #4, or #5's medication refusals. She stated that she has been through many administrator and has no idea where the documentation is located to verify if contacts were made to notify the doctor or the family as needed.

Class I

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

Based on observation and interview the facility failed to immediately update residents strength of medication changes for 2 (Resident #1 and Resident #4) of 6 residents.

Findings:

1.On , record review of Resident #1 Medication Observation record revealed: Medication refusals from through , for:

, 10mg ( , ),
, 81mg ( Health),
Levothroxine 25mg ( ),
, 20mg ,
, 25mg, 75mg,
, 200mg (Mood stabilization),
, 0.5mg ( ),
, 15mg (Sleep).

On through , documentation shows resident was in the hospital. Review of residents file revealed no documentation that the resident's primary care physician or family were contacted regarding refusal of medications. Resident #1's Doctors orders on file for the following medications: 25 mcg with a start date of to take 1 tablet by mouth every morning 1 hour before breakfast. The Medication Observation Record shows residentis currently take 1 tablet by mouth daily at 8:00AM for , after breakfast. Resident #1's doctors order for , 0.5mg tablets, take 1 tablet by mouth every 12 hours as needed for , with a start date of ; the residents MOR shows

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, 0.5mg tablets, and he is currently takeing 1 tablet by mouth twice a day for , at 8:00AM and 5:00PM. , 81mg tablet chewable, chew 1 tablet daily; the residents MOR shows the same. , 10mg tablet, take 1 tablet by mouth daily; the residents MAR shows the same. , 200mg tablet, take 1 tablet by mouth 2 times a day; the residents MAR shows the same. Doctors order for , 25 mg tablets, resident to take 1 tablet by mouth 2 times a day with a start date of ; the resident is currently taking , 50mg tablets, take 1 tablet by mouth 2 times a day ; hold if BR<60 or SBP<100. , 2mg capsule, take 1 capsule by mouth 4 times daily as needed for with a start date of ; the residents MAR shows , 2mg capsule, take 1 capsule by mouth every 6 hours as needed for . No order on file for , 15mg capsule at time of observation.

On at 1:36PM, interview conducted with first shift staff A, when asked questions regarding: Resident #1: Staff stated she was not aware resident's medication were changed on on his , , , , , , and Levothyroxin. She states that all doctors orders go to the administrator and they make the necessary changes or updated to the medication record then update the Med Techs as to the changes to include the start date and/or discharged medication if any. Staff A stated, "If the administrator or manager does not notify the staff of medication changer, there is no way that staff would have known of the orders". In reference to resident medication refusals, Staff A stated "staff notified the manager and owner of resident refusing his medication but she only documented the information on the back of the medication record and did not notate it on his observation log the she report it to management. She states she was not sure if the manager or owner contacted the physician or resident family during the earlier parts of . She states that the doctor visits the facility to provide care and treatment on occasion but she was not sure of the date of his last visit, no documentation is on file related to physician's visits to the facility for the month of and . Regarding the incident with resident going to the hospital via ; staff stated the resident son was call due to decline and the resident's son informed staff to call 911 for medical attention, so they did. Staff A stated, "Resident had not been eating or taking his medication for many days; she states information regarding resident not eating was not put in staff communication log book. She stated the communications logbook is kept in the administrator office.

On at 3:07PM, interview conducted with the facilities administrator; he stated "I am new here and unaware of the location of resident files, the communication log book, how change in medication orders are handled and if the physician was notified of the five resident medication refusals prior to the notification made today by the son of Manuel to call 911 for his father." "I will contact the owner to address those questions for you because I'm still learning this facility".

On at 5:15PM, interview conducted with the facilities owner ; she stated "I have been

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through three administrators and I don't know where anything is, I have to call my son". She stated the doctor conducts visits to the facility monthly but she does not know when. When ask for any supporting documentation, she stated, "I don't have any because it's not written down". When ask for the location of the observation logbook, she stated, "I have to call and ask my son". When ask for supporting documentation of notification to primary care physician and family in regards to resident's refusals of medication from 12/1- , she stated, "I am not aware of any documentation, I will call and ask my son". She stated all that information should have been written down, but she does not know where and she has to look for it.

2.On , Record review of resident #4's medication observation record revealed , 30mg tablets, take 1 tablet by mouth at bedtime. Doctors order dated shows an order to decrease , to 15mg. Resident is still receiving the 30mg dose as of . Doctors' orders dated indicate to start 5mg; resident medication record shows medication was started on .

On during a record review, no other orders or documentation were located in residents file to show compliance with the following medication as it relates to strength and frequency: , 75mg, , 20mg, sulf 325mg, , 2.5mg, Pantopazole 40mg, 250 mcg, D2 5,000 units, Mapap 325mg, 160mg, and NA 20mg.

On at 2:07PM, interview conducted with Staff A; she stated as it relates to resident #4's medication refusals for the month of 2017, documentation was made on under the nurses medication notes on the back of the residents medication record. She stated, "The refusal of medication was not placed on any other form regarding the refusals. Staff stated, "The refusals were brought to the attention of the administrator and manager; and she is not sure if they notified the primary care physician or the resident family. Staff states that she was not aware the resident had a change in medication on because the administrator did not update the medication record or notify the staff. She states she can only go by what the medication records says with assisting with self-administration of medication. (Staff was observed to discuss the medication changes with the new administrator but he is unaware of the changes and cannot locate the needed information, he stated he would call the facility owner for assistance to address the issue).

On at 5:25PM, The facility owner stated she does not know if the primary care physician or family had been contacted about Resident #2, #3, #4, or #5's medication refusals. She stated that she has been through many administrator and has no idea where the documentation is located to verify if contacts were made to notify the doctor or the family as needed.

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

Class II

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

Based on observation and interview the facility failed to update changes in direction for use of medication for 2 (Resident #1 and Resident #4) of 6 residents.

Findings:

1. On , record review of Resident #1 Medication Observation record revealed: Medication refusals from through for:

, , 10mg ( , ),
, 81 mg ( Health),
Levothroxine 25mg ( , ), , 20 mg ,
, 25mg,
75 mg,
, 200 mg (Mood stabilization),
, 0.5 mg ( , ),
, 15 mg (Sleep).

On through , documentation shows resident was in the hospital. Review of residents file revealed no documentation that the resident's primary care physician or family were contacted regarding refusal of medications. Resident #1's Doctors orders on file for the following medications: , 25 mcg with a start date of to take 1 tablet by mouth every morning 1 hour before breakfast. The Medication Observation Record shows residents currently take 1 tablet by mouth daily at 8:00 AM for , , after breakfast. Resident #1's doctors order for , , 0.5 mg tablets, take 1 tablet by mouth every 12 hours as needed for , with a start date of ; the residents MOR shows , 0.5 mg tablets, and he is currently taking 1 tablet by mouth twice a day for , at 8:00 AM and 5:00 PM. , 81 mg tablet chewable, chew 1 tablet daily; the residents MOR shows the same. , 10mg tablet, take 1 tablet by mouth daily; the residents MAR shows the same. , 200 mg tablet, take 1 tablet by mouth 2 times a day; the residents MAR shows the same. Doctors order for , 25 mg tablets, resident to take 1 tablet by mouth 2 times a day with a start date of ; the resident is currently taking , 50 mg tablets, take 1 tablet by mouth 2 times a day ; hold if BR<60 or SBP<100. , 25mg capsule, take 1 capsule by mouth 4 times daily as needed for with a start date of ; the residents MAR shows , 25mg capsule, take 1 capsule by mouth every 6 hours as needed for . No order on

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file for , 15 mg capsule at time of observation. The residents MOR was not updated to reflect the order.

On at 1:36 PM, interview conducted with first shift staff A, when asked questions regarding: Resident #1: Staff stated she was not aware resident's medication were changed on on his , , , , , , and Levothyroxin. She states that all doctors orders go to the administrator and they make the necessary changes or updated to the medication record then update the Med Techs as to the changes to include the start date and/or discharged medication if any. Staff A stated, "If the administrator or manager does not notify the staff of medication changer, there is no way that staff would have known of the orders". In reference to resident medication refusals, Staff A stated "staff notified the manager and owner of resident refusing his medication but she only documented the information on the back of the medication record and did not write it on his observation log the she report it to management. She states she was not sure if the manager or owner contacted the physician or resident family during the earlier parts of . She states that the doctor visits the facility to provide care and treatment on occasion but she was not sure of the date of his last visit, no documentation is on file related to physician's visits to the facility for the month of and . Regarding the incident with resident going to the hospital via ; staff stated the resident son was call due to decline and the resident's son informed staff to call 911 for medical attention, so they did. Staff A stated, "Resident had not been eating or taking his medication for many days; she states information regarding resident not eating was not put in staff communication log book. She stated the communications logbook is kept in the administrator office.

On at 3:07 PM, interview conducted with the facilities administrator; he stated "I am new here and unaware of the location of resident files, the communication log book, how change in medication orders are handled and if the physician was notified of the five resident medication refusals prior to the notification made today by the son of Manuel to call 911 for his father." "I will contact the owner to address those questions for you because I'm still learning this facility".

On at 5:15 PM, interview conducted with the facilities owner ; she stated "I have been through three administrators and I don't know where anything is, I have to call my son". She stated the doctor conducts visits to the facility monthly but she does not know when. When ask for any supporting documentation, she stated, "I don't have any because it's not written down". When ask for the location of the observation logbook, she stated, "I have to call and ask my son". When ask for supporting documentation of notification to primary care physician and family in regards to resident's refusals of medication from 12/1- , she stated, "I am not aware of any documentation, I will call and ask my son". She stated all that information should have been written down, but she does not know where and she has to look for it.

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2. On , Record review of resident #4's medication observation record revealed , 30 mg tablets, take 1 tablet by mouth at bedtime. Doctors order dated shows an order to decrease , to 15 mg. Resident is still receiving the 30 mg dose as of . Doctors' orders dated indicate to start 25mg; resident medication record shows medication was started on . Attempted to contact prescribing physician to inquire about possible side effect due to continues strength of 30 mg being consumed by resident, at time of call, there was no answer, message was left to return call to surveyor. Recorded message stated all calls would be returned within 48 hours. No other orders or documentation were located in residents file to show compliance with the following medication as it relates to strength and frequency: , 75 mg, , 20 mg, sulf 325 mg, , 2.5 mg, Pantopazole 40 mg, 250 mcg, D2 5,000 units, Mapap 325 mg, 160 mg, and NA 20 mg.

On at 2:07 PM, interview conducted with Staff A; she stated as it relates to resident #4's medication refusals for the month of 2017, documentation was made on under the nurses medication notes on the back of the residents medication record. She stated, "The refusal of medication was not placed on any other form regarding the refusals. Staff stated, "The refusals were brought to the attention of the administrator and manager; and she is not sure if they notified the primary care physician or the resident family. Staff states that she was not aware the resident had a change in medication on because the administrator did not update the medication record or notify the staff. She states she can only go by what the medication records says with assisting with self-administration of medication. (Staff was observed to discuss the medication changes with the new administrator but he is unaware of the changes and cannot locate the needed information, he stated he would call the facility owner for assistance to address the issue).

On at 5:25 PM, The facility owner stated she does not know if the primary care physician or family had been contacted about Resident #2, #3, #4, or #5's medication refusals. She stated that she has been through many administrator and has no idea where the documentation is located to verify if contacts were made to notify the doctor or the family as needed.

Class II

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**0000 - Initial Comments**

On a monitoring survey was conducted at Good Samaritan Assisted Living Facility at 507 SE 1st Ave, Williston, FL. (License number 25). Deficient practice was identified at time of survey.

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

Based on observation and interview the facility failed to have a signed Resident Health Assessment (AHCA Form 1823) by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner within 60 days before admission to the facility for 1 (#5) of 6 residents.

Findings:

On , Record review of Residents #5's file revealed an incomplete Resident Health Assessment (AHCA Form 1823); only the first 3 pages of the health assessment are on file at the facility. Resident #5's health assessment has not been completed or signed by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner.

On at 5:20 PM, the facility's owner confirmed Resident #5 did not have a signed resident health assessment on file at the facility.

Class III

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

Based on observation and interview the facility failed to document in residents record significant change in the residents health, specific to medication refusals and report it immediately to the health care provider for 5 (Resident #1, #2, #3, #4, and #5) of 6 residents.

Findings:

1. On , record review of Resident #1 Medication Observation record revealed: Medication refusals from through , for the following medications:

, 10 mg ( , ), refused 8 dosages.
, 81 mg ( Health), refused 8 dosages.
Levothroxine 25 mg ( ), refused 8 dosages.
, 20 mg. , 25mg. refused 19 dosages.
75 mg, , 200 mg (Mood stabilization), refused 22 dosages.

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200 mg (for mood), refused 17 dosages.
0.5 mg ( ), refused 18 dosages.
15 mg (Sleep), refused 10 dosages.
25 mg, refused 12 dosages.

On a record review of residents records revealed no documentation that the resident's primary care physician or family were contacted regarding refusal of above medications.

On at 1:36 PM, interview conducted with first shift staff A, in reference to resident #1 medication refusals, Staff A stated "staff notified the manager and owner of the resident refusing his medication but she only documented the refusal information on the back of the medication record and did not write it on residents observation log that she reported it to management. She states she was not sure if the manager or owner contacted the physician or resident family when resident refused his medication during the earlier dates of . Staff A stated that the doctor visits the facility to provide care and treatment on occasion but she was not sure of the last visit, no documentation is on file related to physician's visits to the facility for the month of and . Regarding the incident on when resident #1 went to the hospital via emergency medical services ( ); staff stated the resident son was called due to resident #1 decline and behavior. The son informed staff to call 911 for medical attention, so they did. Staff A stated, "Resident had not been eating or taking his medication for several days; she states information regarding resident not eating was not documented in the staff communication log which is kept in the administrator office.

On at 3:07 PM, interview conducted with the facilities administrator; he stated, I am new here and unaware of the location of resident files, the communication log book, how change in medication orders are handled and if the physician was notified concerning resident medication refusals.

On at 5:15 PM, interview conducted with the facilities owner; She stated "I have been through three administrators and I don't know where anything is, I have to call my son". She stated the doctor conducts visits to the facility monthly but she does not know when. When ask for any supporting documentation, she stated, "I don't have any because it's not written down". When ask for the location of the observation logbook, she stated, "I have to call and ask my son". When ask for supporting documentation of notification to primary care physician and family in regards to resident's refusals of medication from 12/1- , she stated, "I am not aware of any documentation, I will call and ask my son". She stated all that information should have been written down, but she does not know where and she has to look for it.

2. During a record review conducted on it was revealed, Resident #2 had 25 documented

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refusals of medication from through for 500 mg tablets, take 1 tablet by mouth 2 times a day.

On A record review of residents #2 file reveal no documentation indicating if primary care physician or family were notified regarding medication refusals by Resident #2.

On at 1:45 PM, Staff A stated the only documentation for resident #2's medication refusals for the month of 2017, was made under the nurses medication notes on the back of the residents medication observation record. She stated there is no other documentation regarding those medication refusals. Staff A stated, "the refusals were brought to the attention of the administrator and manager; and she is not sure if they notified the primary care physician or the resident family.

On at 5:25 PM, The facility owner stated she does not know if the primary care physician or family had been contacted about Resident #2, #3, #4, or #5's medication refusals. She stated that she has been through many administrator and has no idea where the documentation is located to verify if contacts were made.

3. On , Record review of Resident #3"s file revealed 14 refusals of medication from through for 100,000, apply to affected area 2 times a day per Medication Observation Record. There were also ten dosages missing from the MOR which required documentation.

Record Review of resident #3 record revealed no indication that the resident primary care physician or family were contacted about resident's refusal of medication.

On at 1:53 PM, interview conducted with Staff A stated concerning resident #3's medication refusals for the month of 2017, She stated the residents refusal of medication was not documented on any other form than the MOR. Staff A stated, "The refusals were brought to the attention of the administrator and manager; and she is not sure if they notified the primary care physician or the resident family.

On at 5:25 PM, The facility owner stated she does not know if the primary care physician or family had been contacted about resident #1 family being contacted prior to today or if the physician was contacted about resident #2, #3, #4, or #5's medication refusals. She stated that she has been through many administrator and has no idea where the documentation is located to verify if contacts were made to notify the doctor or the family as needed.

4. On , Record review of resident #4's medication observation record revealed on he

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refused all his AM medication for the following;

, 75 mg tablet take 1 tablet by mouth once a day for .
20 mg tablet take 1 tablet by mouth once a day for .
Sulf 325 MG tab take 1 tablet by mouth once a day.
2.5 mg tablet take 1 tablet by mouth in the morning for high .
SOD DR 40 mg T take 1 tablet by mouth daily for .
D2 5,000 unit softg take 1 capsule by mouth once a day.
MAPAP 325 Tablet take 1 tablet by mouth twice a day for pain.

On at 2:07 PM, interview conducted with Staff A; she stated as it relates to resident #4's medication refusals for the month of 2017, the refusals were documented under the nurses medication notes on the back of the residents medication record. She stated, "The refusal of medication was not placed on any other form regarding the refusals. Staff stated, "The refusals were brought to the attention of the administrator and manager; and she is not sure if they notified the primary care physician or the resident family.

On at 5:25 PM, The facility owner stated she does not know if the primary care physician or family had been contacted about Resident #2, #3, #4, or #5's medication refusals. She stated that she has been through many administrator and has no idea where the documentation is located to verify if contacts were made to notify the doctor or the family as needed.

5. On , Record review of resident #5's medication observation record revealed medication refusals from through . Documentation shows resident refused his 8:00 AM dose of 180 mg tablets, take 1 tablet by mouth daily. Resident refused his 8:00 AM dose of 600 mg tablets, take 1 tablet by mouth 3 times daily; no documentation displayed for the 12:00 PM dose, section observed to be blank. Refusals documented for residents 8:00 PM dose of , 25mg tablet, take 1 tablet by mouth twice daily (12/1- ). Review of residents file revealed no doctors' orders, and no observation notes on file.

On at 11:13 AM, interview conducted with office manager of doctors office. She stated that no one from the facility as of today had notified the office that resident #5 had been refusing his medications since , 2017. She stated that is a concern and she would notify the doctor immediately and she would contact the facility as to the doctor's response on the concern.

On at 2:16 PM, interview with Staff A stated as it relates to resident #5's medication refusals for the month of 2017, refusal documentation was made under the nurses medication notes on

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the back of the residents medication record. She stated, "the refusal of medication was not placed on any other form regarding the refusals. Staff stated, "the refusals were brought to the attention of the administrator and manager; and she is not sure if they notified the primary care physician or the resident family.

On at 5:25 PM, The facility owner stated she does not know if the primary care physician or family had been contacted about Resident #2, #3, #4, or #5's medication refusals. She stated that she has been through many administrator and has no idea where the documentation is located to verify if contacts were made to notify the doctor or the family as needed.

Class I

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

Based on observation and interview the facility failed to immediately update residents strength of medication changes for 2 (Resident #1 and Resident #4) of 6 residents.

Findings:

1.On , record review of Resident #1 Medication Observation record revealed: Medication refusals from through , for:

, 10mg ( , ),
, 81mg ( Health),
Levothroxine 25mg ( ),
, 20mg ,
, 25mg, 75mg,
, 200mg (Mood stabilization),
, 0.5mg ( ),
, 15mg (Sleep).

On through , documentation shows resident was in the hospital. Review of residents file revealed no documentation that the resident's primary care physician or family were contacted regarding refusal of medications. Resident #1's Doctors orders on file for the following medications: 25 mcg with a start date of to take 1 tablet by mouth every morning 1 hour before breakfast. The Medication Observation Record shows residentis currently take 1 tablet by mouth daily at 8:00AM for , after breakfast. Resident #1's doctors order for , 0.5mg tablets, take 1 tablet by mouth every 12 hours as needed for , with a start date of ; the residents MOR shows

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, 0.5mg tablets, and he is currently takeing 1 tablet by mouth twice a day for , at 8:00AM and 5:00PM. , 81mg tablet chewable, chew 1 tablet daily; the residents MOR shows the same. , 10mg tablet, take 1 tablet by mouth daily; the residents MAR shows the same. , 200mg tablet, take 1 tablet by mouth 2 times a day; the residents MAR shows the same. Doctors order for , 25 mg tablets, resident to take 1 tablet by mouth 2 times a day with a start date of ; the resident is currently taking , 50mg tablets, take 1 tablet by mouth 2 times a day ; hold if BR<60 or SBP<100. , 2mg capsule, take 1 capsule by mouth 4 times daily as needed for with a start date of ; the residents MAR shows , 2mg capsule, take 1 capsule by mouth every 6 hours as needed for . No order on file for , 15mg capsule at time of observation.

On at 1:36PM, interview conducted with first shift staff A, when asked questions regarding: Resident #1: Staff stated she was not aware resident's medication were changed on on his , , , , , , and Levothyroxin. She states that all doctors orders go to the administrator and they make the necessary changes or updated to the medication record then update the Med Techs as to the changes to include the start date and/or discharged medication if any. Staff A stated, "If the administrator or manager does not notify the staff of medication changer, there is no way that staff would have known of the orders". In reference to resident medication refusals, Staff A stated "staff notified the manager and owner of resident refusing his medication but she only documented the information on the back of the medication record and did not notate it on his observation log the she report it to management. She states she was not sure if the manager or owner contacted the physician or resident family during the earlier parts of . She states that the doctor visits the facility to provide care and treatment on occasion but she was not sure of the date of his last visit, no documentation is on file related to physician's visits to the facility for the month of and . Regarding the incident with resident going to the hospital via ; staff stated the resident son was call due to decline and the resident's son informed staff to call 911 for medical attention, so they did. Staff A stated, "Resident had not been eating or taking his medication for many days; she states information regarding resident not eating was not put in staff communication log book. She stated the communications logbook is kept in the administrator office.

On at 3:07PM, interview conducted with the facilities administrator; he stated "I am new here and unaware of the location of resident files, the communication log book, how change in medication orders are handled and if the physician was notified of the five resident medication refusals prior to the notification made today by the son of Manuel to call 911 for his father." "I will contact the owner to address those questions for you because I'm still learning this facility".

On at 5:15PM, interview conducted with the facilities owner ; she stated "I have been

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through three administrators and I don't know where anything is, I have to call my son". She stated the doctor conducts visits to the facility monthly but she does not know when. When ask for any supporting documentation, she stated, "I don't have any because it's not written down". When ask for the location of the observation logbook, she stated, "I have to call and ask my son". When ask for supporting documentation of notification to primary care physician and family in regards to resident's refusals of medication from 12/1- , she stated, "I am not aware of any documentation, I will call and ask my son". She stated all that information should have been written down, but she does not know where and she has to look for it.

2.On , Record review of resident #4's medication observation record revealed , 30mg tablets, take 1 tablet by mouth at bedtime. Doctors order dated shows an order to decrease , to 15mg. Resident is still receiving the 30mg dose as of . Doctors' orders dated indicate to start 5mg; resident medication record shows medication was started on .

On during a record review, no other orders or documentation were located in residents file to show compliance with the following medication as it relates to strength and frequency: , 75mg, , 20mg, sulf 325mg, , 2.5mg, Pantopazole 40mg, 250 mcg, D2 5,000 units, Mapap 325mg, 160mg, and NA 20mg.

On at 2:07PM, interview conducted with Staff A; she stated as it relates to resident #4's medication refusals for the month of 2017, documentation was made on under the nurses medication notes on the back of the residents medication record. She stated, "The refusal of medication was not placed on any other form regarding the refusals. Staff stated, "The refusals were brought to the attention of the administrator and manager; and she is not sure if they notified the primary care physician or the resident family. Staff states that she was not aware the resident had a change in medication on because the administrator did not update the medication record or notify the staff. She states she can only go by what the medication records says with assisting with self-administration of medication. (Staff was observed to discuss the medication changes with the new administrator but he is unaware of the changes and cannot locate the needed information, he stated he would call the facility owner for assistance to address the issue).

On at 5:25PM, The facility owner stated she does not know if the primary care physician or family had been contacted about Resident #2, #3, #4, or #5's medication refusals. She stated that she has been through many administrator and has no idea where the documentation is located to verify if contacts were made to notify the doctor or the family as needed.

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Class II

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

Based on observation and interview the facility failed to update changes in direction for use of medication for 2 (Resident #1 and Resident #4) of 6 residents.

Findings:

1. On , record review of Resident #1 Medication Observation record revealed: Medication refusals from through for:

, , 10mg ( , ),
, 81 mg ( Health),
Levothroxine 25mg ( , ), , 20 mg ,
, 25mg,
75 mg,
, 200 mg (Mood stabilization),
, 0.5 mg ( , ),
, 15 mg (Sleep).

On through , documentation shows resident was in the hospital. Review of residents file revealed no documentation that the resident's primary care physician or family were contacted regarding refusal of medications. Resident #1's Doctors orders on file for the following medications: , 25 mcg with a start date of to take 1 tablet by mouth every morning 1 hour before breakfast. The Medication Observation Record shows residents currently take 1 tablet by mouth daily at 8:00 AM for , , after breakfast. Resident #1's doctors order for , , 0.5 mg tablets, take 1 tablet by mouth every 12 hours as needed for , with a start date of ; the residents MOR shows , 0.5 mg tablets, and he is currently taking 1 tablet by mouth twice a day for , at 8:00 AM and 5:00 PM. , 81 mg tablet chewable, chew 1 tablet daily; the residents MOR shows the same. , 10mg tablet, take 1 tablet by mouth daily; the residents MAR shows the same. , 200 mg tablet, take 1 tablet by mouth 2 times a day; the residents MAR shows the same. Doctors order for , 25 mg tablets, resident to take 1 tablet by mouth 2 times a day with a start date of ; the resident is currently taking , 50 mg tablets, take 1 tablet by mouth 2 times a day ; hold if BR<60 or SBP<100. , 25mg capsule, take 1 capsule by mouth 4 times daily as needed for with a start date of ; the residents MAR shows , 25mg capsule, take 1 capsule by mouth every 6 hours as needed for . No order on

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file for , 15 mg capsule at time of observation. The residents MOR was not updated to reflect the order.

On at 1:36 PM, interview conducted with first shift staff A, when asked questions regarding: Resident #1: Staff stated she was not aware resident's medication were changed on on his , , , , , , and Levothyroxin. She states that all doctors orders go to the administrator and they make the necessary changes or updated to the medication record then update the Med Techs as to the changes to include the start date and/or discharged medication if any. Staff A stated, "If the administrator or manager does not notify the staff of medication changer, there is no way that staff would have known of the orders". In reference to resident medication refusals, Staff A stated "staff notified the manager and owner of resident refusing his medication but she only documented the information on the back of the medication record and did not write it on his observation log the she report it to management. She states she was not sure if the manager or owner contacted the physician or resident family during the earlier parts of . She states that the doctor visits the facility to provide care and treatment on occasion but she was not sure of the date of his last visit, no documentation is on file related to physician's visits to the facility for the month of and . Regarding the incident with resident going to the hospital via ; staff stated the resident son was call due to decline and the resident's son informed staff to call 911 for medical attention, so they did. Staff A stated, "Resident had not been eating or taking his medication for many days; she states information regarding resident not eating was not put in staff communication log book. She stated the communications logbook is kept in the administrator office.

On at 3:07 PM, interview conducted with the facilities administrator; he stated "I am new here and unaware of the location of resident files, the communication log book, how change in medication orders are handled and if the physician was notified of the five resident medication refusals prior to the notification made today by the son of Manuel to call 911 for his father." "I will contact the owner to address those questions for you because I'm still learning this facility".

On at 5:15 PM, interview conducted with the facilities owner ; she stated "I have been through three administrators and I don't know where anything is, I have to call my son". She stated the doctor conducts visits to the facility monthly but she does not know when. When ask for any supporting documentation, she stated, "I don't have any because it's not written down". When ask for the location of the observation logbook, she stated, "I have to call and ask my son". When ask for supporting documentation of notification to primary care physician and family in regards to resident's refusals of medication from 12/1- , she stated, "I am not aware of any documentation, I will call and ask my son". She stated all that information should have been written down, but she does not know where and she has to look for it.

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2. On , Record review of resident #4's medication observation record revealed , 30 mg tablets, take 1 tablet by mouth at bedtime. Doctors order dated shows an order to decrease , to 15 mg. Resident is still receiving the 30 mg dose as of . Doctors' orders dated indicate to start 25mg; resident medication record shows medication was started on . Attempted to contact prescribing physician to inquire about possible side effect due to continues strength of 30 mg being consumed by resident, at time of call, there was no answer, message was left to return call to surveyor. Recorded message stated all calls would be returned within 48 hours. No other orders or documentation were located in residents file to show compliance with the following medication as it relates to strength and frequency: , 75 mg, , 20 mg, sulf 325 mg, , 2.5 mg, Pantopazole 40 mg, 250 mcg, D2 5,000 units, Mapap 325 mg, 160 mg, and NA 20 mg.

On at 2:07 PM, interview conducted with Staff A; she stated as it relates to resident #4's medication refusals for the month of 2017, documentation was made on under the nurses medication notes on the back of the residents medication record. She stated, "The refusal of medication was not placed on any other form regarding the refusals. Staff stated, "The refusals were brought to the attention of the administrator and manager; and she is not sure if they notified the primary care physician or the resident family. Staff states that she was not aware the resident had a change in medication on because the administrator did not update the medication record or notify the staff. She states she can only go by what the medication records says with assisting with self-administration of medication. (Staff was observed to discuss the medication changes with the new administrator but he is unaware of the changes and cannot locate the needed information, he stated he would call the facility owner for assistance to address the issue).

On at 5:25 PM, The facility owner stated she does not know if the primary care physician or family had been contacted about Resident #2, #3, #4, or #5's medication refusals. She stated that she has been through many administrator and has no idea where the documentation is located to verify if contacts were made to notify the doctor or the family as needed.

Class II