STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968286	R 02/26/2018
NAME OF PROVIDER OR SUPPLIER **CHRISTALLIS MANOR, CORP.**	STREET ADDRESS, CITY, STATE, ZIP CODE **2119 WILSON STREET** **HOLLYWOOD, FL 33020**	

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

0000 - Initial Comments

A Limited Nursing Service (LNS) monitoring revisit was conducted on at Christallis Manor, Corp., License #12232. The facility had new and uncorrected deficiencies at the time of the visit.

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview and record review, the facility failed to ensure acceptable professional nursing standards of practice were followed for administration of . This was evidenced by the nurses' failure to follow manufacturer recommendations for expiration dates with opened for 2 of 2 sampled , dependent residents (Residents #3 and #7).

The findings include:

1. Review of Resident #3 Resident Health Assessment form dated on indicated that the resident required medication management and skilled nursing to administer . Review of the , 2018 Medication Observation Record (MOR) indicated that Resident #3 had a diagnosis of dependent and was prescribed Levimir 25 units and 5 units every morning and evening. During an observation of Resident #3's medication on at 10:00AM, an opened box of five 3 ml Levimir pens, dispensed on was observed inside the facility medication cart. Further review of the packaging indicated that the pens should be stored in a place until first use, and to store at 36 - 46 degrees F. Observation made of the outside of the pen box revealed no date when it had been opened. Review of Resident #3's prescription box revealed it was dispensed from the pharmacy on . The prescription box was open and had the bottle inside with the protective seal broken off, both had no date indicating when opened by the nurse. In an additional observation, an unopened box/vial of , dated , was being stored inside the medication refrigerator.

Review of the manufacturers instructions for use of the Levimir and indicated that unopened pens should be kept in the refrigerator at a temperature range between 36-46 degrees F until each pen is opened for use. Review of the instructions for use indicated that an opened bottle/vial should be used within 28 days of being opened and then the bottle discarded.

2. Review of Resident #7 Resident Health Assessment form dated on indicated that the resident required medication management and skilled nursing to administer . Review of the , 2018 Medication Observation Record (MOR) indicated that Resident #7 had a diagnosis of

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dependent and was prescribed 18 units in the morning and Humulog 6 units every morning and evening. Review of Resident #7's medication revealed a prescription of N dispensed from the pharmacy on . The prescription box was open and the bottle inside had the protective seal broken off, neither had a date indicating when it had been opened by the nurse. In an observation of the Humulog prescription dispensed from the pharmacy on , the bottle had been opened but no date was written on the bottle. In an additional observation, unopened boxes of N and Humulog dated , were being stored inside the medication refrigerator.

Review of the manufacturers instructions for use of the opened vials of -N and Humulog indicated that the should be used within 28 days of being opened and then the bottle discarded.

In an interview with the Owner RN on at 11:00 AM she stated that the facility did not employ nurses, but contracted with a Home Health Agency to provide a nurse who would conduct daily glucose testing and administer to the residents as ordered by their physician. The Owner RN stated that she did not administer any of the medications to the residents. She stated that she would expect the Home Health nurse to adhere to professional nursing standards of practice for medication administration, which included following pharmacy and drug manufacturer guidelines for proper use and documentation. She stated that she expected the nurse to document on the vial when it is initially opened and discarding the vial based on manufacturers recommendations. She stated that she could not explain why the Home Health nurse had not utilized the new prescription bottles for use for Resident #3 and #7 and incorrectly stored the Levimir pens inside the medication cart. She stated that she would be contacting the Home Health nurse to discuss the findings and review medication administration practices for the facility.

Class III

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

Based on observation, interview and record review, the facility failed to maintain an accurate daily Medication Observation Record (MOR) for the residents. This was evidenced by the failure of the nurse to accurately document the prescribed medications that were administered on the MOR, for 1 of 2 sampled residents (Resident #3).

The findings include:

Record review of the , 2018 MOR for Resident #3 indicated that the resident had not been

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administered the morning medication dose as prescribed by the healthcare provider on .

Review of Resident #3 ' s Health Assessment form dated on indicated that the resident required medication management and skilled nursing to administer . Further review of the , 2018 MOR indicated that Resident #3 had a diagnosis of dependent and was prescribed 5 units every morning and every evening.

In an interview with the Owner Registered Nurse (RN) on at 11:00AM, she was informed of the omissions on the resident's MOR and stated that it was the facility policy, that when medication is administered to a resident, the MOR must be completed at that time. She stated that the facility did not employ nurses, but contracted with a Home Health Agency to provide a nurse who would conduct glucose testing and administer to the resident as ordered by their physician. Owner RN stated that she would expect that administered to a resident should be documented as given on the MOR. The owner RN stated that she had no explantion why the Home Health Nurse failed to document that the prescribed had been administered.

Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on observation, interview and record review, the facility failed to maintain an accurate daily Medication Observation Record (MOR) for the residents. This was evidenced by the failure of the nurse to accurately document on the MOR prescribed medication that was administered for 1 of 2 sampled residents (Resident #3).

The findings include:

Record review of the , 2018 MOR for Resident #3 indicated that the resident had not been administered the morning medication on as prescribed by the resident's healthcare provider.

Review of Resident #3 ' s Health Assessment form dated on indicated that the resident required medication management and skilled nursing to administer . Review of the , 2018 MOR indicated that Resident #3 had a diagnosis of dependent and was prescribed 5 units every morning and every evening.

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In an interview with the Owner Registered Nurse (RN) on at 11:00 AM, she was informed of the omissions on the resident's MOR and stated that it was the facility policy, that when medication is administered to a resident, the MOR must be completed at that time. She stated that the facility did not employ nurses, but contracted with a Home Health Agency to provide a nurse who would conduct glucose testing and administer to the resident as ordered by their physician. Owner RN stated that she would expect that the administered to the resident should be documented as given on the MOR. The owner RN stated that she had no explanation why the Home Health Nurse failed to document that the prescribed had been administered.

Based on the uncorrected class III deficiency concerning failure to maintain an accurate daily medication observation record (MOR) for the residents, it is recommended the facility employ the consultation services of a licensed pharmacist or licensed registered nurse. This serves as a written notification of the recommendation for the above described consultation services.

Class III