STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969178	**04/10/2018**
NAME OF PROVIDER OR SUPPLIER **CAIRN PARK 5**	STREET ADDRESS, CITY, STATE, ZIP CODE **2003 ACADEMY BLVD CAPE CORAL, FL 33990**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR #2018002968 and CCR #2018003988 was conducted on at Cairn Park 5, an assisted living facility (license #12986) in Cape Coral, Florida.

The following is description of the deficiencies.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review and staff interview, the facility failed to demonstrate that a procedure for receiving and responding to resident complaints was implemented on receipt of a complaint.

The findings included:

On at 7:10 a.m., night shift Resident Aid ( ) Staff A said both shifts do laundry. Staff A said almost all residents' clothes are labeled or marked, but sometimes, if there is a new staff member, they are unfamiliar with the residents and the clothes can go to the wrong person.

On at 7:10 a.m., day shift Staff B agreed that both shifts do laundry. She said she was aware of a family being dissatisfied with missing laundry and the wrong clothes on a resident. Staff B did not indicate which resident this was. Staff B said this happens when a staff member covers a shift that is not familiar with the residents.

During an interview on at 7:27 a.m., the Administrator said she had only been with the facility for 2 weeks and she was unaware of issues with clothing. The Administrator said she wasn't aware of a grievance log or how the complaints would have been handled.

Class III

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

Based on record review and staff interview, the facility failed to update the Medication Observation Record (MOR) each time a medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors for 4 (Residents 2,3,4, and 5) out of 5 resident MORS reviewed.

The findings included:

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A review of Resident #2's MOR for , 2018 revealed a blank spot on at 8:00 p.m. for , ( ) 500 mg 1 tablet by mouth (PO) 2 times a day for 10 days. There was no documentation on the back of the MOR to indicate why the medication had not been given.

A review of Resident #3's MOR for , 2018 revealed Resident #3 had not been given (supplement) 50 mg 1 tablet twice a day . The back of the MOR indicated it was "out". The MOR also had a blank spot on at 8:00 p.m. for Lumigan , solution (eye drop) 1 drop in each eye at 8:00 p.m. There was no documentation on the back of the MOR to indicate why the eye drops had not been given.

A review of Resident #4's MOR for , 2018 revealed a blank spot on at 8:00 p.m. for both Rosuvastatin (medication for high) 20 mg take 1 tablet by mouth at 8:00 p.m. and ( ) 8.6 mg take two tablets by mouth at bedtime. A blank spot was also noted on at 8:00 a.m. for ( ) 75-0.2 mg take 1 tablet by mouth daily. There was no documentation on the back of the MOR to indicate why the medications had not been given.

A review of Resident #5's MOR for , 2018 revealed a blank spot on at 8:00 p.m. for , (anti depressant) 30 mg take 1 tablet by mouth at 8:00 p.m., ( ) 1 mg by mouth at bedtime and Divaloprex (medicine) 250 mg by mouth at bedtime. There was no documentation on the back of the MOR to indicate why the medications had not been given.

During an interview on at 9:15 a.m., the Administrator agreed there was missing documentation on the MORs and she was disappointed by this.

Class III

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

Based on record review and staff interview, the facility failed to ensure that prescriptions for residents who receive assistance with self-administration of medications are filled or refilled in a timely manner and family/responsible party is given ample notice of need to refill or notice of change in prescription for 2 (Residents #3 and #1) of 5 resident records reviewed.

The findings included:

Resident #3's chart showed an order dated for (supplement) 50 mg take 1 tab twice a day. Family to provide. Resident #3's Medication Observation Record (MOR) for , 2018 showed resident

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hasn't been given all month, with the back of MOR indicating "out" for reason not given. No documentation was found in chart that the family had been notified it needed refilling. On at 8:30 a.m., the Administrator said she had been worried about all the herbals the resident was taking and interactions with other medications. The Administrator said she asked the family to contact the doctor, however had no documentation of this, nor any order to discontinue giving the medication to the resident. The Administrator admitted she hadn't realized there was a physician's order for the .

Resident #1's chart revealed a prescription for 0.25 mg by mouth as needed for , dated . Resident #1's Health Assessment Form 1823 (1823) dated signed by the facility Advanced Registered Nurse Practitioner indicated ( ) 0.5 mg 1 tab as needed every 6 hours by mouth. Resident #1's original 1823 signed by a Medicine Doctor on did not include this medication. There was no documentation in the chart that the resident's power of attorney/health surrogate had been notified of the change in medications.

On at 8:05 a.m., the Administrator replied "that's a good question" when asked where the documentation of family notification of medican changes was. The Administrator explained she had only been with the facility for 2 weeks and was beginning to go through the charts and felt this was a form/process that would need to be added.

Class III