STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968902	R 02/14/2018
NAME OF PROVIDER OR SUPPLIER **MAGNOLIA GARDENS LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **350 MAGNOLIA RD** **VENICE, FL 34293**	

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

0000 - Initial Comments

An unannounced revisit survey was conducted on at Magnolia Gardens LLC, an assisted living facility (license #12776) in Venice, Florida.

This was a follow-up to the relicensure survey completed on and follow-up survey completed on .

The following is description of the deficiencies found at the time of the visit.

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

Based on record review and staff and resident interview, the facility failed to accurately implement physician orders for 2 (Resident #3 and #4) out of 3 residents reviewed for physician orders.

The findings included:

1. Review of the Agency for Health Care AdministrationForm 1823 (AHCA Form 1823) for Resident #3 dated , revealed that Resident #3 had a physician's order for "medication administration." Upon interview on at 2:30 p.m., unlicensed caregiver Staff C stated that she assists the resident with self-administration of medications. Staff C acknowledged that only a licensed nurse can administer medications.

Review of the , 2018 Medication Record, for Resident #3, revealed an order for , 325 mg tablet, take 1 by mouth every 4 hours as needed for pain/ . This order was also noted on AHCA Form 1823, dated . When questioned regarding the order, Staff C stated "I don't understand. I cannot give that, only a nurse can." Staff C acknowledged that she cannot give medication that requires judgement or evaluation (of a).

2. Resident #4 was admitted to the facility on . Review of the medical record revealed physician's orders dated . Review of the resident's Medication Record, for the time period of to , revealed that it did not agree with the physician's orders. When questioned, unlicensed caregiver Staff C could not explain the discrepancy.

The facility Administrator was contacted by telephone on at 1:00 p.m., and when questioned he advised that an AHCA Form 1823 was recently completed for Resident #4 and he had that form in his possession. He continued to state that he would fax the form to the AHCA area office.

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3. During an interview on [redacted] at 2:00 p.m., Resident #2 stated that Staff C (unlicensed caregiver) brought her medications earlier today and she took them. She also said that Staff C gives her breathing medication and "I put it (the medication) in the [redacted] and do that myself."

An AHCA Form 1823, page 4, and a medication list, both dated [redacted], was received via fax on [redacted]. Review of page 4 revealed that Question B was not answered by the physician, resulting in a failure to have physician's orders indicating how Resident #4 should be receiving her medications.

Class III

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

Based on medication record review and staff interview, the facility failed to maintain an accurate record of medication received by 2 (Resident #3 and #4) out of 3 residents.

The findings included:

1. Review of Resident #3's medication record, for the time period of [redacted] through [redacted], revealed that the following medications were not received by the resident, as ordered by the physician:
-Metroprolol [redacted] 50 mg tablet, one tablet by mouth twice daily, was not given at 8:00 p.m. on [redacted].
- [redacted] 500 mg tablet, one tablet by mouth by mouth twice daily, was not given at 8:00 p.m. on [redacted].
- [redacted] 0.4 mg capsule, one capsule by mouth two times a day, was not given at 8:00 p.m. on [redacted].

Further record review revealed no documentation stating why the medications were not given.

During an interview on [redacted] at 3:15 p.m., unlicensed caregiver Staff C revealed that she did not have any knowledge as to why the medications were not given.

2. Review of Resident #4's medication record, for the time period of [redacted] through [redacted], revealed that the following medications were not received by the resident as ordered by the physician:
- [redacted], 15 mcg/2 ml solution, inhale the contents of one vial two times a day, was not given at 8 p.m. on [redacted] and [redacted].
- [redacted] 0.5 mcg/2 ml suspension, inhale the contents of 1 vial via [redacted] 2 times a day, was not given at 8:00 a.m. on [redacted] and [redacted], and at 8:00 p.m. on [redacted], [redacted], and [redacted].

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- 20mg tablet, one tablet by mouth daily, was not given at 12:00 p.m. on .

Further record review revealed documentation stating " , Bronava ( ), don't have it." No other documentation was evidenced as to why the other medications were not given.

During an interview on at 3:15 p.m., caregiver Staff C revealed that she did not have any knowledge as to why the medications were not given.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and staff interview, the facility failed to develop and submit a Comprehensive Emergency Management Plan (CEMP) to the local Emergency Management Agency, in a timely manner.

The findings included:

During a second follow-up survey, conducted on , the facility Administrator was not in the facility and could only be contacted via telephone. Upon telephone interview at 11:45 a.m., the Administrator stated he had submitted the facility CEMP to Sarasota County last week. When asked if he had any documentation that Sarasota County received the plan, he said "Yes." When asked where the CEMP and verification that it was submitted was located in the facility, he stated it was not in the facility, he had it with him. The Administrator continued to state that he would fax the documentation to the Agency for Health Care Administration (AHCA). When asked if there was a copy of the CEMP in the facility for staff to refer to in the event the plan needed to be implemented, the Administrator said "No."

A fax was received from the Administrator on . It stated "Plan received, thank you. You will be notified upon review." It was noted to be signed by an Emergency Management at the local County Emergency Management Agency. This documentation verifies that the facility does not have an approved CEMP.

Class III

0182 - Emergency Mgmt - Plan Implementation - 58A-5.026(3) FAC

Based on record review, observation, and staff interview, the facility failed to train all staff relating to their duties for implementation of the facility Comprehensive Emergency Management Plan (CEMP).

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The findings included:

Upon entrance to the facility on [redacted] at 11:30 a.m., unlicensed caregiver Staff C advised that the Administrator was not in the facility and could be reached via telephone. Observation and interview revealed that caregiver Staff C was the only staff member in the facility. When asked where the facility CEMP was located, Staff C stated "I don't have anything to do with that. That is not my job." When asked if she ever had any training regarding implementation of the CEMP, she stated, "No, I don't know what it is."

During an interview via telephone on [redacted] at 11:45 a.m., the Administrator said he had the CEMP with him and there was not a copy in the facility for staff to refer to. When asked if staff had been trained on how to implement the emergency plan, he stated "No, I just submitted it to the county."

Class III