STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967749	**12/28/2017**
NAME OF PROVIDER OR SUPPLIER **ANGEL CARE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **4301 31ST ST SOUTH** **SAINT PETERSBURG, FL 33712**	

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

0000 - Initial Comments

Assisted Living Facility

Two complaint surveys, (CCR# 2017014452 and CCR# 2017015429), were conducted in conjunction with a biennial re-licensure survey at Angel Care Assisted Living Facility on . Deficient practice was identified during the complaint survey.

(License # 11734)

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

Based on interviews and record reviews, the facility failed to ensure that Medical Observation Records (MORs) were accurate and free from omissions and errors and were immediately updated each time medications were offered for six Residents (#1, #3, #8, #9, #19, and #20) of nine sampled residents that need assistance with self-administration of medications (med).

Findings included:

A MOR review conducted on for Resident #1, who needs assistance with self-administration of medications, revealed that orders for , 1mg take one tablet every 6 hours and , 1mg tablet take three tablets every day at 6pm were not being followed. Haloperidal scheduled for 9:00am, 1:00pm, 6:00pm, and 9:00pm. revealed no distinction between how many tablets were signed for at 6:00pm.

Medications not signed as given include:
- , on at 9am and 1pm, at 9am and 1pm, at 1pm, at 1pm, at 1pm and at 9am and 1pm
- 50mg tablet on at 9pm and at 9pm
- 550mg tablet on at 9am, at 9am and 9pm, at 9pm and at 9am.

Medications circled as not given with no documented reason included:
- , 1mg at 9am and 1pm
- circled on through at 9am

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- 400mg on through , , , and through at 9am
- , DR 20mg on , , , , through at 9am
- ER 10meq on through at 9am

A MOR review conducted on for Resident #3, who needs assistance with self-administration of medication, revealed that 10GM/15ml oral solution take every 8 hours was scheduled on the MOR at 7am, 2pm, and 10pm (not every 8 hours as ordered).

Medications not signed as given included:
- , DR 125mg on through and at 9am
- , DR 250mg on at 9am, at 9am and 9pm, at 9pm, and at 9am
- , 300mg on and through at 9pm

Medications circled as not given with no documented reason included:
- 750mg on at 8am
- , 100mg on at 9pm
- 0.4mg on at 9pm

A MOR review conducted on for Resident #8, who needs assistance with self-administration of medications, revealed there were medications not signed as given which include:
- , 1mg on and at 9am and through and through at 9pm
- , 125mg DR at 9am and and at 9pm

Medications circled as not given with no documented reason included:
- , 1mg on through , , and at 9am and at 9pm
- , 125mg DR on at 9pm and at 9am

A MOR review conducted on for Resident #9, who needs assistance with self-administration of medications, revealed two orders for Tears. The first order was for tears twice every day and the second was for Tears four times every day. The discontinued twice daily Tears was not indicated on the MOR and was being signed for at 9am and 9pm. The Tears order for four times (order date:) a day was also being signed as given every day at 8am, 12pm, 4pm, and 8pm.

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Other meds not signed as given as ordered included:
- 4mg on through at 9pm
- 20mg on and at 9pm

A MOR review conducted on for Resident #19, who needs assistance with self-administration of medication, discovered meds not signed as given which included:
- 0.1% solution on through and at 08:00am and on at 06:00pm
- 40mg on , and at 08:00am and on at 06:00pm
- Amlodopine 10mg at 09:00am

A MOR review conducted on for Resident #20, who needs assistance with self-administration of medications, revealed meds not signed as given which included , 0.5mg on and at 8pm. There were also meds circled as not given with no reason documented on the back of the MOR and included: , 0.5mg on , through , , , , at 8pm.

A review of facility policy and procedure conducted on revealed the facility failed to follow Policy and Procedure Medication Standards which states "the facility must maintain a daily MOR for each Resident who receives assistance with self-administration of medication. A chart for recording each time the medication is taken, any missed dosages, refusals to take medications as prescribed, or med errors. MOR must immediately be updated each time the medication is offered. MOR must have dates for discontinued medications. MOR must document when Resident is away from the facility.

A staff interview conducted on at 03:21pm with the Assistant Administrator confirmed and acknowledged that the facility failed to follow Facility Policy and Procedure Medication Standards with the lack of documentation and errors on MORs.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation, interview, and record review the facility failed to maintain secured storage of medications (meds), placing all residents at risk for potentially serious outcomes by accessing meds that are not their own.

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Findings included:

An observation conducted on at 11:37am revealed unsecured meds at the med station next to the salon. The med cart was found to be unlocked and the med was wide open. The refrigerator in the med many medications, including , (See Photographic Evidence2). No staff was in attendance at the med station.

An interview was conducted on at 11:44am with Staff B, (Med Tech) who revealed that it is not unusual that the med is unlocked. Staff B stated that, "There's nothing in there but and eye drops."

Review of Facility Policy and Procedure on revealed that the Medication Storage Policy stated that, "centrally stored medications must be kept in a locked cabinet, locked cart or other locked storage receptacle, , or area at all times. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked or by keeping the area in which the refrigerator is located locked."

An interview conducted on at 02:02pm with the Assistant Administrator revealed that the med carts and the med "should be locked at all times."

Class III

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

Based on observation, interview, and record review, the facility failed to ensure proper transfer of medications from one storage container to another for one resident (#1) who requires assistance with self-administration of medication.

Findings included:

An observation of the med cart conducted on at 11:15am revealed a bottle of 50mg for Resident #1. Resident #1 has an order for 50mg take one tablet by

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mouth every night at bedtime for mood. According to the medication bottle, it was filled on . The medication bottle contained three whole tablets and eighteen half tablets (See Photographic Evidence1). No other bottles of were found in the med cart for Resident #1.

During an interview conducted on at 03:21pm the Assistant Administrator confirmed and acknowledged that there were two different pills within the bottle for Resident #1.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on interview and observation, the facility failed to provide a safe and clean living environment.

Findings included:

An observation of the facility laundry area on revealed piles of dirty and soiled linens outside of the laundry .

During interview with the Staff "C", on at 10:45am, she stated "I do the laundry and wash resident clothes. The aides bring bagged clothes to me. I wash, fold, and return them to the residents. "

A second observation of the facility laundry area, on at 4:00pm still revealed piles of dirty and soiled linens remaining outside of the laundry . Staff E stated that Staff "C" had gone for the day.

During an interview with Staff "E", on at 4:05pm, she stated the linen should have been placed inside of the laundry , to staff leaving from work.

Class III