STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968854	**05/11/2018**
NAME OF PROVIDER OR SUPPLIER **LEGACY AT HIGHWOODS PRESERVE**	STREET ADDRESS, CITY, STATE, ZIP CODE **18600 HIGHWOODS PRESERVE PARKWAY TAMPA, FL 33647**	

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

0000 - Initial Comments

Assisted Living Facility

On - a Complaint CCR#2018003448 and CCR#2018003879 survey in conjunction with a Revisit to 3/13/18 Biennial Re-licensure survey was conducted at Legacy at Highwoods Preserve. Deficiencies were identified during the visit.
(license #12715)

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

Based on observation, interview and records review, the facility failed to store discontinued medications in a separate medication storage area, clearly marked, for 1 of 3 residents observed.

Findings Included:

During an observation of a medication pass performed by Staff C at 9:15am on , the facility failed to have Resident #2's currently prescribed medication for on the medication cart. The Medication Technician (Med Tech), Staff C, while in the process of locating Resident #2's Telmisarton 80mg medication, for , which was due at 9:00am and was to be given 1 time per day, instead found, on the cart, Resident #2's discontinued Telmisarton 40mg/HCTZ 12.5mg combination medication. Staff C then presented the discontinued medication to Resident #2 and inquired if the resident would take 2 pills, since the correct medication was missing.

The resident refused the discontinued medication and stated that a said not to take the Telmisarton 40mg/HCTZ 12.5mg combination medication anymore. In an interview at 9:30am, Staff C avowed no knowledge of why the discontinued medication was still on the medication cart. Staff C also looked in the facility's overflow medication cabinet and was not able to locate the prescribed medication for for Resident #2. Staff C said that the Nursing Supervisor would be informed about the prescribed medication not being available and would ask why the discontinued medication was still on the medication cart.

In an interview with the Nursing Supervisor and the Resident Services Coordinator at 10:00am on , both of them stated that they had recently done a medication cart audit to insure that the medications located on the medication carts matched the doctor's orders as they appeared on the Medication Observation Records (MORs). The Nursing Supervisor had no explanation of why the

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discontinued medication for Resident #2 was found on the medication cart. Photographic evidence obtained.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on records review and interview, the facility failed to maintain resident records onsite, and readily available, including resident care records, home health and health care provider assessments, new orders, changes in health status, progress notes, hospital records, ( ) status, and demographic data for 2 of 2 resident's records reviewed (#1 and #2).

Findings Included:

In an interview with the Business Manager at 10:00 am on , the Business Manager stated that the facility does not keep any paper records and that all of their resident records are kept electronically and would have to be printed out in order to be reviewed. The Business Manager also stated that in the case of a resident emergency, the facility would have to print out off the computer, needed information, such as medication orders, demographic data and status.

On at 10:15 am, a request was made to the Nursing Supervisor and Resident Services Coordinator for Resident #2's records. Over the course of more than 4 hours, and multiple requests for more information, the Nursing Supervisor and Resident Services Coordinator brought sections of Resident #2's records that were printed out off of their computer. No resident demographic data or status was ever provided. The only care records for Resident #2 received, by 2:30 pm, were the medication observation records (MORs) for the months of , , and , 2018 and progress notes containing only 2 entries - 1 dated and 1 dated . The progress note was written the day that the resident was admitted to the facility and included a brief assessment stating that there was a and that a dressing was applied to it, that the resident had a productive and other information pertaining to the resident's vital signs and physical condition. The other entry, dated , related an incident where the resident was found on the floor, sustained an injury to the back of the head - which was , and the resident was taken to a hospital emergency evaluation and treatment. (Photographic evidence obtained). The printed records presented by the Nursing Supervisor and Resident Services Coordinator, after the first request for Resident #2's records, more than 4 hours later, were vastly incomplete and left out such information as any further treatment for Resident #2's or any further mention or assessment of the resident's "productive ", any home health or health care provider assessments and treatment plans, any changes in the resident's

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SUMMARY STATEMENT OF DEFICIENCIES
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orders and the information from the hospital visit on when the resident apparently and sustained a head injury. No demographic or information was ever presented by the facility for Resident #2.

At 12:30 pm on , a request was made to the Nursing Supervisor for Resident #1's record. At 1:30 pm the Nursing Supervisor presented Resident #1's 1823 assessment dated and the MORs for the month of 2018. The facility's Admission and Discharge log showed that Resident #1 was admitted to the facility on and moved out on . The Nursing Supervisor stated that Resident #1 was only in to facility for a short while and that was all of the records they had. The facility never provided portions of the resident's record including the MORs for the month of , 2018, the resident's demographic data, ( ) order status, care records, progress notes, home health of health care provider assessments and any new orders and other pertinent information about the resident's care in the facility's memory care unit.

Class III