STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968931	R 04/18/2018
NAME OF PROVIDER OR SUPPLIER **VITALITY RESORT ALF LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1258 ERMINE ST** **PORT SAINT LUCIE, FL 34953**	

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

0000 - Initial Comments

A follow-up to the Relicensure survey was conducted on at Vitality Resort ALF, License #12786. The facility had both uncorrected and new deficiencies at the time of the revisit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on resident record review and staff interview, the facility failed to confirm the appropriateness of 1 of 6 residents based on medical examination and completion of health assessment (AHCA Form 1823) prior to admission (Resident #4).

The findings included:

During a review of the initial and current health assessment for Resident #4, dated , the physician who completed the health assessment documented in Section 1, Part D that, in the physician's professional opinion, Resident #4's need could not be met in an assisted living facility which is not a medical, nursing or , , facility. This would make Resident #4 inappropriate for this ALF, as this facility is not a medical, nursing or , , facility.

During an interview with the Manager of the facility on at 10:00 AM, he stated the physician had marked the health assessment incorrectly, and he would contact the physician and get it corrected immediately. A corrected copy was not submitted to this surveyor for review prior to the conclusion of the revisit survey.

The initial Health Assessment was to be reviewed by the Administrator at the time of admission to enable the administrator to determine the appropriateness of the resident for placement in their facility. Had this Health Assessment, dated , been reviewed by the administrator at the time of admission, the response in Section 1, Part D regarding the inappropriateness of Resident #4 for an ALF could have been addressed with the health care provider.

Class III

0051 - Medication - Pill Organizers - 58A-5.0185(2) FAC

Based on observation and staff interview, the facility Manager, who is a Registered Nurse, was managing a pill organizer for 1 of 6 residents who required assistance with self-administered medications (Resident #6).

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The findings included:

During medication pass observation, it was noted that Resident #6's medications were provided from a pill organizer instead of a labeled medication container. Resident #6 is a severely resident who is unable to self-administer her own medications.

The following medications were removed from Resident #6's pill organizer and provided to her during the morning medication pass:
81 mg
mg
20 mg
50 mg
20 mg
20 mg
Melaxicam 7.5 mg

On at 10:45 AM, during interview with the facility Manager, he confirmed that he is the person who manages Resident #6's pill organizer. He stated he is a Registered Nurse and believed himself to have the authority to manage the resident's pill organizer. The state regulation was read to the Manager, and he it was explained that a Nurse may only manage a pill organizer for a resident who is able to self-administer their medications. The Manager agreed that Resident #6 is not able to self-administer her medications.

Class III

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

Based on observation, interview and record review, Staff B failed to follow proper procedure for assisting with self administered medications, as outlined in the state required annual training for staff who assist residents with self-administered medications, for 4 of 4 residents (Resident #3, #4, #5 and #6) and 1 of 2 daycare participants (#2)observed for assistance with medications

The findings included:

On at 9:30 AM, an observation was made of Staff B providing assistance with self-administered medications to Resident #3. Staff B sanitized her hands and performed the following steps:

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1) Staff B removed medication packet from locked cabinet;
2) Staff B took the medication packet to the resident who was sitting at the Dining and said, "Here is your medications."
3) Staff B tore open the packet of medication and picked up the capsule of 20 mg with her ungloved hands and broke open the capsule and dumped the contents into a pill crusher. She then proceeded to empty all of the remaining pills into the pill crusher and crushed them together:
4) When all the pills were sufficiently crushed, Staff B mixed the crushed medication with applesauce in a small container and handed it to the resident to eat.
5) Staff B observed Resident #5 eat all of the applesauce and medication mixture; and
6) Staff B initialed the MOR [Medication Observation Record].

On at 9:35 AM, an observation was made of Staff B providing assistance with self-administered medications to Resident #4. Staff B sanitized her hands and performed the following steps:
1) Staff B removed medication packets from locked cabinet;
2) Staff B took the medication packets to the resident who was sitting at the Kitchen table and said, "Here is your medications."
3) Staff B tore open the packets of medication and provided the pills to the resident.
4) Staff B observed Resident #4 swallow the medications.
5) Staff B took the medication packets, crumpled them up and headed toward the trash receptacle to throw away. The surveyor stopped Staff B and took the medication packets to record the medication given. It was at this time the surveyor noticed 1/2 a pill still left within the medication packet. The pill was identified as 5 mg, 1/2 tab dosage prescribed in the morning. The missed dosage was brought to Staff B's attention, and the medication was provided to Resident #4.
6) Staff B initialed the MOR

On at 9:35 AM, an observation was made of Staff B providing assistance with self-administered medications to Resident #5. Staff B sanitized her hands and performed the following steps:
1) Staff B removed medication packet from locked cabinet;
2) Staff B took the medication packet to the resident who was sitting at the Dining and said, "Here is your medications."
3) Staff B tore open the packet of medication and provided the pills to the resident.
4) Staff B observed Resident #5 swallow the medication.
5) Staff B initialed the MOR

On at 9:37 AM, an observation was made of Staff B providing assistance with self-administered medications to Resident #6, who is severely . Staff B sanitized her hands and performed the following steps:

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1) Staff B removed medication packet from locked cabinet;
2) Staff B took the medication packet to the resident who was sitting at the Kitchen table and said, "I have your medications."
3) Staff B tore open the packet of medication dumped the contents into a pill crusher. She then proceeded to crush all of the pills together:
4) When all the pills were sufficiently crushed, Staff B mixed the crushed medication with applesauce in a small container and spooned out a portion and handed the spoon to the resident. The resident held the spoon, and Staff B placed her hand over the resident's hand and guided the medication to her mouth.
5) Staff B repeatedly filled the spoon with the applesauce and pill mixture and helped resident place it in her mouth, several times prompting the resident to take her medication, until all the applesauce was finished.
6) Staff B initialed the MOR [Medication Observation Record].

On at 9:35 AM, an observation was made of Staff B providing assistance with self-administered medications to Daycare Resident #2. Staff B sanitized her hands and performed the following steps:
1) Staff B removed medication bubble-packed card from locked cabinet;
2) Staff B took the bubble pack to the resident who was sitting at the Dining and said, "Here is your medications."
3) Staff B popped open the back of the bubble and pushed pills from the bubble-pack into a small cup. She handed the pills to Daycare Participant #2.
4) Staff B observed Daycare Participant #2 swallow the medications and initialed the MOR.
5) Staff B handed the surveyor the medication card to record medications given. At this time, one of Daycare Participant #2's pills from the bubble pack for his morning medications had been left in the bubble-pack, and it out and landed on the counter. This pill was identified as 2 mg.
6) The Manager took the pill to discard and stated he would notify the pharmacist and physician.

According to the proper procedure outlined in the state required annual training for staff who assist residents with self-administered medications, staff must:
1) Take the properly dispensed and labeled medication from where it is stored and bring it to the resident;
2) In the presence of the resident, read the label.
Staff B did not follow Step 2 and identify the medication being provided before dispensing the medication to the Residents and Daycare Participant.
It was also observed that in 2 instances, with Resident #4 and Daycare Participant #2, medications were left inside the package. Staff B was in the process of signing off that medications were provided, when

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in fact, these 2 medications had not been provided, and would not have been caught except for surveyor intervention.

On . . . . . at 10:45 AM, the Administrator acknowledged Staff B did not follow the proper procedure while assisting Residents with there medications.

Class III

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

Based on medication record reviews and staff interview, the facility failed to ensure the Medication Observation Record (MOR) was immediately updated each time a medication was offered or provided for 4 of 6 medication records reviewed (Resident #1, #3, #4, and #5).

The findings included:

A review was conducted of the , 2018 MOR for all residents residing in the facility at the time of the revisit. The following omissions to the MOR were found.

1) Resident #1:
On . . . . . at 12 noon, there was no staff initials signifying dose of Metoclopram 10 mg was provided. There was no additional comments on the back of the MOR to explain the missing staff initials.

2) Resident #3:
On . . . . . and . . . at 8 AM, there were no staff initials signifying doses of . . D3 5000 units were provided. There was no additional comments on the back of the MOR to explain the missing staff initials.

3) Resident #4:
On . and at 8 AM, there were no staff initials signifying (Patch) 4.6 mg were applied. There was no additional comments on the back of the MOR to explain the missing staff initials.

4) Resident #5:
On . . . . . at 8 AM, there was no staff initials signifying dose of . . . . . / . . . . mg was provided. There was no additional comments on the back of the MOR to explain the missing staff initials.

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During interview with the Manager on at 10:45 AM, he acknowledges the missing initials and stated, "I don't think the resident missed the doses; I think the staff just forgot to put their initials on the MOR." The Manager acknowledged the MOR must be immediately updated each time medication is provided, and if the medication cannot be provided, comments must be added to the back of the MOR to explain the reason.

Class III

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

Based on observation, medication record review, and staff interview, Staff B crushed medications for 2 of 4 residents without a physician's order allowing medications to be crushed (Resident #3 and #6)

The findings included:

I. On at 9:45 AM, an observation was made of Staff B providing assistance with self-administered medications to Resident #3. Staff B sanitized her hands and performed the following steps:
1) Staff B removed medication packet from locked cabinet;
2) Staff B took the medication packet to the resident who was sitting at the Dining and said, "Here is your medications."
3) Staff B tore open the packet of medication and picked up the capsule of 20 mg with her ungloved hands and broke open the capsule and dumped the contents into a pill crusher. She then proceeded to empty all of the following pills into the pill crusher, crushing them them together:
ER 25 mg
100 mg
C 500 mg
5 gr
1 mg
500 mg
81 mg
4) When all the pills were sufficiently crushed, Staff B mixed the crushed medication with applesauce in a small container and handed it to the resident to eat.
5) Staff B observed Resident #5 eat all of the applesauce and medication mixture;
6) Staff B initialed the MOR [Medication Observation Record].

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II. On [redacted] at 9:37 AM, an observation was made of Staff B providing assistance with self-administered medications to Resident #6, who is severely [redacted]. Staff B sanitized her hands and performed the following steps:
1) Staff B removed medication packet from locked cabinet;
2) Staff B took the medication packet to the resident who was sitting at the Kitchen table and said, "I have your medications."
3) Staff B tore open the packet of medication dumped the following contents into the pill crusher:
[redacted] 81 mg
[redacted] mg
[redacted] 20 mg
[redacted] 50 mg
[redacted] 20 mg
[redacted] 20 mg
Melaxicam 7.5 mg
Staff B then proceeded to crush all of the medications together:
4) When all the pills were sufficiently crushed, Staff B mixed the crushed medication with applesauce in a small container and spooned out a portion and handed the spoon to the resident. The resident held the spoon, and Staff B placed her hand over the resident's hand and guided the medication to her mouth.
5) Staff B repeatedly filled the spoon with the applesauce and pill mixture and helped resident place it in her mouth, several times prompting the resident to take her medication, until all the applesauce was finished.
6) Staff B initialed the MOR.

A review was made of the physician orders on file for Resident #3 and #6. There was no indication on any of the orders that it was permissible for these residents' medications to be crushed.

During interview with the Manager on [redacted] at 10:45 AM, he stated he was unaware that Resident #3 and #6 had their medications crushed. A request was made to the Manager for a copy of a physician order stating Resident #3's and Resident #6's medications were permitted to be crushed, but no order was provided at the time of the survey.

Class III