STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965739	R 04/16/2018
NAME OF PROVIDER OR SUPPLIER **HERON CLUB AT PRESTANCIA (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **3749 SARASOTA SQUARE BLVD. SARASOTA, FL 34238**	

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

0000 - Initial Comments

An unannounced revisit survey was conducted on at The Heron Club at Prestancia, an Assisted Living Facility in Sarasota, Florida. This was a follow-up to the re-licensure survey completed on and .

The following is description of the deficiencies at the time of the visit.

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

Based on observation, record review and interview, the facility failed to ensure residents sampled received their medications as ordered by their health care provider for 15 (Resident's #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28) out of 15 residents sampled.

The findings included:

1. Resident #14's had no documentation if the resident had received medication on at 4:00 p.m., and no reason was documented why the resident did not receive the medication.
The medication , ( ) 300 mg (milligrams) to be taken twice daily was scheduled at 8:00 a.m., and 4:00 p.m.
The medication , (,) 10 mg, to be taken 1 tablet daily was scheduled at 8:00 p.m. There was no documentation by the facility staff that the resident received the medication on at 8:00 p.m., and no reason was documented as to why it was not given.

2. Resident #15's medication ( ) 20 mg, to be taken 1 tablet by mouth every evening and scheduled for and at 6:00 p.m. The doses were not given and the reason it was not given, was not documented by the facility staff.

3. Resident #16's medication , , to instill 2 drops in both eyes three times daily for 5 days was scheduled at 8:00 a.m., 12:00 p.m. and 4:00 p.m. There was no documentation by the facility staff that the resident received the medication on dates through at 4:00 p. m., and on at 12:00 p.m., and no reason was listed why the resident did not receive the medication.

4. Resident #17's medication ( ) to be taken 20 mg tablet, take 1 tablet by mouth at bedtime as prescribed by health care provider and scheduled at 8:00 p.m. was not documented by facility staff as given on dates and . There was no reason documented by facility staff why the medications were not given.

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5. Resident #18's medication [redacted], PF solution to be taken as instill 1 drop each eye twice daily was scheduled at 8:00 a.m. and 8:00 p.m.. There was documentation by facility staff that medication was not given on [redacted] through [redacted] at 8:00 a.m. and [redacted] through [redacted] at 8:00 p.m. There was no reason documented by facility staff as to why the medication was not given.
The medication [redacted] ([redacted]) 20 mg tablets to be taken 1 tablet by mouth at bedtime was scheduled at 8:00 p.m. There was no documentation that the medication was given on date at 8:00 p.m., and no reason as to why the medication was not given documented by facility staff.

6. Resident #19's medication [redacted] ([redacted]) (pain medication) 10 mg tablet, to be given 1 tablet by mouth 3 times daily and scheduled 8:00 a.m., 2:00 p.m., and 8:00 p.m. There was no documentation by facility staff that the medication was given at 8:00 p.m., on [redacted] and 2:00 p.m., on [redacted] all 3 times and no reason documented by the facility staff as to why the medication was not given.

7. Resident #20's medication [redacted] Tears 1.4%, for 2 drops in each eye twice daily and scheduled at 8:00 a.m., and 4:00 p.m. There was no documentation that the medication was given by facility staff on [redacted] at 8:00 a.m., and no reason documented by the facility staff as to why the medication was not given.

8. Resident #21's medication [redacted], ([redacted]) 40 mg tablet, to be taken 1 tablet by mouth daily and scheduled 8:00 a.m. The medication was charted by the facility staff as not given on [redacted] and [redacted] through [redacted] at 8:00 a.m., and no reason was documented by the facility staff as to why medication was not given.
The medication [redacted] ([redacted]) 2 mg tablet, to be taken 1 tablet by mouth twice daily and scheduled at 8:00 a.m., and 4:00 p.m. There was no documentation by the facility staff that medication was given on [redacted] through [redacted] at 8:00 a.m., and 4:00 p.m., and no reason was documented by the facility staff as to why the medication was not given.

9. Resident #22's medication [redacted] ([redacted]) ([redacted] med) 125 mcg (micrograms), to be taken 1 tablet by mouth once daily was scheduled 6:00 p.m. There was no documentation by the facility staff that the medication was given on [redacted] and [redacted] at 6:00 p.m., and no reason documented by the facility staff as to why the medication was not given.
The medication [redacted] 30 mg, to be taken one capsule by mouth three times daily was scheduled at 6:00 a.m., 12:00 p.m., and 10:00 p.m. There was no documentation by the facility staff that the medication was given on [redacted] and [redacted] at 12:00 p.m., and [redacted] at 10:00 p.m., and [redacted] at 10:00 p.m., and no reason was documented by the facility staff as to why the medication was not given.

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10. Resident #23's medication [illegible] ([illegible])([illegible]) 20 mg, to be taken 1 tablet by mouth once daily was scheduled 8:00 a.m. There was no documentation that the medication was given by the facility staff on [illegible] at 8:00 a.m., and no reason was documented by the facility staff as to why the medication was not given.
The medication [illegible] 50 mg, to be taken one tablet by mouth once daily was scheduled at 8:00 a.m. There was no documentation by the facility staff that the medication was given on [illegible] at 8:00 a.m., and no reason was documented by the facility staff as to why the medication was not given.
The medication [illegible] 10 mg, to be taken 3 tablets by mouth once daily before dinner was scheduled at 4:00 p.m. There was no documentation by the facility staff that the resident received the medication on [illegible] at 4:00 p.m., and no reason documented by the facility staff as to why medication was not given.
The medication [illegible] 25 mg, to be taken 2 tablets by mouth twice daily was scheduled 8:00 a.m., and 4:00 p.m. There was no documentation by the facility staff that the medication was given on [illegible] at 4:00 p. m., and [illegible] at 8:00 a.m., and no reason documented by the facility staff as to why the medication was not given.
The medication [illegible] (anti-clotting med) 15 mg, to be taken one tablet by mouth twice daily for 13 days was scheduled at 8:00 a.m., and 4:00 p.m. The medication was not documented by the facility staff as given on [illegible] at 4:00 p.m., and [illegible] at 8:00 a.m., and no reason documented by the facility staff as to why the medication was not given.

11. Resident #24's medication [illegible] ([illegible], [illegible]) ([illegible] med) tab 1000 mg, to be taken 1 tablet by mouth every evening was scheduled at 5:00 p.m. The medication was not documented by the facility staff as given on [illegible], [illegible] through [illegible] at 5:00 p.m., and no documentation by facility staff as to why the medication was not given.
The medication [illegible] ([illegible]) 40 mg tablet, to be taken one tablet by mouth daily was scheduled at 9:00 p.m. The medication was not documented by the facility staff as given on 4/6.18, [illegible] and [illegible] and no reason was documented by the facility staff as to why the medication was not given.
The medication [illegible], (Dalmane) 15 mg cap, to be taken 1 capsule by mouth at bedtime was scheduled at 8:00 p.m. The medication was not documented by the facility staff as given on [illegible], [illegible] and [illegible] and no reason was documented by the facility staff as to why the medication was not given.
The medication [illegible], ([illegible]) 15 mg tablet, to be taken 1 tablet by mouth at bedtime at (unknown time). The medication was not documented by the facility staff as given on [illegible], [illegible] and [illegible] and no reason documented by the facility staff as to why the medication was not given.

12. Resident #25's medication [illegible] tablet 325 mg (Feosol)(iron med), to be taken 1 tablet by

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mouth daily was scheduled at 8:00 a.m. The medication was not documented by the facility staff as given on and and no reason documented by the facility staff as to why the medication was not given.
The medication Cream 2% ( ) right 4th finger to be applied , , to affected areas twice daily was scheduled at 8:00 a.m., and 4:00 p.m. The medication was not documented by the facility staff as given on through and through and and at 8:00 a.m.. and at 4:00 p.m., and no reason documented by the facility staff as to why the medication was not given.

13. Resident #26's medication tab 10000 mcg (,) 10000 mcg tablet, to be taken 1 tablet by mouth daily was scheduled at 8:00 a.m. The medication was not documented by facility as given on and and no reason was documented by the facility staff as to why the medication was not given.
The medication , ( ) 10 mg tablet, to be taken 1 tablet by mouth daily was scheduled at 8:00 a.m. The medication was not documented by the facility staff as given on and no reason documented by the facility staff as to why medication was not given.
The medication , ( ) ER 500 mg tablet, to be taken 2 tablets (1000 mg) by mouth daily was scheduled at 8:00 a.m. The medication was not documented by the facility staff as given and no reason was documented by the facility staff as to why the medication was not given.
The medication ( ) 20 mg tablet, to be taken 1/2 tab (10 mg) by mouth at bedtime was scheduled at 8:00 p.m. The medication was not documented by facility staff as given on and and no reason was documented by the facility staff as to why the medication was not given.
The medication (Hytrin) 1 mg capsule, to be taken 1 capsule by mouth at bedtime was scheduled at 8:00 p.m. The medication was not documented by the facility staff as given on and and no reason was documented by the facility staff as to why the medication was not given.
The medication , , 25 mg, to be taken 1 tablet by mouth once daily at bedtime was scheduled at 8:00 p.m. The medication was not documented by the facility staff as given on and and no reason was documented by the facility staff as to why the medication was not given.

14. Resident #27's medication 20 meq ER tab (Kdur) 20 meq, to be taken 1 tablet by mouth daily was scheduled 8:00 a.m. The medication was not documented by the facility staff as given on through and no reason was documented by the facility staff as to why the medication was not given.

15. Resident #28's medication , Inhaler 100-25, to inhale 1 puff by mouth daily with device (family to provide) was scheduled at 10:00 a.m. The medication was not documented by the facility staff as given on through and no reason was documented by the facility staff as to why the

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medication was not given.

16. On at 1:00 p.m., the Director of Health and Wellness reported that he was not aware medications for residents were not documented as given by the facility staff and the information on Medication Observation Records were incomplete.

Class III

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

Based on observation, record review, and interview, the facility failed to maintain a daily Medication Observation Record (MOR) for 2 (Residents #23 and #26) out of 15 resident MOR's sampled and the facility failed to update immediately each time a medication was offered to 15 (Residents #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28) out of 15 residents sampled.

The findings included:

1. Resident #14's had no documentation if the resident had received medication on at 4:00 p.m., and no reason was documented why the resident did not receive the medication.
The medication ( ) 300 mg (milligrams) to be taken twice daily was scheduled at 8:00 a.m., and 4:00 p.m.
The medication ( ) 10 mg, to be taken 1 tablet daily was scheduled at 8:00 p.m. There was no documentation by the facility staff that the resident received the medication on at 8:00 p.m., and no reason was documented as to why it was not given.

Resident #15's medication ( ) 20 mg, to be taken 1 tablet by mouth every evening and scheduled for and at 6:00 p.m. The doses were not given and the reason it was not given, was not documented by the facility staff.

Resident #16's medication , , to instill 2 drops in both eyes three times daily for 5 days was scheduled at 8:00 a.m., 12:00 p.m. and 4:00 p.m. There was no documentation by the facility staff that the resident received the medication on dates through at 4:00 p. m., and on at 12:00 p.m., and no reason was listed why the resident did not receive the medication.

Resident #17's medication ( ) to be taken 20 mg tablet, take 1 tablet by mouth at bedtime as prescribed by health care provider and scheduled at 8:00 p.m. was not documented by

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facility staff as given on dates and . There was no reason documented by facility staff why the medications were not given.

Resident #18's medication , PF solution to be taken as instill 1 drop each eye twice daily was scheduled at 8:00 a.m. and 8:00 p.m.. There was documentation by facility staff that medication was not given on , through at 8:00 a.m. and through at 8:00 p.m. There was no reason documented by facility staff as to why the medication was not given.
The medication ( ) 20 mg tablets to be taken 1 tablet by mouth at bedtime was scheduled at 8:00 p.m. There was no documentation that the medication was given on date at 8:00 p.m., and no reason as to why the medication was not given documented by facility staff.

Resident #19's medication ( ) (pain medication) 10 mg tablet, to be given 1 tablet by mouth 3 times daily and scheduled 8:00 a.m., 2:00 p.m., and 8:00 p.m. There was no documentation by facility staff that the medication was given at 8:00 p.m., on and 2:00 p.m., on all 3 times and no reason documented by the facility staff as to why the medication was not given.

Resident #20's medication Tears 1.4%, for 2 drops in each eye twice daily and scheduled at 8:00 a.m., and 4:00 p.m. There was no documentation that the medication was given by facility staff on at 8:00 a.m., and no reason documented by the facility staff as to why the medication was not given.

Resident #21's medication , ( ) 40 mg tablet, to be taken 1 tablet by mouth daily and scheduled 8:00 a.m. The medication was charted by the facility staff as not given on and through at 8:00 a.m., and no reason was documented by the facility staff as to why medication was not given.
The medication ( ) 2 mg tablet, to be taken 1 tablet by mouth twice daily and scheduled at 8:00 a.m., and 4:00 p.m. There was no documentation by the facility staff that medication was given on through at 8:00 a.m., and 4:00 p.m., and no reason was documented by the facility staff as to why the medication was not given.

Resident #22's medication ( ) (med) 125 mcg (micrograms), to be taken 1 tablet by mouth once daily was scheduled 6:00 p.m. There was no documentation by the facility staff that the medication was given on and at 6:00 p.m., and no reason documented by the facility staff as to why the medication was not given.
The medication 30 mg, to be taken one capsule by mouth three times daily was scheduled at 6:00 a.m., 12:00 p.m., and 10:00 p.m. There was no documentation by the facility staff that the medication was given on and at 12:00 p.m., and at 10:00 p.m., and at

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10:00 p.m., and no reason was documented by the facility staff as to why the medication was not given.

Resident #23's medication ( )( ) 20 mg, to be taken 1 tablet by mouth once daily was scheduled 8:00 a.m. There was no documentation that the medication was given by the facility staff on at 8:00 a.m., and no reason was documented by the facility staff as to why the medication was not given.
The medication 50 mg, to be taken one tablet by mouth once daily was scheduled at 8:00 a.m. There was no documentation by the facility staff that the medication was given on at 8:00 a.m., and no reason was documented by the facility staff as to why the medication was not given.
The medication 10 mg, to be taken 3 tablets by mouth once daily before dinner was scheduled at 4:00 p.m. There was no documentation by the facility staff that the resident received the medication on at 4:00 p.m., and no reason documented by the facility staff as to why medication was not given.
The medication 25 mg, to be taken 2 tablets by mouth twice daily was scheduled 8:00 a.m., and 4:00 p.m. There was no documentation by the facility staff that the medication was given on at 4:00 p. m., and at 8:00 a.m., and no reason documented by the facility staff as to why the medication was not given.
The medication (anti-clotting med) 15 mg, to be taken one tablet by mouth twice daily for 13 days was scheduled at 8:00 a.m., and 4:00 p.m. The medication was not documented by the facility staff as given on at 4:00 p.m., and at 8:00 a.m., and no reason documented by the facility staff as to why the medication was not given.

Resident #24's medication (,) (med) tab 1000 mg, to be taken 1 tablet by mouth every evening was scheduled at 5:00 p.m. The medication was not documented by the facility staff as given on , through at 5:00 p.m., and no documentation by facility staff as to why the medication was not given.
The medication ( ) 40 mg tablet, to be taken one tablet by mouth daily was scheduled at 9:00 p.m. The medication was not documented by the facility staff as given on 4/6.18, and and no reason was documented by the facility staff as to why the medication was not given.
The medication , (Dalmane) 15 mg cap, to be taken 1 capsule by mouth at bedtime was scheduled at 8:00 p.m. The medication was not documented by the facility staff as given on , and and no reason was documented by the facility staff as to why the medication was not given.
The medication , ( ) 15 mg tablet, to be taken 1 tablet by mouth at bedtime at (unknown time). The medication was not documented by the facility staff as given on , and and no reason documented by the facility staff as to why the medication was not given.

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Resident #25's medication tablet 325 mg (Feosol)(iron med), to be taken 1 tablet by mouth daily was scheduled at 8:00 a.m. The medication was not documented by the facility staff as given on and and no reason documented by the facility staff as to why the medication was not given.
The medication Cream 2% ( ) right 4th finger to be applied , , to affected areas twice daily was scheduled at 8:00 a.m., and 4:00 p.m. The medication was not documented by the facility staff as given on through and through and and at 8:00 a.m.. and at 4:00 p.m., and no reason documented by the facility staff as to why the medication was not given.

Resident #26's medication tab 10000 mcg (,) 10000 mcg tablet, to be taken 1 tablet by mouth daily was scheduled at 8:00 a.m. The medication was not documented by facility as given on and and no reason was documented by the facility staff as to why the medication was not given.
The medication , , ( ) 10 mg tablet, to be taken 1 tablet by mouth daily was scheduled at 8:00 a.m. The medication was not documented by the facility staff as given on and no reason documented by the facility staff as to why medication was not given.
The medication , (,) ER 500 mg tablet, to be taken 2 tablets (1000 mg) by mouth daily was scheduled at 8:00 a.m. The medication was not documented by the facility staff as given and no reason was documented by the facility staff as to why the medication was not given.
The medication ( ) 20 mg tablet, to be taken 1/2 tab (10 mg) by mouth at bedtime was scheduled at 8:00 p.m. The medication was not documented by facility staff as given on and and no reason was documented by the facility staff as to why the medication was not given.
The medication (Hytrin) 1 mg capsule, to be taken 1 capsule by mouth at bedtime was scheduled at 8:00 p.m. The medication was not documented by the facility staff as given on and and no reason was documented by the facility staff as to why the medication was not given.
The medication , , 25 mg, to be taken 1 tablet by mouth once daily at bedtime was scheduled at 8:00 p.m. The medication was not documented by the facility staff as given on and and no reason was documented by the facility staff as to why the medication was not given.

Resident #27's medication 20 meq ER tab (Kdur) 20 meq, to be taken 1 tablet by mouth daily was scheduled 8:00 a.m. The medication was not documented by the facility staff as given on through and no reason was documented by the facility staff as to why the medication was not given.

Resident #28's medication , Inhaler 100-25, to inhale 1 puff by mouth daily with device (family to provide) was scheduled at 10:00 a.m. The medication was not documented by the facility staff as

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given on through and no reason was documented by the facility staff as to why the medication was not given.

On at 1:00 p.m., the Director of Health and Wellness reported that he was not aware medications for residents were not documented as given by the facility staff and the information on Medication Observation Records were incomplete.

2. A review of Resident #26's Medication Observation Record (MOR) on at 11:30 a.m., revealed no required name of resident, no physician name or telephone number and no listed of resident.

A review of Resident #23's Medication Observation Record (MOR) on at 11:30 a.m., revealed no physician name or telephone number on one MOR sheet and another sheet had no required information such as name of resident, physician name and telephone number and no listed of resident.

3. During the interview with the Director of Health and Wellness on at 1:00 p.m., he reported that he was not aware that the medications for residents were not documented as being given by the facility staff and information on Medication Observation Records (MORS) was incomplete.

Class III

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