STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910121	R 02/19/2018
NAME OF PROVIDER OR SUPPLIER **ROCKY CREEK VILLAGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **8606 BOULDER COURT** **TAMPA, FL 33615**	

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

0000 - Initial Comments

Assisted Living Facility

An unannounced 2nd Revisit to 10/5/17 & 12/27/17 Complaint (CCR# 2017007859) was conducted on 2/19/18, in conjunction with an unannounced Biennial Survey and Complaint Investigation (CCR# 2017015459, 2018000842, & 2018001445).

Deficient practice was identified at the time of this visit.

License #5227

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

Based on observation, record review, and interview, the facility failed to ensure proper maintenance of a daily medication observation record (MOR) for 4 of 7 sampled residents (Residents #7, 13, 14 and 15) who receive assistance with self-administration of medications, including the name, strength, and physician directions for use of each medication, recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.

Findings included:

Four Medication Observation Records (MORs) randomly selected for review at the facility on beginning at 11:00am contained errors and omissions including the following:

Resident #7 was prescribed 10mg tab with physician orders to take 1 tablet by mouth at 7am, 1pm, & 7pm; Resident #7's Medication Observation Record (MOR) listed the medication to be taken at 8am, 12noon, & 9pm. This medication was not initialed as provided at noon (or 1pm) on . This medication was not listed on reverse of the MOR-no date, time, reason, results, or staff initials <photographic evidence obtained>.

Resident #7 was prescribed 0.025% cream with physician orders to apply to lower back 4 times per day at 8am, 12pm, 5pm, & 9pm. This medication was not initialed as provided at 12pm on and not listed on reverse of the MOR-no date, time, reason, results, or staff initials <photographic evidence obtained>.

Resident #13 was prescribed 325mg tablet with physician orders to take 2 tablets by

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mouth every 6 hours. Resident #13's Medication Observation Record (MOR) listed the medication to be taken at 8am, 12noon, 5pm, & 9pm, at 4- and 5-hour intervals, not every 6 hours as prescribed. As of review, the medication was initialed as provided 4 times per day at the times indicated on the MOR from 2/1 through and at 8am on <photographic evidence obtained>.

Resident #14 was prescribed 5mg with physician orders to take ½ tab at bedtime. This medication was written on the MOR to be provided at 5pm. Per observation, the was placed by the pharmacy in the same bedtime pack section as 40mg tab prescribed to be provided at 9:00pm. The medication was provided at the prescribed time because it was placed by the pharmacy with Resident #14's other bedtime med; however, the medication was documented incorrectly as provided at 5pm from 2/1 through . This medication was not initialed as provided - and not listed on reverse of the MOR-no date, time, reason, results, or staff initials <photographic evidence obtained>.

Resident #15 was prescribed with physician orders to be provided on (Day 4) at 7am, 12pm, & 8pm. The medication was not initialed as provided on at 7am & 12pm. The medication was also prescribed to be provided on (Day 5) at 7am & 8pm. The medication was not initialed as provided on at 8pm as of review. The medication was not listed on reverse of MOR-no date, time, reason, results, or staff initials <photographic evidence obtained>.

Per interview conducted with the Licensed Practical Nurse (LPN) on at 11:20am, the LPN emphasized that residents are getting medications as prescribed by their physicians; however, the facility's documentation did not ensure accurate provision.

Uncorrected Class III

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

Based on record review and interview, the facility failed to implement a corrective action plan to address an uncorrected class III deficiency directly relating to facility medication practices and provide a signed and dated review of the corrective action plan by a licensed pharmacist or registered nurse.

Findings included:

Class III Deficient medication practice was cited on and not corrected by the Revisit. The facility was required to employ the consultant services of a licensed pharmacist or registered nurse

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to provide, at a minimum, onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. The facility was required to develop and implement a corrective action plan for deficiencies related to assistance with the self-administration of medication within 48 hours after notification of such deficiency and have available for review by the agency the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit.

On :30am, the Assisted Living Facility (ALF) Manager provided a "Pharmacy Service Agreement" stating the Pharmacy "MAY offer the quarterly, 4-hour training Assistance with Self-Administration of Medications for the staff ..." dated . On :30pm, the Manager provided a Pharmacy Contract to Provide Services quarterly beginning .

Per Florida Statute, the initial on-site consultant visit must take place within 14 working days of the notice of the ( ) uncorrected class III deficiency. Per record review and interview with the Manager, training was provided by the Pharmacy on . The Administrator provided a Corrective Action Plan dated stating pharmacy training will be conducted . The facility did not have available for review by the Agency on the consultant's signed and dated review of the corrective action plan required no later than 10 working days subsequent to the initial on-site consultant visit. The Manager stated that Assisted Living medication services are new to the Pharmacy, so the facility is working with the pharmacy to improve services.

Class III Deficient medication practice (Tag 0054) cited on was not corrected by the Revisit and not corrected by the 2nd Revisit conducted 2/19/18. The facility is required to develop and implement a corrective action plan, provide the licensed pharmacist or registered nurse consultant's license and signed and dated review of the corrective action plan, and ensure that the consultant provides a minimum of quarterly onsite consultation until the inspection team from the agency determines that such consultation services are no longer required.

Uncorrected Class III