

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943102	(X3) DATE SURVEY COMPLETED 12/08/2016
NAME OF PROVIDER OR SUPPLIER SAVANNAH COURT OF THE PALM BEA	STREET ADDRESS, CITY, STATE, ZIP CODE 2090 N. CONGRESS AVENUE WEST PALM BEACH, FL 33401	

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

0000 - Initial Comments

An unannounced complaint survey for CCR #2016011365, CCR#2016013429 and CCR #201613504 was conducted through at Savannah Court of the Palm Beach (license #8367). The facility had deficiencies identified at the time of the survey.

Deficient practice identified at a Class II for the following: A0025, A0052, A0056

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

Based on record review and interview, it was determined that the facility failed to provide care and services appropriate to the needs of a resident with respect to medication assistance and monitoring of a resident's well-being, for 1 out of 3 sampled residents (Resident #1). This is evidence of the facility's failure to provide medications as prescribed by the physician to Resident #1 resulting in medications not being provided on numerous days and ultimately resulting in Resident #1 being transferred to the hospital for treatment.

The findings included:

A record review of Resident #1's progress notes dated at 11:40 AM revealed documentation that a third party Physical Assistant reported to Staff D that the resident had a of over 200 . Staff D re-measured the and it was found to be mmHg. The Advanced Registered Nurse Practitioner (ARNP) was made aware and orders received. The progress notes documented that the resident was later taken to a local area hospital by her family at 2:40 PM on and was discharge and returned to the facility on . Resident #1 was again taken to the emergency , her family on with high and returned to the facility the same day. Review of the progress notes for Resident #1 dated at 6:15 PM indicated the resident was transferred to the Emergency . 6:20 PM. The progress notes documented that the resident 's health care practitioner increased the dosages of / 5-20mg to 10-20mg daily (medication) and 12.5 mg (used to treat high and fluid retention) was increased to 25mg daily.

During an interview with Resident #1 on at 10:35 AM, she stated that she was just in the hospital twice for high and she was feeling at the present moment.

During an interview on at 5:30 PM with Resident #1's family member, she stated that she was

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made aware that Resident #1's was high. When she arrived at the facility to transport Resident #1 to the hospital on, she was told by the nurse on duty that Resident #1 didn't get her medication for 4 days. She stated that later in communication with staff, it was determined Resident #1 had missed several doses of her anti-..... medication. Resident #1's family member stated that when Resident #1 returned from the hospital on, the facility still did not have the medications available. As a result, Resident #1 did not receive her medications on or which caused her to become high again resulting in another emergency on A Review of the Medication Observation Record (MOR), confirmed the resident was prescribed two medications to control her / 5-20mg daily and 12.5mg (.....) every other day. Review of hospital records revealed that Resident #1 was admitted on with Hypertensive Urgency complaining of fatigue, malaise, ... and According to the American Association, Hypertensive Urgency is a reading or greater which could be accompanied by severe nose and severe Her is documented as mmHg at 3:05 PM and she was given two medications; 5mg and 0.2mg tablet by mouth. was re-evaluated at 4:00 PM and had decreased to mmHg. Resident #1 was discharged from the hospital on at 2:30 PM with orders to be continued which included two medications, ... 12.5 mg every other day and / 5-10mg daily. Review of additional hospital records dated revealed Resident #1 was seen again in the emergency with a complaint of high with a documented of mmHg. Resident #1 was treated with one dose of 0.1 mg tablet by mouth. was re-evaluated and decreased to Resident #1 was discharged that same evening with a prescription for 0.1mg as needed (PRN) for elevated On at 10:25 AM, an interview with the Physical Assistant was conducted and she stated, "I normally take Resident #1's when I see her. "She stated that during her visit with Resident #1 on, the resident stated she was not feeling well and she was lightheaded. The Physical Assistant stated that she routinely takes the before working with a resident. However, she further stated that since Resident #1 complained of feeling lightheaded she remembers that she took it. She further stated, "I don't remember the exact reading but it was high and I went to get the nurse. The nurse took the two more times and it was still high. The Physical Assistant stated that the Nurse said something to the effect of, 'I will take care of it' and I left. " The Physical Assistant stated that later, the family informed her that Resident #1 was admitted to the hospital. During an interview on at 9:30 AM with Resident #1's ARNP (Advanced Registered Nurse		

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Practitioner), she stated that she was told on [redacted] that Resident #1 's [redacted] was about 180 [redacted] and the diastolic in the 90's, which was high enough to give her an extra dose of [redacted] medication. She stated that she increased Resident #1's [redacted] medications under the assumption that Resident #1 was receiving the appropriate medication and that they were not working. The ARNP stated that she later found out that Resident #1 had not been receiving the prescribed order. She confirmed that the facility informed her of Resident #1's hospitalization the same day but she was never informed that her [redacted] was 200 mmHg [redacted] or she would have sent her immediately to the ER (Emergency [redacted]). The ARNP stated that she was under the impression that the extra dose did not work and that is why her family took her to the emergency [redacted]. The ARNP continued to state that she was made aware of the missed medications by a family member of Resident #1. The ARNP confirmed that prior to the hospitalization, Resident #1 was stable for some time and confirmed that if Resident #1 misses her anti-[redacted] or [redacted] medications, she becomes unstable. The ARNP stated that missing doses of her [redacted] medication [redacted], would cause her to be more tired, increased [redacted] and increased fatigue; missed doses of the [redacted] would cause [redacted], increasing her [redacted]. She further stated that prescriptions are written for three months of refills and sometimes changes the doses of [redacted] (aka [redacted]) and [redacted] but there is no reason she should have missed the medications. Record review of the [redacted] 2016 Medication Observation Record (MOR) for Resident #1 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) [redacted] 5-20 mg ([redacted]), one capsule by mouth daily scheduled for 9:00 AM, were missed on [redacted] through [redacted] indicated by staff initials being circled. During an interview on [redacted] at 1:20 PM with Staff D, LPN (Licensed Practical Nurse), he stated that on [redacted] he found out that Staff F, CNA/Medication Technician had not given the [redacted] medication [redacted] [redacted] 5-20mg] to Resident #1 on [redacted] but signed off as if she had. Staff D said the resident could not have been given the medication since it was not available in the facility. b) [redacted] 50 mcg ([redacted] hormones), one tablet by mouth once daily scheduled for 6:00 AM were missed on [redacted] through [redacted] indicated by staff initials being circled. c) [redacted] 10mg (anti-[redacted]), one tablet by mouth twice daily scheduled for twice a day. Doses scheduled for 9:00 AM were missed on [redacted] through [redacted] and [redacted] through [redacted] as indicated by staff initials being circled. Doses scheduled for 5:00 PM on [redacted] through [redacted] and [redacted] were missed as indicated by blank spaces, and [redacted] through [redacted] were missed as indicated by staff initials being circled. d) [redacted] 25mg (for [redacted]), one tablet by mouth twice daily scheduled for 9:00 AM and 5:00 PM.		

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The 9:00 AM doses were missed on [redacted] through [redacted] as indicated by staff initials being circled. Doses scheduled for 5:00 PM were missed on [redacted] & [redacted] in which documentation was left blank and on [redacted] through [redacted], in which initials were circled. e) [redacted] 81 mg (chewable), one tablet by mouth once daily before meals scheduled for 9:00 AM was missed on [redacted] indicated by the box being left blank. f) [redacted] 0.25mg tablet (for [redacted]) by mouth three times a day was originally prescribed three times daily 9:00 AM, 1:00 PM, and 9:00 PM. Documentation was left blank, for the 9:00 AM doses on [redacted] through [redacted], documentation was left blank for the 1:00 PM doses scheduled for [redacted] through [redacted], and the 9:00 PM doses scheduled for [redacted] through [redacted]. The staff initials were circled, indicating the medication was not given on [redacted] through [redacted] & [redacted], the 1:00 PM dose for [redacted] and the 9:00 PM dose on [redacted] through [redacted]. The medication times were changed on [redacted] to 8:00 AM, 1:00 PM, & 6:00 PM. The medication documentation areas were left blank indicating it was not given to the resident on [redacted] at 8:00 AM and [redacted] at 1:00 PM. There is no documentation on the back of the MOR's or in the progress notes to indicate why these aforementioned medications were not given. Further record review and interview with the Executive Director on [redacted] at 12 PM revealed there were no MORs available for Resident #1 at the time of survey for the months of [redacted] and [redacted] of 2016. During an interview on [redacted] at 1:40 PM with Staff A (Medication Technician), stated that if a medication is not given, she initials and circles her initials and writes on back why she did not give the medication. She confirmed that she did not write anything on the back of Resident # [redacted] MOR on the days her initials were circled. She further stated, "If we don't have the medication, we fill out the facility's Medication Request form and give it to the nurse." A call was placed to the pharmacy in question on 11/ [redacted] at 10:45 AM by this surveyor. The staff confirmed that they usually deliver the medications for the resident to the facility but the last couple of days the facility has been coming to pick them up. They confirmed that a 30-day supply of [redacted] was ordered for Resident #1 on [redacted] and prior to that not since [redacted] and [redacted]. The pharmacy confirmed that the medications were automatically paid for by insurance and a credit card on file, so there was no reason why they could not get the medication. During a follow-up interview with Resident #1 on [redacted] at 8:45 AM, she stated that after the hospital visits, the facility had been giving her medications late around 10:00 AM but lately it's been okay but they just give them to her without explaining what they are giving her. She stated that she hopes she is getting her [redacted] and [redacted] medications because she worries about her [redacted] and [redacted]		

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she gets very nervous. During an interview on _____ at 1:15 PM with the interim DON (Director of Nursing), she confirmed that the MOR's lacked the appropriate documentation. She confirmed she was aware of everything going on with the medications including missed doses and lack of documentation. She stated that was why they have the pharmacy in the building today to review everyone's medications and MOR. During an interview on _____ at 2:20 PM, the Executive Director stated the previous Health and Wellness Director was not doing anything to ensure the medications were received from the pharmacy in time. He confirmed there is no system in place to ensure the medications were ordered. He stated that they are aware they have a problem with medications not being ordered and available for the residents in a timely manner. A Medication Error Report was completed by the Administrator on 11/_____, regarding Resident #1, which indicated the error as _____, cap 5-20mg was not re-ordered. Refer to A 0052 and A 0056 Class II 0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3) Based on record review and interview, the facility failed to provide assistance with self-administration of medication(s) as physician ordered and to notify the physician of any concerns regarding the medications, including missed doses, for 3 of 3 sampled residents (Residents #1, #2 and #3). The findings included: Based on record review and interview, it was determined that the facility failed to provide care and services appropriate to the needs of a resident with respect to medication assistance and monitoring of a resident's well-being, for 1 out of 3 sampled residents (Resident #1). This is evidence of the facility's failure to provide medications as prescribed by the physician to Resident #1 resulting in medications not being provided on numerous days and ultimately resulting in Resident #1 being transferred to the hospital for treatment. The findings included: A record review of Resident #1's progress notes dated _____ at 11:40 AM revealed documentation		

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that a third party Physical Assistant reported to Staff D that the resident had a of over 200 mmHg. Staff D re-measured the and it was found to be mmHg. The Advanced Registered Nurse Practitioner (ARNP) was made aware and orders received. The progress notes documented that the resident was later taken to a local area hospital by her family at 2:40 PM on and was discharge and returned to the facility on Resident #1 was again taken to the emergency her family on with high and returned to the facility the same day. Review of the progress notes for Resident #1 dated at 6:15 PM indicated the resident was transferred to the Emergency 6:20 PM. The progress notes documented that the resident's health care practitioner increased the dosages of / 5-20mg to 10-20mg daily (medication) and 12.5 mg (used to treat high and fluid retention) was increased to 25mg daily. During an interview with Resident #1 on at 10:35 AM, she stated that she was just in the hospital twice for high and she was feeling at the present moment. During an interview on at 5:30 PM with Resident #1's family member, she stated that she was made aware that Resident #1's was high. When she arrived at the facility to transport Resident #1 to the hospital on she was told by the nurse on duty that Resident #1 didn't get her medication for 4 days. She stated that later in communication with staff, it was determined Resident #1 had missed several doses of her anti- medication. Resident #1's family member stated that when Resident #1 returned from the hospital on the facility still did not have the medications available. As a result, Resident #1 did not receive her medications on or which caused her to become high again resulting in another emergency on A Review of the Medication Observation Record (MOR), confirmed the resident was prescribed two medications to control her / 5-20mg daily and 12.5mg (every other day. Review of hospital records revealed that Resident #1 was admitted on with Hypertensive Urgency complaining of fatigue, malaise, and According to the American Association, Hypertensive Urgency is a reading or greater which could be accompanied by severe nose and sever Her is documented as mmHg at 3:05 PM and she was given two medications; 5mg and 0.2mg tablet by mouth. was re-evaluated at 4:00 PM and had decreased to mmHg. Resident #1 was discharged from the hospital on at 2:30 PM with orders to be continued which included two medications, 12.5 mg every other day and 5-10mg daily. Review of addition hospital records dated revealed Resident #1 was seen again in the		

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emergency with a complaint of high with a documented of mmHg. Resident #1 was treated with one dose of 0.1 mg tablet by mouth. was re-evaluated and decreased to Resident #1 was discharged that same evening with a prescription for 0.1mg as needed (PRN) for elevated On at 10:25 AM, an interview with the Physical Assistant was conducted and she stated, "I normally take Resident #1's when I see her. "She stated that during her visit with Resident #1 on the resident stated she was not feeling well and she was lightheaded. The Physical Assistant stated that she routinely takes the before working with a resident. However, she further stated that since Resident #1 complained of feeling lightheaded she remembers that she took it. She further stated, "I don't remember the exact reading but it was high and I went to get the nurse. The nurse took the two more times and it was still high. The Physical Assistant stated that the Nurse said something to the effect of, 'I will take care of it' and I left. "The Physical Assistant stated that later, the family informed her that Resident #1 was admitted to the hospital. During an interview on at 9:30 AM with Resident #1's ARNP (Advanced Registered Nurse Practitioner), she stated that she was told on that Resident #1's was about 180 and the diastolic in the 90's, which was high enough to give her an extra dose of medication. She stated that she increased Resident #1's medications under the assumption that Resident #1 was receiving the appropriate medication and that they were not working. The ARNP stated that she later found out that Resident #1 had not been receiving the prescribed order. She confirmed that the facility informed her of Resident #1's hospitalization the same day but she was never informed that her was 200 mmHg or she would have sent her immediately to the ER (Emergency). The ARNP stated that she was under the impression that the extra dose did not work and that is why her family took her to the emergency. The ARNP continued to state that she was made aware of the missed medications by a family member of Resident #1. The ARNP confirmed that prior to the hospitalization, Resident #1 was stable for some time and confirmed that if Resident #1 misses her anti- or medications, she becomes unstable. The ARNP stated that missing doses of her medication would cause her to be more tired, increased and increased fatigue; missed doses of the would cause increasing her. She further stated that prescriptions are written for three months of refills and sometimes changes the doses of (aka) and but there is no reason she should have missed the medications. Record review of the 2016 Medication Observation Record (MOR) for Resident #1 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left		

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blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) _____, 5-20 mg (_____), one capsule by mouth daily scheduled for 9:00 AM, were missed on _____ through _____ indicated by staff initials being circled. During an interview on _____ at 1:20 PM with Staff D, LPN (Licensed Practical Nurse), he stated that on _____ he found out that Staff F, CNA/Medication Technician had not given the _____ medication [_____, 5-20mg] to Resident #1 on _____ but signed off as if she had. Staff D said the resident could not have been given the medication since it was not available in the facility. b) _____, 50 mcg (_____ hormones), one tablet by mouth once daily scheduled for 6:00 AM were missed on _____ through _____ indicated by staff initials being circled. c) _____, 10mg (anti- _____), one tablet by mouth twice daily scheduled for twice a day. Doses scheduled for 9:00 AM were missed on _____ through _____ and _____ through _____ as indicated by staff initials being circled. Doses scheduled for 5:00 PM on _____ through _____ and _____ were missed as indicated by blank spaces, and _____ through _____ were missed as indicated by staff initials being circled. d) _____, 25mg (for _____), one tablet by mouth twice daily scheduled for 9:00 AM and 5:00 PM. The 9:00 AM doses were missed on _____ through _____ as indicated by staff initials being circled. Doses scheduled for 5:00 PM were missed on _____, _____, & _____ in which documentation was left blank and on _____ through _____, in which initials were circled. e) _____, 81 mg (chewable), one tablet by mouth once daily before meals scheduled for 9:00 AM was missed on _____ indicated by the box being left blank. f) _____, 0.25mg tablet (for _____) by mouth three times a day was originally prescribed three times daily 9:00 AM, 1:00 PM, and 9:00 PM. Documentation was left blank, for the 9:00 AM doses on _____ through _____, documentation was left blank for the 1:00 PM doses scheduled for _____ through _____, and the 9:00 PM doses scheduled for _____ through _____. The staff initials were circled, indicating the medication was not given on _____ through _____ & _____, the 1:00 PM dose for _____ and the 9:00 PM dose on _____ through _____. The medication times were changed on _____ to 8:00 AM, 1:00 PM, & 6:00 PM. The medication documentation areas were left blank indicating it was not given to the resident on _____ at 8:00 AM and _____ at 1:00 PM. There is no documentation on the back of the MOR's or in the progress notes to indicate why these aforementioned medications were not given. Further record review and interview with the Executive Director on _____ at 12 PM revealed there were no MORs available for Resident #1 at the time of survey for the months of _____ and _____ of 2016. During an interview on _____ at 1:40 PM with Staff A (Medication Technician), stated that if a		

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medication is not given, she initials and circles her initials and writes on back why she did not give the medication. She confirmed that she did not write anything on the back of Resident # MOR on the days her initials were circled. She further stated, " If we don't have the medication, we fill out the facility 's Medication Request form and give it to the nurse. " A call was placed to the pharmacy in question on 11/ at 10:45 AM by this surveyor. The staff confirmed that they usually deliver the medications for the resident to the facility but the last couple of days the facility has been coming to pick them up. They confirmed that a 30-day supply of was ordered for Resident #1 on and prior to that not since and . The pharmacy confirmed that the medications were automatically paid for by insurance and a credit card on file, so there was no reason why they could not get the medication. During a follow-up interview with Resident #1 on at 8:45 AM, she stated that after the hospital visits, the facility had been giving her medications late around 10:00 AM but lately it's been okay but they just give them to her without explaining what they are giving her. She stated that she hopes she is getting her and medications because she worries about her and she gets very nervous. 2) Review of the and 2016 MOR for Resident #2 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) 50mg (), one tab by mouth daily at bedtime, scheduled for 9:00 PM. The daily dose was missed through as indicated by staff initials circled and documentation area left blank. b) 300mg (anticonvulsant), one capsule by mouth once daily at 1PM. A dose was missed on as indicated by documentation area left blank. c) 25-500mg (), two tablets (50-1000mg) by mouth every night at bedtime, scheduled for 9:00 PM. A dose was missed on as indicated by documentation area left blank. Review of the and 2016 MOR revealed that the only documentation that provided an explanation of missed doses were on at 9:00pm; which documented that the was " On Order ". During further record review and interview with the Executive Director on at 12:00 PM, it was revealed that there were no MORs available at the time of survey for the months of and 2016. During an interview with Resident #2 on at 10:45 AM, he stated that they run out of his		

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medications all the time and it happens too often. He says either they forget to order it or they order it and it goes downstairs and never makes it upstairs. 3) Review of the and 2016 MOR for Resident #3 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) One-Daily Tab , one tablet by mouth once daily scheduled for 9:00 AM. The medication was not given on and as indicated by the documentation areas left blank. b) 100mg (for), one tablet by mouth daily, scheduled for 9:00 PM. The medication was not given on through as indicated by the documentation areas left blank. c) 50mg Tablet (pain medication), give two tablets (100mg) by mouth three times daily scheduled for 6:00 AM, 2:00 PM and 10:00 PM. The medication was not given on at 10:00 PM as indicated by the documentation areas left blank. d) Tab 10mg (anti-depressant), one tablet by mouth once daily, scheduled for 9:00 AM. The medication was not given on as indicated by the documentation areas left blank. e) 0.4 mg Capsule (medication), one capsule by mouth every night at bedtime, scheduled for 9:00 PM. The medication was not given on & as indicated by staff initials being circled and was missed as indicated by the documentation areas left blank. The back of the MOR indicated the resident refused the on but there is no other documentation as to why the medication was not given the other days. f) 500mg (), one tab by mouth twice daily times one week scheduled for 9:00 AM and 5:00 PM. The transcriber indicated the medication was to be started on the morning of . There is illegible writing in the column for the 18th which do not coincide with staff signatures along with blank spaces on the 9:00 AM and 5:00 PM. The MOR indicates only 10 of the 14 doses of were documented as given. There is no indication on the back of the MOR's as to why the medications were missed. g) Limbrel mg (), one cap by mouth twice daily, scheduled for 9:00 AM and 5:00 PM. The order is written twice on the 2016 MOR. Staff initials are circled for the 9:00 AM dose on and documentation areas left blank from through . The 5:00 PM doses were not given as evidenced by staff initials circled from through , through and . Documentation areas were left blank on , through and . There is no indication on the back of the MOR's as to why the medications were missed. During further		

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record review and interview with the Executive Director on 12/08/2016 at 12 PM, it was revealed there were no MOR's available for Resident #3 at the time of survey for the months of 11/2016 and 12/2016. During an interview with Resident #3 on 12/08/2016 at 11:15 AM, he stated, " They have no checks and balances with the Med-Techs to ensure they are passing the medications correctly. In the last month, two nights they failed to have the right meds and two nights they missed the (Medication). Resident #3 stated that he got a copy of his medication list and started keeping track of the amount of pills they would bring versus what I was supposed to be getting. They are always out of one pill or another." On 12/08/2016 at 1:15 PM during an interview with the interim DON (Director of Nursing), she confirmed that the MOR's lacked the appropriate documentation. She confirmed she was aware of everything going on with the medications including missed doses and lack of documentation. She stated that was why they have pharmacy in the building today to review everyone's medications and MOR. During an interview on 12/08/2016 at 2:20 PM, the Executive Director stated the previous Health and Wellness Director was not doing anything to ensure the medications were received from pharmacy in time. He confirms there is no system in place to ensure the medications were ordered. He stated that they are aware they have a problem with medications not being ordered and available for the residents in a timely manner. A Medication Error Report was completed by the Administrator on 11/2016, regarding Resident #1, which indicated the error as 5-20mg cap 5-20mg was not re-ordered. Refer to A 0025 and A 0056 Class II 0054 - Medication - Records - 58A-5.0185(5) FAC Based on record review and interview, the facility failed to update the medication observation record (MOR) each time the medication was offered or due to be administered to a resident and to maintain a chart accurately for recording missed doses or refusals of medications, for 3 of 3 residents' MORs reviewed (Resident#1-#3). The findings included: The form titled Medication Record is a form used by the facility to document medication assistance and administration for residents in the facility. When a person is assisting with self-administration or		

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administering medication to a resident, standard practice is for the initials of the staff to be circled, indicating that the medication was not consumed by the resident. A reason should then be documented in the appropriate place. 1) Record review of the 2016 Medication Observation Record (MOR) for Resident #1 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) 5-20 mg (), one capsule by mouth daily scheduled for 9:00 AM, were missed on through indicated by staff initials being circled. During an interview on at 1:20 PM with Staff D, LPN (Licensed Practical Nurse), he stated that on he found out that Staff F, CNA/Medication Technician had not given the medication [5-20mg] to Resident #1 on but signed off as if she had. Staff D said the resident could not have been given the medication since it was not available in the facility. b) 50 mcg (hormones), one tablet by mouth once daily scheduled for 6:00 AM were missed on through indicated by staff initials being circled. c) 10mg (anti-), one tablet by mouth twice daily scheduled for twice a day. Doses scheduled for 9:00 AM were missed on through and through as indicated by staff initials being circled. Doses scheduled for 5:00 PM on through and were missed as indicated by blank spaces, and through were missed as indicated by staff initials being circled. d) 25mg (for), one tablet by mouth twice daily scheduled for 9:00 AM and 5:00 PM. The 9:00 AM doses were missed on through as indicated by staff initials being circled. Doses scheduled for 5:00 PM were missed on , & in which documentation was left blank and on through , in which initials were circled. e) 81 mg (chewable), one tablet by mouth once daily before meals scheduled for 9:00 AM was missed on indicated by the box being left blank. f) 0.25mg tablet (for) by mouth three times a day was originally prescribed three times daily 9:00 AM, 1:00 PM, and 9:00 PM. Documentation was left blank, for the 9:00 AM doses on through , documentation was left blank for the 1:00 PM doses scheduled for through , and the 9:00 PM doses scheduled for through . The staff initials were circled, indicating the medication was not given on through & , the 1:00 PM dose for and the 9:00 PM dose on through . The medication times were changed on to 8:00 AM, 1:00 PM, & 6:00 PM. The medication documentation areas were left blank indicating it was not given to the resident on at 8:00 AM and at 1:00 PM.		

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There is no documentation on the back of the MOR's or in the progress notes to indicate why these medications were not given. Further record review and interview with the Executive Director on at 12 PM revealed there were no MORs available for Resident #1 at the time of survey for the months of _____ and _____ of 2016. During an interview on _____ at 1:40 PM with Staff A (Medication Technician), stated that if a medication is not given, she initials and circles her initials and writes on back why she did not give the medication. She confirmed that she did not write anything on the back of Resident # _____ MOR on the days her initials were circled. She further stated " If we don't have the medication, we fill out the facility 's Medication Request form and give it to the nurse." 2)Review of the _____ and _____ 2016 MOR for Resident #2 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) _____ 50mg (_____), one tab by mouth daily at bedtime, scheduled for 9:00 PM. The daily dose was missed _____ through _____ as indicated by staff initials circled and _____ documentation area left blank. b) _____ 300mg (anticonvulsant), one capsule by mouth once daily at 1PM. A dose was missed on _____ as indicated by documentation area left blank. c) _____ 25-500mg (_____), two tablets (50-1000mg) by mouth every night at bedtime, scheduled for 9:00 PM. A dose was missed on _____ as indicated by documentation area left blank. Review of the _____ and _____ 2016 MOR revealed that the only documentation that provided an explanation of missed doses were on _____ at 9:00pm; which documented that the _____ was " On Order ". During further record review and interview with the Executive Director on _____ at 12:00 PM, it was revealed that there were no MORs available at the time of survey for the months of _____ and _____ 2016. 3)Review of the _____ and _____ 2016 MOR for Resident #3 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) One-Daily Tab _____, one tablet by mouth once daily scheduled for 9:00 AM. The medication was not given on _____ and _____ as indicated by the documentation areas left blank.		

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b) 100mg (for), one tablet by mouth daily, scheduled for 9:00 PM. The medication was not given on through as indicated by the documentation areas left blank. c) 50mg Tablet (pain medication), give two tablets (100mg) by mouth three times daily scheduled for 6:00 AM, 2:00 PM and 10:00 PM. The medication was not given on at 10:00 PM as indicated by the documentation areas left blank. d) Tab 10mg (anti-depressant), one tablet by mouth once daily, scheduled for 9:00 AM. The medication was not given on as indicated by the documentation areas left blank. e) 0.4 mg Capsule (..... medication), one capsule by mouth every night at bedtime, scheduled for 9:00 PM. The medication was not given on & as indicated by staff initials being circled and was missed as indicated by the documentation areas left blank. The back of the MOR indicated the resident refused the on but there is no other documentation as to why the medication was not given the other days. f) 500mg (.....), one tab by mouth twice daily times one week scheduled for 9:00 AM and 5:00 PM. The transcriber indicated the medication was to be started on the morning of There is illegible writing in the column for the 18th which do not coincide with staff signatures along with blank spaces on the 9:00 AM and 5:00 PM. The MOR indicates only 10 of the 14 doses of were documented as given. There is no indication on the back of the MOR's as to why the medications were missed. g) Limbrel mg (.....), one cap by mouth twice daily, scheduled for 9:00 AM and 5:00 PM. The order is written twice on the 2016 MOR. Staff initials are circled for the 9:00 AM dose on and documentation areas left blank from through The 5:00 PM doses were not given as evidenced by staff initials circled from through through Documentation areas were left blank on through and and There is no indication on the back of the MOR's as to why the medications were missed. During further record review and interview with the Executive Director on at 12 PM, it was revealed there were no MOR's available for Resident #3 at the time of survey for the months of and 2016. On at 1:15 PM during an interview with the interim DON (Director of Nursing), she confirmed that the MOR's lacked the appropriate documentation. She confirmed she was aware of everything going on with the medications including missed doses and lack of documentation. She stated that was why they have pharmacy in the building today to review everyone's medications and MOR. During an interview on at 2:20 PM, the Executive Director stated the previous Health and Wellness Director was not doing anything to ensure the medications were received from pharmacy in		

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time. He confirmed there is no system in place to ensure the medications were ordered. He stated that they are aware they have a problem with medications not being ordered and available for the residents in a timely manner. A Medication Error Report was completed by the Administrator on 11/ , regarding Resident #1, which indicated the error as . . . , / cap 5-20mg was not re-ordered. Class III 0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC Based on record review and interview and observation, the facility failed to make a reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner for 3 of 3 residents' records reviewed. This also resulted in the transfer to a higher level of care of 1 (Resident #1) of 3 residents' records reviewed. The findings included: On , a copy of the policy and procedures related to medication assistance, administration, documenting, and ordering medications from the pharmacy was requested. A copy of the Medication Management Lesson Plan was provided which did not include any of the requested information. The policy was again requested during an interview with the Executive Director on at 11:30 AM; he confirmed there was no policy in place related to documentation and ordering of medication(s) from pharmacy. On at 1:15 PM during an interview with the interim Director of Nursing (DON), she confirmed that the MOR's lacked the appropriate documentation. She confirmed she was aware of everything going on with the medications including missed doses and lack of documentation. She stated that was why they have Pharmacy Consultants in the building today to review everyone's medications and MOR. During an interview on at 2:20 PM, the Executive Director stated the previous Health and Wellness Director was not doing anything to ensure the medications were received [from pharmacy] in time. He confirmed there is no system in place to ensure the medications were ordered. He stated that they are aware they have a problem with medications not being ordered and available for the residents in a timely manner. A Medication Error Report was completed by the Administrator on 11/		

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regarding Resident #1, which indicated the error as _____ cap 5-20mg was not re-ordered. During an interview on _____ at 2:00 PM with Staff C, she stated that the med-techs let the nurse know when they need meds. They take the sticker off the punch card put it on the paper and give it to the nurse because the med-techs can't order meds. She is unsure which nurse she reported it to but stated she verbally told the nurse because there was no sticker there so they should have long ordered it. She stated when the nurse faxes the order off, they are supposed to have a receipt that says 'ok'. A confidential interview was conducted during the survey with a staff member. He/she stated that " There are residents here whose medications have been missing for a month and they don't do anything. The pharmacy will say that the insurance won't pay for it or will pay only for some but they don't get them anything else. " The following was noted specifically: 1) A record review of Resident #1's progress notes dated _____ at 11:40 AM revealed documentation that a third party Physical _____ Assistant reported to Staff D that the resident had a _____ of over 200 _____. Staff D re-measured the _____ and it was found to be _____ mmHg. The Advanced Registered Nurse Practitioner (ARNP) was made aware and orders received. The progress notes documented that the resident was later taken to a local area hospital by her family at 2:40 PM on _____ and was discharge and returned to the facility on _____. Resident #1 was again taken to the emergency _____ her family on _____ with high _____ and returned to the facility the same day. Review of the progress notes for Resident #1 dated _____ at 6:15 PM indicated the resident was transferred to the Emergency _____ 6:20 PM. The progress notes documented that the resident 's health care practitioner increased the dosages of _____ / _____ 5-20mg to 10-20mg daily (_____ medication) and _____ 12.5 mg (_____ used to treat high _____ and fluid retention) was increased to 25mg daily. During an interview with Resident #1 on _____ at 10:35 AM, she stated that she was just in the hospital twice for high _____ and she was feeling _____ at the present moment. During an interview on _____ at 5:30 PM with Resident #1's family member, she stated that she was made aware that Resident #1's _____ was high. When she arrived at the facility to transport Resident #1 to the hospital on _____, she was told by the nurse on duty that Resident #1 didn't get her _____ medication for 4 days. She stated that later in communication with staff, it was		

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determined Resident #1 had missed several doses of her anti-... medication. Resident #1's family member stated that when Resident #1 returned from the hospital on..., the facility still did not have the medications available. As a result, Resident #1 did not receive her... medications on... or... which caused her... to become high again resulting in another emergency... on... A Review of the Medication Observation Record (MOR), confirmed the resident was prescribed two medications to control her... 5-20mg daily and... 12.5mg () every other day. Review of hospital records revealed that Resident #1 was admitted on... with Hypertensive Urgency complaining of fatigue, malaise, ... and... According to the American... Association, Hypertensive Urgency is a... reading... or greater which could be accompanied by severe... nose... and sever... Her... is documented as... mmHg at 3:05 PM and she was given two... medications;... 5mg... and... 0.2mg tablet by mouth... was re-evaluated at 4:00 PM and had decreased to... mmHg. Resident #1 was discharged from the hospital on... at 2:30 PM with orders to be continued which included two medications, ... 12.5 mg every other day and... /... 5-10mg daily. Review of additional hospital records dated... revealed Resident #1 was seen again in the emergency... with a complaint of high... with a documented... of... mmHg. Resident #1 was treated with one dose of... 0.1 mg tablet by mouth... was re-evaluated and decreased to... Resident #1 was discharged that same evening with a prescription for... 0.1mg as needed (PRN)for elevated... On... at 10:25 AM, an interview with the Physical... Assistant was conducted and she stated, "I normally take Resident #1's... when I see her." She stated that during her visit with Resident #1 on..., the resident stated she was not feeling well and she was lightheaded. The Physical... Assistant stated that she routinely takes the... before working with a resident. However, she further stated that since Resident #1 complained of feeling lightheaded she remembers that she took it. She further stated, "I don't remember the exact reading but it was high and I went to get the nurse. The nurse took the... two more times and it was still high. The Physical... Assistant stated that the Nurse said something to the effect of, 'I will take care of it' and I left." The Physical... Assistant stated that later, the family informed her that Resident #1 was admitted to the hospital. During an interview on... at 9:30 AM with Resident #1's ARNP (Advanced Registered Nurse Practitioner), she stated that she was told on... that Resident #1's... was about 180... and the diastolic in the 90's, which was high enough to give her an extra dose of... medication. She stated that she increased Resident #1's... medications under the		

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assumption that Resident #1 was receiving the appropriate medication and that they were not working. The ARNP stated that she later found out that Resident #1 had not been receiving the prescribed order. She confirmed that the facility informed her of Resident #1's hospitalization the same day but she was never informed that her blood pressure was 200 mmHg or she would have sent her immediately to the ER (Emergency Room). The ARNP stated that she was under the impression that the extra dose did not work and that is why her family took her to the emergency room. The ARNP continued to state that she was made aware of the missed medications by a family member of Resident #1. The ARNP confirmed that prior to the hospitalization, Resident #1 was stable for some time and confirmed that if Resident #1 misses her anti-seizure or other medications, she becomes unstable. The ARNP stated that missing doses of her blood pressure medication would cause her to be more tired, increased blood pressure and increased fatigue; missed doses of the blood pressure medication would cause her to increase her blood pressure. She further stated that prescriptions are written for three months of refills and sometimes changes the doses of (aka) and but there is no reason she should have missed the medications. Record review of the 2016 Medication Observation Record (MOR) for Resident #1 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) 5-20 mg (), one capsule by mouth daily scheduled for 9:00 AM, were missed on through indicated by staff initials being circled. During an interview on at 1:20 PM with Staff D, LPN (Licensed Practical Nurse), he stated that on he found out that Staff F, CNA/Medication Technician had not given the medication [5-20mg] to Resident #1 on but signed off as if she had. Staff D said the resident could not have been given the medication since it was not available in the facility. b) 50 mcg (hormones), one tablet by mouth once daily scheduled for 6:00 AM were missed on through indicated by staff initials being circled. c) 10mg (anti-), one tablet by mouth twice daily scheduled for twice a day. Doses scheduled for 9:00 AM were missed on through and through as indicated by staff initials being circled. Doses scheduled for 5:00 PM on through and were missed as indicated by blank spaces, and through were missed as indicated by staff initials being circled. d) 25mg (for), one tablet by mouth twice daily scheduled for 9:00 AM and 5:00 PM. The 9:00 AM doses were missed on through as indicated by staff initials being circled. Doses scheduled for 5:00 PM were missed on , & in which documentation was left blank and on through , in which initials were circled.		

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e) 81 mg (chewable), one tablet by mouth once daily before meals scheduled for 9:00 AM was missed on [redacted] indicated by the box being left blank. f) 0.25mg tablet (for [redacted]) by mouth three times a day was originally prescribed three times daily 9:00 AM, 1:00 PM, and 9:00 PM. Documentation was left blank, for the 9:00 AM doses on [redacted] through [redacted], documentation was left blank for the 1:00 PM doses scheduled for [redacted] through [redacted], and the 9:00 PM doses scheduled for [redacted] through [redacted]. The staff initials were circled, indicating the medication was not given on [redacted] through [redacted] & [redacted], the 1:00 PM dose for [redacted] and the 9:00 PM dose on [redacted] through [redacted]. The medication times were changed on [redacted] to 8:00 AM, 1:00 PM, & 6:00 PM. The medication documentation areas were left blank indicating it was not given to the resident on [redacted] at 8:00 AM and [redacted] at 1:00 PM. There is no documentation on the back of the MOR's or in the progress notes to indicate why these aforementioned medications were not given. Further record review and interview with the Executive Director on [redacted] at 12 PM revealed there were no MORs available for Resident #1 at the time of survey for the months of [redacted] and [redacted] of 2016. During an interview on [redacted] at 1:40 PM with Staff A (Medication Technician), stated that if a medication is not given, she initials and circles her initials and writes on back why she did not give the medication. She confirmed that she did not write anything on the back of Resident # [redacted] MOR on the days her initials were circled. She further stated, "If we don't have the medication, we fill out the facility's Medication Request form and give it to the nurse." A call was placed to the pharmacy in question on 11/[redacted] at 10:45 AM by this surveyor. The staff confirmed that they usually deliver the medications for the resident to the facility but the last couple of days the facility has been coming to pick them up. They confirmed that a 30-day supply of [redacted] was ordered for Resident #1 on [redacted] and prior to that not since [redacted] and [redacted]. The pharmacy confirmed that the medications were automatically paid for by insurance and a credit card on file, so there was no reason why they could not get the medication. During a follow-up interview with Resident #1 on [redacted] at 8:45 AM, she stated that after the hospital visits, the facility had been giving her medications late around 10:00 AM but lately it's been okay but they just give them to her without explaining what they are giving her. She stated that she hopes she is getting her [redacted] and [redacted] medications because she worries about her [redacted] and she gets very nervous. 2) Review of the [redacted] and [redacted] 2016 MOR for Resident #2 showed that Medication		

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Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) 50mg (.....), one tab by mouth daily at bedtime, scheduled for 9:00 PM. The daily dose was missed through as indicated by staff initials circled and documentation area left blank. b) 300mg (anticonvulsant), one capsule by mouth once daily at 1PM. A dose was missed on as indicated by documentation area left blank. c) / 25-500mg (.....), two tablets (50-1000mg) by mouth every night at bedtime, scheduled for 9:00 PM. A dose was missed on as indicated by documentation area left blank. Review of the and 2016 MOR revealed that the only documentation that provided an explanation of missed doses were on at 9:00pm; which documented that the was "On Order". During further record review and interview with the Executive Director on at 12:00 PM, it was revealed that there were no MORs available at the time of survey for the months of and 2016. During an interview with Resident #2 on at 10:45 AM, he stated that they run out of his medications all the time and it happens too often. He says either they forget to order it or they order it and it goes downstairs and never makes it upstairs. 3) Review of the and 2016 MOR for Resident #3 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) One-Daily Tab , one tablet by mouth once daily scheduled for 9:00 AM. The medication was not given on and as indicated by the documentation areas left blank. b) 100mg (for), one tablet by mouth daily, scheduled for 9:00 PM. The medication was not given on through as indicated by the documentation areas left blank. c) 50mg Tablet (pain medication), give two tablets (100mg) by mouth three times daily scheduled for 6:00 Am, 2:00 PM and 10:00 PM. The medication was not given on at 10:00 PM as indicated by the documentation areas left blank. d) Tab 10mg (anti-depressant), one tablet by mouth once daily, scheduled for 9:00 AM. The medication was not given on as indicated by the documentation areas left blank. e) 0.4 mg Capsule (..... medication), one capsule by mouth every night at bedtime,		

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scheduled for 9:00 PM. The medication was not given on _____ & _____ as indicated by staff initials being circled and _____ was missed as indicated by the documentation areas left blank. The back of the MOR indicated the resident refused the _____ on _____ but there is no other documentation as to why the medication was not given the other days. f) _____ 500mg (_____), one tab by mouth twice daily times one week scheduled for 9:00 AM and 5:00 PM. The transcriber indicated the medication was to be started on the morning of _____. There is illegible writing in the column for the 18th which do not coincide with staff signatures along with blank spaces on the _____ 9:00 AM and _____ 5:00 PM. The MOR indicates only 10 of the 14 doses of _____ were documented as given. There is no indication on the back of the MOR's as to why the medications were missed. g) Limbrel _____ mg (_____), one cap by mouth twice daily, scheduled for 9:00 AM and 5:00 PM. The order is written twice on the _____ 2016 MOR. Staff initials are circled for the 9:00 AM dose on _____ and documentation areas left blank from _____ through _____. The 5:00 PM doses were not given as evidenced by staff initials circled from _____ through _____, _____ through _____ and _____. Documentation areas were left blank on _____, _____ through _____ and _____. There is no indication on the back of the MOR's as to why the medications were missed. During further record review and interview with the Executive Director on _____ at 12 PM, it was revealed there were no MOR's available for Resident #3 at the time of survey for the months of _____ and _____ 2016. During an interview with Resident #3 on _____ at 11:15 AM, he stated, " They have no checks and balances with the Med-Techs to ensure they are passing the medications correctly. In the last month, two nights they failed to have the right meds and two nights they missed the _____ (_____). Resident #3 stated that he got a copy of his medication list and started keeping track of the amount of pills they would bring versus what I was supposed to be getting. They are always out of one pill or another." Refer to A 0025, A 0052 Class II D165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC Based on record review and interview, the facility failed to provide, within 1 business day, an Adverse		

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Incident Report to the Agency for Health Care Administration related to an incident requiring a resident's transfer to a higher level of care, for 1 out of 3 residents' records reviewed (Resident #1). This is evidenced by: Review of Resident #1's record found that the progress notes dated [redacted] at 11:40 AM documented that a third party Physical [redacted] Assistant reported to Staff D that the resident had a [redacted] of over 200 [redacted] after which Staff D re-measured the [redacted] and it was found to be [redacted] mmHg. The progress notes document the resident was later taken to a local area hospital by her family at 2:40 PM on [redacted] and was discharge and returned to the facility on [redacted]. Resident #1 was again taken to the emergency [redacted] her family on [redacted] with high [redacted] and returned to the facility the same day. Review of the progress notes for Resident #1 dated [redacted] at 6:15 PM indicated resident was transferred to the Emergency [redacted] at 6:20 PM, the progress notes document that the resident's health care practitioner increased the dosages of [redacted] 5-20mg to 10-20mg daily ([redacted] medication) and [redacted] 12.5 mg ([redacted] used to treat high [redacted] and fluid retention) was increased to 25mg daily. Review of hospital records for Resident #1 confirmed that the resident was taken to the Emergency [redacted] aforementioned dates and received medical care due to physician order medications not provided as prescribed resulting in elevated [redacted]. During an interview on [redacted] with Resident #1 family member, she stated that she was made aware that Resident #1's [redacted] was high. When she arrived at the facility to transport Resident #1 to the hospital on [redacted], she was told that Resident #1 didn't get her [redacted] medication for 4 days and later found out that she has missed several doses of her anti-[redacted] medication. On [redacted] at 1:15 PM during an interview with the interim DON, she confirmed that the MOR's lacked the appropriate documentation. She confirmed she is aware of everything going on with the medications including missed doses and lack of documentation. She stated that was why they have pharmacy in the building today to review everyone's medications and MOR. Review of the Medication Observation Record (MOR), confirmed the [redacted] medication ([redacted]) had not been given for four days and the anti-[redacted] ([redacted]) medication was not given for numerous days. There is also documentation that other medications were not given in the month of [redacted] 2016. However, there is no explanation on the MORs or within the residents records for the missed doses..		

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During an interview on _____ at 2:20 PM, the Executive Director stated the previous Health and Wellness Director was not doing anything to ensure the medications were received [from pharmacy] in time. He confirmed there is no system in place to ensure the medications were ordered. He stated that they are aware they have a problem with medications not being ordered and available for the residents in a timely manner. A Medication Error Report was completed by the Administrator on 11/_____, regarding Resident #1, which indicated the error as _____ cap 5-20mg was not re-ordered. Refer to A 0025. Class III		

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0000 - Initial Comments

An unannounced complaint survey for CCR #2016011365, CCR#2016013429 and CCR #201613504 was conducted through at Savannah Court of the Palm Beach (license #8367). The facility had deficiencies identified at the time of the survey.

Deficient practice identified at a Class II for the following: A0025, A0052, A0056

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

Based on record review and interview, it was determined that the facility failed to provide care and services appropriate to the needs of a resident with respect to medication assistance and monitoring of a resident's well-being, for 1 out of 3 sampled residents (Resident #1). This is evidence of the facility's failure to provide medications as prescribed by the physician to Resident #1 resulting in medications not being provided on numerous days and ultimately resulting in Resident #1 being transferred to the hospital for treatment.

The findings included:

A record review of Resident #1's progress notes dated at 11:40 AM revealed documentation that a third party Physical Assistant reported to Staff D that the resident had a of over 200 Staff D re-measured the and it was found to be mmHg. The Advanced Registered Nurse Practitioner (ARNP) was made aware and orders received. The progress notes documented that the resident was later taken to a local area hospital by her family at 2:40 PM on and was discharge and returned to the facility on Resident #1 was again taken to the emergency her family on with high and returned to the facility the same day. Review of the progress notes for Resident #1 dated at 6:15 PM indicated the resident was transferred to the Emergency 6:20 PM. The progress notes documented that the resident's health care practitioner increased the dosages of / 5-20mg to 10-20mg daily (medication) and 12.5 mg (used to treat high and fluid retention) was increased to 25mg daily.

During an interview with Resident #1 on at 10:35 AM, she stated that she was just in the hospital twice for high and she was feeling at the present moment.

During an interview on at 5:30 PM with Resident #1's family member, she stated that she was

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made aware that Resident #1's was high. When she arrived at the facility to transport Resident #1 to the hospital on, she was told by the nurse on duty that Resident #1 didn't get her medication for 4 days. She stated that later in communication with staff, it was determined Resident #1 had missed several doses of her anti-..... medication. Resident #1's family member stated that when Resident #1 returned from the hospital on, the facility still did not have the medications available. As a result, Resident #1 did not receive her medications on or which caused her to become high again resulting in another emergency on A Review of the Medication Observation Record (MOR), confirmed the resident was prescribed two medications to control her 5-20mg daily and 12.5mg (.....) every other day. Review of hospital records revealed that Resident #1 was admitted on with Hypertensive Urgency complaining of fatigue, malaise, ... and According to the American Association, Hypertensive Urgency is a reading or greater which could be accompanied by severe nose and severe Her is documented as mmHg at 3:05 PM and she was given two medications; 5mg and 0.2mg tablet by mouth. was re-evaluated at 4:00 PM and had decreased to mmHg. Resident #1 was discharged from the hospital on at 2:30 PM with orders to be continued which included two medications, ... 12.5 mg every other day and 5-10mg daily. Review of additional hospital records dated revealed Resident #1 was seen again in the emergency with a complaint of high with a documented of mmHg. Resident #1 was treated with one dose of 0.1 mg tablet by mouth. was re-evaluated and decreased to Resident #1 was discharged that same evening with a prescription for 0.1mg as needed (PRN) for elevated On at 10:25 AM, an interview with the Physical Assistant was conducted and she stated, "I normally take Resident #1's when I see her. "She stated that during her visit with Resident #1 on, the resident stated she was not feeling well and she was lightheaded. The Physical Assistant stated that she routinely takes the before working with a resident. However, she further stated that since Resident #1 complained of feeling lightheaded she remembers that she took it. She further stated, "I don't remember the exact reading but it was high and I went to get the nurse. The nurse took the two more times and it was still high. The Physical Assistant stated that the Nurse said something to the effect of, 'I will take care of it' and I left. " The Physical Assistant stated that later, the family informed her that Resident #1 was admitted to the hospital. During an interview on at 9:30 AM with Resident #1's ARNP (Advanced Registered Nurse		

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Practitioner), she stated that she was told on [redacted] that Resident #1's [redacted] was about 180 [redacted] and the diastolic in the 90's, which was high enough to give her an extra dose of [redacted] medication. She stated that she increased Resident #1's [redacted] medications under the assumption that Resident #1 was receiving the appropriate medication and that they were not working. The ARNP stated that she later found out that Resident #1 had not been receiving the prescribed order. She confirmed that the facility informed her of Resident #1's hospitalization the same day but she was never informed that her [redacted] was 200 mmHg [redacted] or she would have sent her immediately to the ER (Emergency [redacted]). The ARNP stated that she was under the impression that the extra dose did not work and that is why her family took her to the emergency [redacted]. The ARNP continued to state that she was made aware of the missed medications by a family member of Resident #1. The ARNP confirmed that prior to the hospitalization, Resident #1 was stable for some time and confirmed that if Resident #1 misses her anti-[redacted] or [redacted] medications, she becomes unstable. The ARNP stated that missing doses of her [redacted] medication [redacted] would cause her to be more tired, increased [redacted] and increased fatigue; missed doses of the [redacted] would cause [redacted] increasing her [redacted]. She further stated that prescriptions are written for three months of refills and sometimes changes the doses of [redacted] (aka [redacted]) and [redacted] but there is no reason she should have missed the medications. Record review of the [redacted] 2016 Medication Observation Record (MOR) for Resident #1 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) [redacted] 5-20 mg ([redacted]), one capsule by mouth daily scheduled for 9:00 AM, were missed on [redacted] through [redacted] indicated by staff initials being circled. During an interview on [redacted] at 1:20 PM with Staff D, LPN (Licensed Practical Nurse), he stated that on [redacted] he found out that Staff F, CNA/Medication Technician had not given the [redacted] medication [redacted] [redacted] 5-20mg] to Resident #1 on [redacted] but signed off as if she had. Staff D said the resident could not have been given the medication since it was not available in the facility. b) [redacted] 50 mcg ([redacted] hormones), one tablet by mouth once daily scheduled for 6:00 AM were missed on [redacted] through [redacted] indicated by staff initials being circled. c) [redacted] 10mg (anti-[redacted]), one tablet by mouth twice daily scheduled for twice a day. Doses scheduled for 9:00 AM were missed on [redacted] through [redacted] and [redacted] through [redacted] as indicated by staff initials being circled. Doses scheduled for 5:00 PM on [redacted] through [redacted] and [redacted] were missed as indicated by blank spaces, and [redacted] through [redacted] were missed as indicated by staff initials being circled. d) [redacted] 25mg (for [redacted]), one tablet by mouth twice daily scheduled for 9:00 AM and 5:00 PM.		

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The 9:00 AM doses were missed on [redacted] through [redacted] as indicated by staff initials being circled. Doses scheduled for 5:00 PM were missed on [redacted] & [redacted] in which documentation was left blank and on [redacted] through [redacted], in which initials were circled. e) [redacted] 81 mg (chewable), one tablet by mouth once daily before meals scheduled for 9:00 AM was missed on [redacted] indicated by the box being left blank. f) [redacted] 0.25mg tablet (for [redacted]) by mouth three times a day was originally prescribed three times daily 9:00 AM, 1:00 PM, and 9:00 PM. Documentation was left blank, for the 9:00 AM doses on [redacted] through [redacted], documentation was left blank for the 1:00 PM doses scheduled for [redacted] through [redacted], and the 9:00 PM doses scheduled for [redacted] through [redacted]. The staff initials were circled, indicating the medication was not given on [redacted] through [redacted] & [redacted], the 1:00 PM dose for [redacted] and the 9:00 PM dose on [redacted] through [redacted]. The medication times were changed on [redacted] to 8:00 AM, 1:00 PM, & 6:00 PM. The medication documentation areas were left blank indicating it was not given to the resident on [redacted] at 8:00 AM and [redacted] at 1:00 PM. There is no documentation on the back of the MOR's or in the progress notes to indicate why these aforementioned medications were not given. Further record review and interview with the Executive Director on [redacted] at 12 PM revealed there were no MORs available for Resident #1 at the time of survey for the months of [redacted] and [redacted] of 2016. During an interview on [redacted] at 1:40 PM with Staff A (Medication Technician), stated that if a medication is not given, she initials and circles her initials and writes on back why she did not give the medication. She confirmed that she did not write anything on the back of Resident # [redacted] MOR on the days her initials were circled. She further stated, "If we don't have the medication, we fill out the facility's Medication Request form and give it to the nurse." A call was placed to the pharmacy in question on 11/ [redacted] at 10:45 AM by this surveyor. The staff confirmed that they usually deliver the medications for the resident to the facility but the last couple of days the facility has been coming to pick them up. They confirmed that a 30-day supply of [redacted] was ordered for Resident #1 on [redacted] and prior to that not since [redacted] and [redacted]. The pharmacy confirmed that the medications were automatically paid for by insurance and a credit card on file, so there was no reason why they could not get the medication. During a follow-up interview with Resident #1 on [redacted] at 8:45 AM, she stated that after the hospital visits, the facility had been giving her medications late around 10:00 AM but lately it's been okay but they just give them to her without explaining what they are giving her. She stated that she hopes she is getting her [redacted] and [redacted] medications because she worries about her [redacted] and [redacted]		

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she gets very nervous. During an interview on _____ at 1:15 PM with the interim DON (Director of Nursing), she confirmed that the MOR's lacked the appropriate documentation. She confirmed she was aware of everything going on with the medications including missed doses and lack of documentation. She stated that was why they have the pharmacy in the building today to review everyone's medications and MOR. During an interview on _____ at 2:20 PM, the Executive Director stated the previous Health and Wellness Director was not doing anything to ensure the medications were received from the pharmacy in time. He confirmed there is no system in place to ensure the medications were ordered. He stated that they are aware they have a problem with medications not being ordered and available for the residents in a timely manner. A Medication Error Report was completed by the Administrator on 11/_____, regarding Resident #1, which indicated the error as _____, cap 5-20mg was not re-ordered. Refer to A 0052 and A 0056 Class II 0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3) Based on record review and interview, the facility failed to provide assistance with self-administration of medication(s) as physician ordered and to notify the physician of any concerns regarding the medications, including missed doses, for 3 of 3 sampled residents (Residents #1, #2 and #3). The findings included: Based on record review and interview, it was determined that the facility failed to provide care and services appropriate to the needs of a resident with respect to medication assistance and monitoring of a resident's well-being, for 1 out of 3 sampled residents (Resident #1). This is evidence of the facility's failure to provide medications as prescribed by the physician to Resident #1 resulting in medications not being provided on numerous days and ultimately resulting in Resident #1 being transferred to the hospital for treatment. The findings included: A record review of Resident #1's progress notes dated _____ at 11:40 AM revealed documentation		

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that a third party Physical Assistant reported to Staff D that the resident had a of over 200 mmHg. Staff D re-measured the and it was found to be mmHg. The Advanced Registered Nurse Practitioner (ARNP) was made aware and orders received. The progress notes documented that the resident was later taken to a local area hospital by her family at 2:40 PM on and was discharge and returned to the facility on Resident #1 was again taken to the emergency her family on with high and returned to the facility the same day. Review of the progress notes for Resident #1 dated at 6:15 PM indicated the resident was transferred to the Emergency 6:20 PM. The progress notes documented that the resident's health care practitioner increased the dosages of / 5-20mg to 10-20mg daily (medication) and 12.5 mg (used to treat high and fluid retention) was increased to 25mg daily. During an interview with Resident #1 on at 10:35 AM, she stated that she was just in the hospital twice for high and she was feeling at the present moment. During an interview on at 5:30 PM with Resident #1's family member, she stated that she was made aware that Resident #1's was high. When she arrived at the facility to transport Resident #1 to the hospital on she was told by the nurse on duty that Resident #1 didn't get her medication for 4 days. She stated that later in communication with staff, it was determined Resident #1 had missed several doses of her anti- medication. Resident #1's family member stated that when Resident #1 returned from the hospital on the facility still did not have the medications available. As a result, Resident #1 did not receive her medications on or which caused her to become high again resulting in another emergency on A Review of the Medication Observation Record (MOR), confirmed the resident was prescribed two medications to control her / 5-20mg daily and 12.5mg (every other day. Review of hospital records revealed that Resident #1 was admitted on with Hypertensive Urgency complaining of fatigue, malaise, and According to the American Association, Hypertensive Urgency is a reading or greater which could be accompanied by severe nose and sever Her is documented as mmHg at 3:05 PM and she was given two medications; 5mg and 0.2mg tablet by mouth. was re-evaluated at 4:00 PM and had decreased to mmHg. Resident #1 was discharged from the hospital on at 2:30 PM with orders to be continued which included two medications, 12.5 mg every other day and 5-10mg daily. Review of addition hospital records dated revealed Resident #1 was seen again in the		

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emergency with a complaint of high with a documented of mmHg. Resident #1 was treated with one dose of 0.1 mg tablet by mouth. was re-evaluated and decreased to Resident #1 was discharged that same evening with a prescription for 0.1mg as needed (PRN) for elevated On at 10:25 AM, an interview with the Physical Assistant was conducted and she stated, "I normally take Resident #1's when I see her." She stated that during her visit with Resident #1 on the resident stated she was not feeling well and she was lightheaded. The Physical Assistant stated that she routinely takes the before working with a resident. However, she further stated that since Resident #1 complained of feeling lightheaded she remembers that she took it. She further stated, "I don't remember the exact reading but it was high and I went to get the nurse. The nurse took the two more times and it was still high. The Physical Assistant stated that the Nurse said something to the effect of, 'I will take care of it' and I left." The Physical Assistant stated that later, the family informed her that Resident #1 was admitted to the hospital. During an interview on at 9:30 AM with Resident #1's ARNP (Advanced Registered Nurse Practitioner), she stated that she was told on that Resident #1's was about 180 and the diastolic in the 90's, which was high enough to give her an extra dose of medication. She stated that she increased Resident #1's medications under the assumption that Resident #1 was receiving the appropriate medication and that they were not working. The ARNP stated that she later found out that Resident #1 had not been receiving the prescribed order. She confirmed that the facility informed her of Resident #1's hospitalization the same day but she was never informed that her was 200 mmHg or she would have sent her immediately to the ER (Emergency). The ARNP stated that she was under the impression that the extra dose did not work and that is why her family took her to the emergency. The ARNP continued to state that she was made aware of the missed medications by a family member of Resident #1. The ARNP confirmed that prior to the hospitalization, Resident #1 was stable for some time and confirmed that if Resident #1 misses her anti- or medications, she becomes unstable. The ARNP stated that missing doses of her medication would cause her to be more tired, increased and increased fatigue; missed doses of the would cause increasing her. She further stated that prescriptions are written for three months of refills and sometimes changes the doses of (aka) and but there is no reason she should have missed the medications. Record review of the 2016 Medication Observation Record (MOR) for Resident #1 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left		

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blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) 5-20 mg (), one capsule by mouth daily scheduled for 9:00 AM, were missed on through indicated by staff initials being circled. During an interview on at 1:20 PM with Staff D, LPN (Licensed Practical Nurse), he stated that on he found out that Staff F, CNA/Medication Technician had not given the medication [5-20mg] to Resident #1 on but signed off as if she had. Staff D said the resident could not have been given the medication since it was not available in the facility. b) 50 mcg (hormones), one tablet by mouth once daily scheduled for 6:00 AM were missed on through indicated by staff initials being circled. c) 10mg (anti-), one tablet by mouth twice daily scheduled for twice a day. Doses scheduled for 9:00 AM were missed on through and through as indicated by staff initials being circled. Doses scheduled for 5:00 PM on through and were missed as indicated by blank spaces, and through were missed as indicated by staff initials being circled. d) 25mg (for), one tablet by mouth twice daily scheduled for 9:00 AM and 5:00 PM. The 9:00 AM doses were missed on through as indicated by staff initials being circled. Doses scheduled for 5:00 PM were missed on , & in which documentation was left blank and on through , in which initials were circled. e) 81 mg (chewable), one tablet by mouth once daily before meals scheduled for 9:00 AM was missed on indicated by the box being left blank. f) 0.25mg tablet (for) by mouth three times a day was originally prescribed three times daily 9:00 AM, 1:00 PM, and 9:00 PM. Documentation was left blank, for the 9:00 AM doses on through , documentation was left blank for the 1:00 PM doses scheduled for through , and the 9:00 PM doses scheduled for through . The staff initials were circled, indicating the medication was not given on through & , the 1:00 PM dose for and the 9:00 PM dose on through . The medication times were changed on to 8:00 AM, 1:00 PM, & 6:00 PM. The medication documentation areas were left blank indicating it was not given to the resident on at 8:00 AM and at 1:00 PM. There is no documentation on the back of the MOR's or in the progress notes to indicate why these aforementioned medications were not given. Further record review and interview with the Executive Director on at 12 PM revealed there were no MORs available for Resident #1 at the time of survey for the months of and of 2016. During an interview on at 1:40 PM with Staff A (Medication Technician), stated that if a		

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NAME OF PROVIDER OR SUPPLIER SAVANNAH COURT OF THE PALM BEACH	STREET ADDRESS, CITY, STATE, ZIP CODE 2090 N. CONGRESS AVENUE WEST PALM BEACH, FL 33401	
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medication is not given, she initials and circles her initials and writes on back why she did not give the medication. She confirmed that she did not write anything on the back of Resident # MOR on the days her initials were circled. She further stated, " If we don't have the medication, we fill out the facility 's Medication Request form and give it to the nurse. " A call was placed to the pharmacy in question on 11/ at 10:45 AM by this surveyor. The staff confirmed that they usually deliver the medications for the resident to the facility but the last couple of days the facility has been coming to pick them up. They confirmed that a 30-day supply of was ordered for Resident #1 on and prior to that not since and . The pharmacy confirmed that the medications were automatically paid for by insurance and a credit card on file, so there was no reason why they could not get the medication. During a follow-up interview with Resident #1 on at 8:45 AM, she stated that after the hospital visits, the facility had been giving her medications late around 10:00 AM but lately it's been okay but they just give them to her without explaining what they are giving her. She stated that she hopes she is getting her and medications because she worries about her and she gets very nervous. 2) Review of the and 2016 MOR for Resident #2 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) 50mg (), one tab by mouth daily at bedtime, scheduled for 9:00 PM. The daily dose was missed through as indicated by staff initials circled and documentation area left blank. b) 300mg (anticonvulsant), one capsule by mouth once daily at 1PM. A dose was missed on as indicated by documentation area left blank. c) 25-500mg (), two tablets (50-1000mg) by mouth every night at bedtime, scheduled for 9:00 PM. A dose was missed on as indicated by documentation area left blank. Review of the and 2016 MOR revealed that the only documentation that provided an explanation of missed doses were on at 9:00pm; which documented that the was " On Order ". During further record review and interview with the Executive Director on at 12:00 PM, it was revealed that there were no MORs available at the time of survey for the months of and 2016. During an interview with Resident #2 on at 10:45 AM, he stated that they run out of his		

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medications all the time and it happens too often. He says either they forget to order it or they order it and it goes downstairs and never makes it upstairs. 3) Review of the and 2016 MOR for Resident #3 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) One-Daily Tab , one tablet by mouth once daily scheduled for 9:00 AM. The medication was not given on and as indicated by the documentation areas left blank. b) 100mg (for), one tablet by mouth daily, scheduled for 9:00 PM. The medication was not given on through as indicated by the documentation areas left blank. c) 50mg Tablet (pain medication), give two tablets (100mg) by mouth three times daily scheduled for 6:00 AM, 2:00 PM and 10:00 PM. The medication was not given on at 10:00 PM as indicated by the documentation areas left blank. d) Tab 10mg (anti-depressant), one tablet by mouth once daily, scheduled for 9:00 AM. The medication was not given on as indicated by the documentation areas left blank. e) 0.4 mg Capsule (medication), one capsule by mouth every night at bedtime, scheduled for 9:00 PM. The medication was not given on & as indicated by staff initials being circled and was missed as indicated by the documentation areas left blank. The back of the MOR indicated the resident refused the on but there is no other documentation as to why the medication was not given the other days. f) 500mg (), one tab by mouth twice daily times one week scheduled for 9:00 AM and 5:00 PM. The transcriber indicated the medication was to be started on the morning of . There is illegible writing in the column for the 18th which do not coincide with staff signatures along with blank spaces on the 9:00 AM and 5:00 PM. The MOR indicates only 10 of the 14 doses of were documented as given. There is no indication on the back of the MOR's as to why the medications were missed. g) Limbrel mg (), one cap by mouth twice daily, scheduled for 9:00 AM and 5:00 PM. The order is written twice on the 2016 MOR. Staff initials are circled for the 9:00 AM dose on and documentation areas left blank from through . The 5:00 PM doses were not given as evidenced by staff initials circled from through , through and . Documentation areas were left blank on , through and . There is no indication on the back of the MOR's as to why the medications were missed. During further		

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record review and interview with the Executive Director on at 12 PM, it was revealed there were no MOR's available for Resident #3 at the time of survey for the months of and 2016. During an interview with Resident #3 on at 11:15 AM, he stated, " They have no checks and balances with the Med-Techs to ensure they are passing the medications correctly. In the last month, two nights they failed to have the right meds and two nights they missed the (). Resident #3 stated that he got a copy of his medication list and started keeping track of the amount of pills they would bring versus what I was supposed to be getting. They are always out of one pill or another." On at 1:15 PM during an interview with the interim DON (Director of Nursing), she confirmed that the MOR's lacked the appropriate documentation. She confirmed she was aware of everything going on with the medications including missed doses and lack of documentation. She stated that was why they have pharmacy in the building today to review everyone's medications and MOR. During an interview on at 2:20 PM, the Executive Director stated the previous Health and Wellness Director was not doing anything to ensure the medications were received from pharmacy in time. He confirms there is no system in place to ensure the medications were ordered. He stated that they are aware they have a problem with medications not being ordered and available for the residents in a timely manner. A Medication Error Report was completed by the Administrator on 11/ , regarding Resident #1, which indicated the error as / , cap 5-20mg was not re-ordered. Refer to A 0025 and A 0056 Class II 0054 - Medication - Records - 58A-5.0185(5) FAC Based on record review and interview, the facility failed to update the medication observation record (MOR) each time the medication was offered or due to be administered to a resident and to maintain a chart accurately for recording missed doses or refusals of medications, for 3 of 3 residents' MORs reviewed (Resident#1-#3). The findings included: The form titled Medication Record is a form used by the facility to document medication assistance and administration for residents in the facility. When a person is assisting with self-administration or		

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administering medication to a resident, standard practice is for the initials of the staff to be circled, indicating that the medication was not consumed by the resident. A reason should then be documented in the appropriate place. 1) Record review of the 2016 Medication Observation Record (MOR) for Resident #1 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) 5-20 mg (), one capsule by mouth daily scheduled for 9:00 AM, were missed on through indicated by staff initials being circled. During an interview on at 1:20 PM with Staff D, LPN (Licensed Practical Nurse), he stated that on he found out that Staff F, CNA/Medication Technician had not given the medication [5-20mg] to Resident #1 on but signed off as if she had. Staff D said the resident could not have been given the medication since it was not available in the facility. b) 50 mcg (hormones), one tablet by mouth once daily scheduled for 6:00 AM were missed on through indicated by staff initials being circled. c) 10mg (anti-), one tablet by mouth twice daily scheduled for twice a day. Doses scheduled for 9:00 AM were missed on through and through as indicated by staff initials being circled. Doses scheduled for 5:00 PM on through and were missed as indicated by blank spaces, and through were missed as indicated by staff initials being circled. d) 25mg (for), one tablet by mouth twice daily scheduled for 9:00 AM and 5:00 PM. The 9:00 AM doses were missed on through as indicated by staff initials being circled. Doses scheduled for 5:00 PM were missed on , & in which documentation was left blank and on through , in which initials were circled. e) 81 mg (chewable), one tablet by mouth once daily before meals scheduled for 9:00 AM was missed on indicated by the box being left blank. f) 0.25mg tablet (for) by mouth three times a day was originally prescribed three times daily 9:00 AM, 1:00 PM, and 9:00 PM. Documentation was left blank, for the 9:00 AM doses on through , documentation was left blank for the 1:00 PM doses scheduled for through , and the 9:00 PM doses scheduled for through . The staff initials were circled, indicating the medication was not given on through & , the 1:00 PM dose for and the 9:00 PM dose on through . The medication times were changed on to 8:00 AM, 1:00 PM, & 6:00 PM. The medication documentation areas were left blank indicating it was not given to the resident on at 8:00 AM and at 1:00 PM.		

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There is no documentation on the back of the MOR's or in the progress notes to indicate why these medications were not given. Further record review and interview with the Executive Director on at 12 PM revealed there were no MORs available for Resident #1 at the time of survey for the months of and of 2016. During an interview on at 1:40 PM with Staff A (Medication Technician), stated that if a medication is not given, she initials and circles her initials and writes on back why she did not give the medication. She confirmed that she did not write anything on the back of Resident # MOR on the days her initials were circled. She further stated " If we don't have the medication, we fill out the facility 's Medication Request form and give it to the nurse." 2)Review of the and 2016 MOR for Resident #2 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) 50mg (), one tab by mouth daily at bedtime, scheduled for 9:00 PM. The daily dose was missed through as indicated by staff initials circled and documentation area left blank. b) 300mg (anticonvulsant), one capsule by mouth once daily at 1PM. A dose was missed on as indicated by documentation area left blank. c) 25-500mg (), two tablets (50-1000mg) by mouth every night at bedtime, scheduled for 9:00 PM. A dose was missed on as indicated by documentation area left blank. Review of the and 2016 MOR revealed that the only documentation that provided an explanation of missed doses were on at 9:00pm; which documented that the was " On Order ". During further record review and interview with the Executive Director on at 12:00 PM, it was revealed that there were no MORs available at the time of survey for the months of and 2016. 3)Review of the and 2016 MOR for Resident #3 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) One-Daily Tab , one tablet by mouth once daily scheduled for 9:00 AM. The medication was not given on and as indicated by the documentation areas left blank.		

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b) 100mg (for), one tablet by mouth daily, scheduled for 9:00 PM. The medication was not given on through as indicated by the documentation areas left blank. c) 50mg Tablet (pain medication), give two tablets (100mg) by mouth three times daily scheduled for 6:00 AM, 2:00 PM and 10:00 PM. The medication was not given on at 10:00 PM as indicated by the documentation areas left blank. d) Tab 10mg (anti-depressant), one tablet by mouth once daily, scheduled for 9:00 AM. The medication was not given on as indicated by the documentation areas left blank. e) 0.4 mg Capsule (..... medication), one capsule by mouth every night at bedtime, scheduled for 9:00 PM. The medication was not given on & as indicated by staff initials being circled and was missed as indicated by the documentation areas left blank. The back of the MOR indicated the resident refused the on but there is no other documentation as to why the medication was not given the other days. f) 500mg (.....), one tab by mouth twice daily times one week scheduled for 9:00 AM and 5:00 PM. The transcriber indicated the medication was to be started on the morning of There is illegible writing in the column for the 18th which do not coincide with staff signatures along with blank spaces on the 9:00 AM and 5:00 PM. The MOR indicates only 10 of the 14 doses of were documented as given. There is no indication on the back of the MOR's as to why the medications were missed. g) Limbrel mg (.....), one cap by mouth twice daily, scheduled for 9:00 AM and 5:00 PM. The order is written twice on the 2016 MOR. Staff initials are circled for the 9:00 AM dose on and documentation areas left blank from through The 5:00 PM doses were not given as evidenced by staff initials circled from through through Documentation areas were left blank on through and and There is no indication on the back of the MOR's as to why the medications were missed. During further record review and interview with the Executive Director on at 12 PM, it was revealed there were no MOR's available for Resident #3 at the time of survey for the months of and 2016. On at 1:15 PM during an interview with the interim DON (Director of Nursing), she confirmed that the MOR's lacked the appropriate documentation. She confirmed she was aware of everything going on with the medications including missed doses and lack of documentation. She stated that was why they have pharmacy in the building today to review everyone's medications and MOR. During an interview on at 2:20 PM, the Executive Director stated the previous Health and Wellness Director was not doing anything to ensure the medications were received from pharmacy in		

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time. He confirmed there is no system in place to ensure the medications were ordered. He stated that they are aware they have a problem with medications not being ordered and available for the residents in a timely manner. A Medication Error Report was completed by the Administrator on 11/ , regarding Resident #1, which indicated the error as . . . , / . . . cap 5-20mg was not re-ordered. Class III 0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC Based on record review and interview and observation, the facility failed to make a reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner for 3 of 3 residents' records reviewed. This also resulted in the transfer to a higher level of care of 1 (Resident #1) of 3 residents' records reviewed. The findings included: On . . . , a copy of the policy and procedures related to medication assistance, administration, documenting, and ordering medications from the pharmacy was requested. A copy of the Medication Management Lesson Plan was provided which did not include any of the requested information. The policy was again requested during an interview with the Executive Director on . . . at 11:30 AM; he confirmed there was no policy in place related to documentation and ordering of medication(s) from pharmacy. On . . . at 1:15 PM during an interview with the interim Director of Nursing (DON), she confirmed that the MOR's lacked the appropriate documentation. She confirmed she was aware of everything going on with the medications including missed doses and lack of documentation. She stated that was why they have Pharmacy Consultants in the building today to review everyone's medications and MOR. During an interview on . . . at 2:20 PM, the Executive Director stated the previous Health and Wellness Director was not doing anything to ensure the medications were received [from pharmacy] in time. He confirmed there is no system in place to ensure the medications were ordered. He stated that they are aware they have a problem with medications not being ordered and available for the residents in a timely manner. A Medication Error Report was completed by the Administrator on 11/ . . . ,		

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regarding Resident #1, which indicated the error as _____ cap 5-20mg was not re-ordered. During an interview on _____ at 2:00 PM with Staff C, she stated that the med-techs let the nurse know when they need meds. They take the sticker off the punch card put it on the paper and give it to the nurse because the med-techs can't order meds. She is unsure which nurse she reported it to but stated she verbally told the nurse because there was no sticker there so they should have long ordered it. She stated when the nurse faxes the order off, they are supposed to have a receipt that says 'ok'. A confidential interview was conducted during the survey with a staff member. He/she stated that " There are residents here whose medications have been missing for a month and they don't do anything. The pharmacy will say that the insurance won't pay for it or will pay only for some but they don't get them anything else. " The following was noted specifically: 1) A record review of Resident #1's progress notes dated _____ at 11:40 AM revealed documentation that a third party Physical _____ Assistant reported to Staff D that the resident had a _____ of over 200 _____. Staff D re-measured the _____ and it was found to be _____ mmHg. The Advanced Registered Nurse Practitioner (ARNP) was made aware and orders received. The progress notes documented that the resident was later taken to a local area hospital by her family at 2:40 PM on _____ and was discharge and returned to the facility on _____. Resident #1 was again taken to the emergency _____ her family on _____ with high _____ and returned to the facility the same day. Review of the progress notes for Resident #1 dated _____ at 6:15 PM indicated the resident was transferred to the Emergency _____ 6:20 PM. The progress notes documented that the resident 's health care practitioner increased the dosages of _____ / _____ 5-20mg to 10-20mg daily (_____ medication) and _____ 12.5 mg (_____ used to treat high _____ and fluid retention) was increased to 25mg daily. During an interview with Resident #1 on _____ at 10:35 AM, she stated that she was just in the hospital twice for high _____ and she was feeling _____ at the present moment. During an interview on _____ at 5:30 PM with Resident #1's family member, she stated that she was made aware that Resident #1's _____ was high. When she arrived at the facility to transport Resident #1 to the hospital on _____, she was told by the nurse on duty that Resident #1 didn't get her _____ medication for 4 days. She stated that later in communication with staff, it was		

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determined Resident #1 had missed several doses of her anti-... medication. Resident #1's family member stated that when Resident #1 returned from the hospital on..., the facility still did not have the medications available. As a result, Resident #1 did not receive her... medications on... or... which caused her... to become high again resulting in another emergency... on... A Review of the Medication Observation Record (MOR), confirmed the resident was prescribed two medications to control her... 5-20mg daily and... 12.5mg () every other day. Review of hospital records revealed that Resident #1 was admitted on... with Hypertensive Urgency complaining of fatigue, malaise, ... and ... According to the American ... Association, Hypertensive Urgency is a... reading... or greater which could be accompanied by severe..., nose... and sever... Her... is documented as... mmHg at 3:05 PM and she was given two... medications;... 5mg... and... 0.2mg tablet by mouth. ... was re-evaluated at 4:00 PM and had decreased to... mmHg. Resident #1 was discharged from the hospital on... at 2:30 PM with orders to be continued which included two medications, ... 12.5 mg every other day and... /... 5-10mg daily. Review of additional hospital records dated... revealed Resident #1 was seen again in the emergency... with a complaint of high... with a documented... of... mmHg. Resident #1 was treated with one dose of... 0.1 mg tablet by mouth. ... was re-evaluated and decreased to... Resident #1 was discharged that same evening with a prescription for... 0.1mg as needed (PRN)for elevated... On... at 10:25 AM, an interview with the Physical... Assistant was conducted and she stated, "I normally take Resident #1's... when I see her." She stated that during her visit with Resident #1 on..., the resident stated she was not feeling well and she was lightheaded. The Physical... Assistant stated that she routinely takes the... before working with a resident. However, she further stated that since Resident #1 complained of feeling lightheaded she remembers that she took it. She further stated, "I don't remember the exact reading but it was high and I went to get the nurse. The nurse took the... two more times and it was still high. The Physical... Assistant stated that the Nurse said something to the effect of, 'I will take care of it' and I left." The Physical... Assistant stated that later, the family informed her that Resident #1 was admitted to the hospital. During an interview on... at 9:30 AM with Resident #1's ARNP (Advanced Registered Nurse Practitioner), she stated that she was told on... that Resident #1's... was about 180... and the diastolic in the 90's, which was high enough to give her an extra dose of... medication. She stated that she increased Resident #1's... medications under the		

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assumption that Resident #1 was receiving the appropriate medication and that they were not working. The ARNP stated that she later found out that Resident #1 had not been receiving the prescribed order. She confirmed that the facility informed her of Resident #1's hospitalization the same day but she was never informed that her blood pressure was 200 mmHg or she would have sent her immediately to the ER (Emergency Room). The ARNP stated that she was under the impression that the extra dose did not work and that is why her family took her to the emergency room. The ARNP continued to state that she was made aware of the missed medications by a family member of Resident #1. The ARNP confirmed that prior to the hospitalization, Resident #1 was stable for some time and confirmed that if Resident #1 misses her anti-seizure or other medications, she becomes unstable. The ARNP stated that missing doses of her blood pressure medication would cause her to be more tired, increased blood pressure and increased fatigue; missed doses of the blood pressure medication would cause her to increase her blood pressure. She further stated that prescriptions are written for three months of refills and sometimes changes the doses of (aka) and but there is no reason she should have missed the medications. Record review of the 2016 Medication Observation Record (MOR) for Resident #1 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) 5-20 mg (), one capsule by mouth daily scheduled for 9:00 AM, were missed on through indicated by staff initials being circled. During an interview on at 1:20 PM with Staff D, LPN (Licensed Practical Nurse), he stated that on he found out that Staff F, CNA/Medication Technician had not given the medication [5-20mg] to Resident #1 on but signed off as if she had. Staff D said the resident could not have been given the medication since it was not available in the facility. b) 50 mcg (hormones), one tablet by mouth once daily scheduled for 6:00 AM were missed on through indicated by staff initials being circled. c) 10mg (anti-), one tablet by mouth twice daily scheduled for twice a day. Doses scheduled for 9:00 AM were missed on through and through as indicated by staff initials being circled. Doses scheduled for 5:00 PM on through and were missed as indicated by blank spaces, and through were missed as indicated by staff initials being circled. d) 25mg (for), one tablet by mouth twice daily scheduled for 9:00 AM and 5:00 PM. The 9:00 AM doses were missed on through as indicated by staff initials being circled. Doses scheduled for 5:00 PM were missed on , & in which documentation was left blank and on through , in which initials were circled.		

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e) 81 mg (chewable), one tablet by mouth once daily before meals scheduled for 9:00 AM was missed on [redacted] indicated by the box being left blank. f) 0.25mg tablet (for [redacted]) by mouth three times a day was originally prescribed three times daily 9:00 AM, 1:00 PM, and 9:00 PM. Documentation was left blank, for the 9:00 AM doses on [redacted] through [redacted], documentation was left blank for the 1:00 PM doses scheduled for [redacted] through [redacted], and the 9:00 PM doses scheduled for [redacted] through [redacted]. The staff initials were circled, indicating the medication was not given on [redacted] through [redacted] & [redacted], the 1:00 PM dose for [redacted] and the 9:00 PM dose on [redacted] through [redacted]. The medication times were changed on [redacted] to 8:00 AM, 1:00 PM, & 6:00 PM. The medication documentation areas were left blank indicating it was not given to the resident on [redacted] at 8:00 AM and [redacted] at 1:00 PM. There is no documentation on the back of the MOR's or in the progress notes to indicate why these aforementioned medications were not given. Further record review and interview with the Executive Director on [redacted] at 12 PM revealed there were no MORs available for Resident #1 at the time of survey for the months of [redacted] and [redacted] of 2016. During an interview on [redacted] at 1:40 PM with Staff A (Medication Technician), stated that if a medication is not given, she initials and circles her initials and writes on back why she did not give the medication. She confirmed that she did not write anything on the back of Resident # [redacted] MOR on the days her initials were circled. She further stated, "If we don't have the medication, we fill out the facility's Medication Request form and give it to the nurse." A call was placed to the pharmacy in question on 11/[redacted] at 10:45 AM by this surveyor. The staff confirmed that they usually deliver the medications for the resident to the facility but the last couple of days the facility has been coming to pick them up. They confirmed that a 30-day supply of [redacted] was ordered for Resident #1 on [redacted] and prior to that not since [redacted] and [redacted]. The pharmacy confirmed that the medications were automatically paid for by insurance and a credit card on file, so there was no reason why they could not get the medication. During a follow-up interview with Resident #1 on [redacted] at 8:45 AM, she stated that after the hospital visits, the facility had been giving her medications late around 10:00 AM but lately it's been okay but they just give them to her without explaining what they are giving her. She stated that she hopes she is getting her [redacted] and [redacted] medications because she worries about her [redacted] and she gets very nervous. 2) Review of the [redacted] and [redacted] 2016 MOR for Resident #2 showed that Medication		

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943102	(X3) DATE SURVEY COMPLETED 12/08/2016
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Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) 50mg (.....), one tab by mouth daily at bedtime, scheduled for 9:00 PM. The daily dose was missed through as indicated by staff initials circled and documentation area left blank. b) 300mg (anticonvulsant), one capsule by mouth once daily at 1PM. A dose was missed on as indicated by documentation area left blank. c) / 25-500mg (.....), two tablets (50-1000mg) by mouth every night at bedtime, scheduled for 9:00 PM. A dose was missed on as indicated by documentation area left blank. Review of the and 2016 MOR revealed that the only documentation that provided an explanation of missed doses were on at 9:00pm; which documented that the was "On Order". During further record review and interview with the Executive Director on at 12:00 PM, it was revealed that there were no MORs available at the time of survey for the months of and 2016. During an interview with Resident #2 on at 10:45 AM, he stated that they run out of his medications all the time and it happens too often. He says either they forget to order it or they order it and it goes downstairs and never makes it upstairs. 3) Review of the and 2016 MOR for Resident #3 showed that Medication Technicians (MT) were assisting with self-administration of medications. The initials of the MT responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication was not taken/given to the resident on several days. This includes the orders: a) One-Daily Tab , one tablet by mouth once daily scheduled for 9:00 AM. The medication was not given on and as indicated by the documentation areas left blank. b) 100mg (for), one tablet by mouth daily, scheduled for 9:00 PM. The medication was not given on through as indicated by the documentation areas left blank. c) 50mg Tablet (pain medication), give two tablets (100mg) by mouth three times daily scheduled for 6:00 Am, 2:00 PM and 10:00 PM. The medication was not given on at 10:00 PM as indicated by the documentation areas left blank. d) Tab 10mg (anti-depressant), one tablet by mouth once daily, scheduled for 9:00 AM. The medication was not given on as indicated by the documentation areas left blank. e) 0.4 mg Capsule (..... medication), one capsule by mouth every night at bedtime,		

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

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scheduled for 9:00 PM. The medication was not given on _____ & _____ as indicated by staff initials being circled and _____ was missed as indicated by the documentation areas left blank. The back of the MOR indicated the resident refused the _____ on _____ but there is no other documentation as to why the medication was not given the other days. f) _____ 500mg (_____), one tab by mouth twice daily times one week scheduled for 9:00 AM and 5:00 PM. The transcriber indicated the medication was to be started on the morning of _____. There is illegible writing in the column for the 18th which do not coincide with staff signatures along with blank spaces on the _____ 9:00 AM and _____ 5:00 PM. The MOR indicates only 10 of the 14 doses of _____ were documented as given. There is no indication on the back of the MOR's as to why the medications were missed. g) Limbrel _____ mg (_____), one cap by mouth twice daily, scheduled for 9:00 AM and 5:00 PM. The order is written twice on the _____ 2016 MOR. Staff initials are circled for the 9:00 AM dose on _____ and documentation areas left blank from _____ through _____. The 5:00 PM doses were not given as evidenced by staff initials circled from _____ through _____, _____ through _____ and _____. Documentation areas were left blank on _____, _____ through _____ and _____. There is no indication on the back of the MOR's as to why the medications were missed. During further record review and interview with the Executive Director on _____ at 12 PM, it was revealed there were no MOR's available for Resident #3 at the time of survey for the months of _____ and _____ 2016. During an interview with Resident #3 on _____ at 11:15 AM, he stated, " They have no checks and balances with the Med-Techs to ensure they are passing the medications correctly. In the last month, two nights they failed to have the right meds and two nights they missed the _____ (_____). Resident #3 stated that he got a copy of his medication list and started keeping track of the amount of pills they would bring versus what I was supposed to be getting. They are always out of one pill or another." Refer to A 0025, A 0052 Class II D165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC Based on record review and interview, the facility failed to provide, within 1 business day, an Adverse		

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Incident Report to the Agency for Health Care Administration related to an incident requiring a resident's transfer to a higher level of care, for 1 out of 3 residents' records reviewed (Resident #1). This is evidenced by: Review of Resident #1's record found that the progress notes dated [redacted] at 11:40 AM documented that a third party Physical [redacted] Assistant reported to Staff D that the resident had a [redacted] of over 200 [redacted] after which Staff D re-measured the [redacted] and it was found to be [redacted] mmHg. The progress notes document the resident was later taken to a local area hospital by her family at 2:40 PM on [redacted] and was discharge and returned to the facility on [redacted]. Resident #1 was again taken to the emergency [redacted] her family on [redacted] with high [redacted] and returned to the facility the same day. Review of the progress notes for Resident #1 dated [redacted] at 6:15 PM indicated resident was transferred to the Emergency [redacted] at 6:20 PM, the progress notes document that the resident's health care practitioner increased the dosages of [redacted] 5-20mg to 10-20mg daily ([redacted] medication) and [redacted] 12.5 mg ([redacted] used to treat high [redacted] and fluid retention) was increased to 25mg daily. Review of hospital records for Resident #1 confirmed that the resident was taken to the Emergency [redacted] aforementioned dates and received medical care due to physician order medications not provided as prescribed resulting in elevated [redacted]. During an interview on [redacted] with Resident #1 family member, she stated that she was made aware that Resident #1's [redacted] was high. When she arrived at the facility to transport Resident #1 to the hospital on [redacted], she was told that Resident #1 didn't get her [redacted] medication for 4 days and later found out that she has missed several doses of her anti-[redacted] medication. On [redacted] at 1:15 PM during an interview with the interim DON, she confirmed that the MOR's lacked the appropriate documentation. She confirmed she is aware of everything going on with the medications including missed doses and lack of documentation. She stated that was why they have pharmacy in the building today to review everyone's medications and MOR. Review of the Medication Observation Record (MOR), confirmed the [redacted] medication ([redacted]) had not been given for four days and the anti-[redacted] ([redacted]) medication was not given for numerous days. There is also documentation that other medications were not given in the month of [redacted] 2016. However, there is no explanation on the MORs or within the residents records for the missed doses..		

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During an interview on _____ at 2:20 PM, the Executive Director stated the previous Health and Wellness Director was not doing anything to ensure the medications were received [from pharmacy] in time. He confirmed there is no system in place to ensure the medications were ordered. He stated that they are aware they have a problem with medications not being ordered and available for the residents in a timely manner. A Medication Error Report was completed by the Administrator on 11/_____, regarding Resident #1, which indicated the error as _____ cap 5-20mg was not re-ordered. Refer to A 0025. Class III		