STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911234	04/04/2018
NAME OF PROVIDER OR SUPPLIER **BETHESDA ON TURKEY CREEK**	STREET ADDRESS, CITY, STATE, ZIP CODE **2800 FORDHAM ROAD, NE** **PALM BAY, FL 32905**	

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

0000 - Initial Comments

A Complaint Investigation #2018001032 was conducted on , , 2018. Bethesda on Turkey Creek, License #4788, had deficiencies at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview, the facility failed to follow an order from a health care provider for 1 of 3 sampled residents (#1), and failed to notify a health care provider and family when a resident was sent to the hospital (#2).

Findings:

1. Review of the medication packages for resident #1 on at 2:45 p.m. revealed a bubble package in which the prescription label indicated the package contained , , 400 milligram (mg.) tablets. Twelve tablets were filled on and twelve tablets remained in the package. Review of the , 2018 Medication Observation Record (MOR) for resident #1 revealed the , was not listed. The resident care director was present during the review, confirmed the findings, and said she would call the pharmacy to obtain the order.

Resident #1's most recent health assessment form 1823, dated on , indicated the resident required assistance with medications.

Resident #1's record did not contain an order from a health care provider for the , but a facility note, dated , indicated , , 400 mg. three times a day with meals was to be started.

On at 3:30 p.m., the resident care director provided an order for , , dated , and said resident #1 did not receive , as prescribed because a hospice nurse sent the order electronically to the pharmacy and the facility did not know about the order.

2. On at 4:10 p.m., the resident care director said resident #2 was sent to the hospital on for and chest pain, and returned to the facility on . Resident #2's record did not contain documentation to indicate she was sent to the hospital, that a health care provider was notified, and that a family member was notified.

On at 4:15 p.m., the resident care director confirmed the findings. At 4:25 p.m., the resident care director said the nurse who sent the resident to the hospital did not notify a health care provider or

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the resident's family, as required.

Class III

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

Based on record review and interview, the facility failed to make every reasonable effort to ensure a prescription was filled in a timely manner for a resident who received assistance with self-administered medications (#2).

Findings:

On at 2:12 p.m., resident #2 said in the last six months she ran out of her pain medications, went several days without them, and due to that she felt an increased amount of pain.

Resident #2's most recent health assessment form, dated , indicated the resident had a diagnosis of chronic back pain and required assistance with self-administered medications.

Resident #2's 2018 and 2018 Medication Observation Records (MORs) indicated she was to receive 150 milligrams (mg.) by mouth three times a day at 8 a.m., 2 p.m., and 8 p.m. for and Extended Release 30 mg. by mouth every 8 hours at 6 a.m., 2 p.m., and 10 p.m. for low back pain.

The staff initials for the dose at 8 a.m., 2 p.m., and 8 p.m. from through , and at 8 a.m. and 2 p.m. on and were circled.

The staff initials for the dose at 10 p.m. on , and at 6 a.m. and 2 p.m. on were also circled.

The 2018 MOR did not have any documentation to indicate why the doses were circled. Documentation on the back of the 2018 MOR indicated and were unavailable.

Resident #2's record did not contain any documentation to indicate the facility made any efforts to obtain a timely refill for . Facility refill request forms indicated that on , a refill request was faxed to the pharmacy, and thirteen tablets remained. On , a refill request was faxed to the pharmacy and six tablets remained. However, there was no documentation to indicate the faxes were received by the pharmacy, and no documentation to indicate anyone from the facility called to follow-up

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with the pharmacy when the refills were not received.

On at 4:10 p.m., the resident care director confirmed the findings, confirmed the resident ran out of her , and , and said she did not know until that the resident did not have any more pain medications, at which time, she contacted hospice who assisted in obtaining refills.

Class II

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observations, review of the menu dates and interview, the facility failed to have current menus posted.

Findings:

Review of the facility's posted menu revealed it was for week two. Review of the menu dates provided by the dietary manager revealed that for the week of , week three menu was to be used.

On at 11:45 a.m., the dietary manager confirmed the wrong menu was posted.

Class

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to maintain a written record when a resident was sent to the hospital (#2).

Findings:

On at 4:10 p.m., the resident care director said resident #2 was sent to the hospital on for and chest pain, and returned to the facility on . Resident #2's record did not contain documentation to indicate she was sent to the hospital, that a health care provider was notified, and that a family member was notified.

On at 4:15 p.m., the resident care director confirmed the findings.

Class