STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964831	**04/26/2018**
NAME OF PROVIDER OR SUPPLIER **ARBOR OAKS AT TYRONE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1701 68 STREET, NORTH** **SAINT PETERSBURG, FL 33710**	

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

0000 - Initial Comments

Assisted Living Facility

A complaint survey, (CCR# 2018003347), was conducted on at Arbor Oaks at Tyrone, (License # 9299), in conjunction with a Revisit to the Biennial state relicensure survey.

Deficiencies were identifed at the time of the visit.

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview the facility failed to ensure that two out two medication carts on the first floor were locked and inaccessible to residents, visitors, and unqualified staff while unattended.

Findings included:

On at 9:00, two unlocked medication carts were observed in the main lobby area of the facility near the reception desk. The drawers were then opened and many prescription medications were observed. No direct care staff were present in the area of the carts. Licensed Practical Nurse A returned to the two carts while the drawers were open. She then locked the carts.

At 2:58 pm on that same date, a medication cart near the receptionist desk was observed to be unlocked. The receptionist was sitting at the desk nearby. No other staff were visible in the area. The Resident Care Director who was in a , was called to the cart. A drawer was then opened, showing that the cart was unlocked. She stated that Nurse A was using the cart and that it should have been locked.

A review of the facility's Policy: Medication Storage (undated) revealed:
#17: All medications, including over the counter, are kept in locked storage at all times.
Policy: Medication Administration and Treatment (undated) included:
#13: Medication carts should be locked when unattended and are discreetly located when in public areas.

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

Class III

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

Based on observation and interview the facility failed to ensure that medications were given as ordered by the health care provider for three (#1, #2 and #3) of three sampled residents.

Findings included:

During an observation of assistance with self-administration of medications on it was observed that the medications scheduled for 9:00 am were being administered for Resident's #1, #2 and #3 between 10:12 am to 11:10 am.

During an interview on at 11:15 am with Staff A she acknowledged and confirmed that the medications were being given late. She stated that the residents sleep late and do not wish to be disturbed.

In an exit interview with Administrator on at 3:50 pm he confirmed and acknowledged that morning medications were being given late due to residents wanting to sleep late. He stated that they have in the past had morning medication times changed to later for the residents.

A review of the facility'sPolicy: Medication Administration and Treatment (undated) conducted on revealed:
#1: Appropriately trained or licensed associates administering or assisting with medications should follow the Seven Rights of Medication: right medication, right dose, right time, right route, right resident, right documentation and right to refuse.
#6: Medication and/or treatments should be prepared for the resident immediately before administration/assistance.

Class III