STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968617	03/08/2018
NAME OF PROVIDER OR SUPPLIER **HOUSE OF LIGHT SENIOR LIVING II**	STREET ADDRESS, CITY, STATE, ZIP CODE **839 CHELSEA AVE NE** **PALM BAY, FL 32905**	

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

0000 - Initial Comments

A re-licensure survey was conducted on . House of Light Senior Living II, license #12496, had deficiencies at the time of the visit.

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

Based on observations, record review and interview the facility failed to ensure the unlicensed staff who assisted 1 of 1 resident (#1) with self-administration of medications followed the correct procedure.

Findings:

During observation of the medication pass at 8:45 AM, staff A unlocked the medication cabinet pantry off the kitchen and removed the box of medications and MOR for Resident #1. She brought them to the resident who was seated in the kitchen. Staff A explained that she was going to give him his medications. She filled a glass with water, put on non-sterile gloves and checked the MOR. She reviewed the MOR, reading it silently to herself. She placed one pill in a small paper cup, handed it to the resident and said, "Here is your ." She then placed several of the tablets in a small dish, searching for a half tablet. She fished it out with the small paper med cup and placed it in the resident's hand saying, "Here is the tiny one, be careful not to drop it." She repeated the process with each med, saying, "Here is your ," "this is , for your ," and "here is the last one."
She returned the medications to the box, documented on the MOR that each was given. Staff A returned everything to the locked cabinet. She did not, in the presence of the resident, read each label out loud to the resident.

In an interview with Staff A at 9:00 AM on , when asked if she read the labels out loud, she confirmed she did not and said she didn't know she was supposed to do that every time.

On at 1:30 PM, the administrator said Staff A knows the proper procedure but she might have been nervous.

Class III

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

Based on observation, review of the Medication Observation Record (MOR) and interview, the facility

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HOUSE OF LIGHT SENIOR LIVING II	**839 CHELSEA AVE NE PALM BAY, FL 32905**

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

failed to follow provider orders for a medication for 1 of 1 sampled residents (#1).

Findings:

During observation of the medication pass, for resident #1, Staff A placed several tablets in a small dish, searching for a half tablet. She fished it out with the small paper med cup and placed it in the resident's hand saying, "Here is the tiny one, be careful not to drop it." She documented in the MOR that the medication was given.

Review of the printed label on the bottle found " 6.25mg Tab; Take one half tablet by mouth twice daily for , less than 110 , /top number; Dr. Joseph Glasner; filled with a quantity of 90 pills.
Review of the printed MOR for 2018 revealed 6.25mg tab with the directions to "Take one tablet by mouth twice a day in the morning and in the evening with food." which was written on .

Review of the order in the resident record written on by the house ARNP read "D/C parameters at ( ), give routine."

Staff A said she did not know the order did not match the label on the bottle. She stated she read the MOR, but had always given him ½ a pill, and did not realize she was supposed to give one whole pill twice a day.

On at 9:30 AM, the administrator, stated resident #1 came to the facility in , 2017 with a large supply of medications from the VA and they were still using them. She stated when the resident first arrived at the facility; she alerted the VA physician that she could not accept a medication to be given with parameters. She said the house ARNP then wrote a new order in , 2017, but they had not needed to get refills yet. She said the new order and the current MORs all had the new instructions and she was not aware that the staff were still giving the one-half tablet as written on the old bottle label.

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on resident contract review and interview, the facility contract did not document a resident must provide a 30 day written notice of intent to discharge for 2 of 2 sampled residents (#1 & #3); In addition, the contract failed to include a statement indicating "if after a contract is terminated, the facility intends to

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SUMMARY STATEMENT OF DEFICIENCIES
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make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond" as per 429.24(3)(a), F. S. for 1 of 2 sampled residents. (#3).

Findings:

Review of the resident contracts for residents #1 & #3 revealed language that the resident was required to provide a 45-day notice to the administrator of intent to discharge.

Review of the contract for resident #3 did not revealed wording regarding a claim against a refund and the notification to the resident required.

On at 1:45PM, the administrator stated she did not realize the contract read the resident needed to provide 45 days' notice. She also stated she had revised the facility contract since resident #3 had been admitted.

Class