STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968854	R 05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY AT HIGHWOODS PRESERVE	**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 [redacted] a Revisit to a 3/13/18 Biennial Re-licensure survey was conducted in conjunction with a Complaint (CCR# 2018003448 and CCR#2018003879) survey at Legacy at Highwoods Preserve. At the time of the visit, Legacy at Highwoods Preserve had deficient practice related to the revisit.

(license #12715)

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

Based on record review, observation and interview the facility failed to ensure 1 of 3 (#2) residents received their medications as ordered by their physician.

Findings Included:

On [redacted], the facility was cited for failure to properly assist residents who needed assistance with medications. On [redacted], a revisit survey was conducted and the deficient practice previously cited was not corrected.

During an observation of a medication pass performed by Staff C at 9:15am on [redacted], the facility failed to have Resident #2's currently prescribed medication for [redacted] on the medication cart. The Medication Technician (Med Tech), Staff C, while in the process of locating Resident #2's Telmisartan 80mg medication, for [redacted], which was due at 9:00am and was to be given 1 time per day, instead found, on the cart, Resident #2's discontinued Telmisartan 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.

An interview with another Med Tech, Staff F, at 10:00am on [redacted] revealed that Resident #2 was given the last [redacted] 80mg pill on [redacted] and that the Nursing Supervisor was notified to reorder the medication. Staff F also stated that the Nursing Supervisor was asked if the facility could offer the resident the discontinued medication ([redacted] 40mg/HCZT 12.5mg) in its place until the current order was refilled.

A review of Resident #2's medication observation records (MOR) for [redacted] and [redacted] indicated that the facility had given the medication [redacted] 80mg, even though the medication had run out on

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and according to the Nursing Supervisor (in an interview at 2:00pm on), had not yet been received from the pharmacy. The review of the resident's MOR revealed that Staff D, another Med Tech, signed the MOR as if the Telmisartan 80mg dose had been given at 9:00am on and Staff E, another Med Tech, signed the MOR that it was given at 9:00am on .

Interviews with Staff D and Staff E, at 2:00pm on , revealed both members stating they had signed that the MOR "in error" on and and that the medication in question still had not been received from the pharmacy. There was no evidence of any attempt to correct the erroneous documentation.

Class III

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

Based on record review and interview the facility failed to ensure 2 of 3 (#1, #2) residents records reviewed medications were refilled in a timely manner.

Findings Included:

On , the facility was cited for failing to make a reasonable effort to ensure that prescriptions for residents who require assistance with medication are filled or refilled in a timely manner. On , a revisit survey was conducted and the deficient practice previously cited was not corrected.

On , a review of Resident #2's health assessment (AHCA form 1823) dated revealed that the resident required assistance with medication self-administration. A review of Resident #2's Medication Observation Record (MOR) for the month of , 2018 was reviewed. The review revealed that the resident's 10mg tablets that were due at 9:00am every day for were not given on , , , , , or (7 days). The reason the medication was not given was written on the back of the MOR as "medication not available - back order". (Photographic evidence obtained.)

On , a review of Resident #1's 1823 assessment dated revealed that the resident required assistance with medication self-administration. Resident #1 had and lung issues and was retaining fluid, a condition known as and also had fluid build-up around the lungs and in the chest. For this reason, Resident #1 was prescribed , also known as , a powerful to rid the body of excess fluid. Resident #1's medication observation record (MOR) for the month of 2018 was reviewed on and it revealed that the resident should have received

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the prescribed 40mg tablet on at 9:00am and at 3:00pm and did not received the dose on at 9:00am. The records showed that the resident missed 3 doses of the required medication and the reason stated on the back of the MOR was "medication not available - back order". Photographic evidence obtained.

Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on observation, records review and interviews, the facility failed to correct 2 out of 2 medication-related deficiencies previously cited at the time of a revisit survey.

Findings Included:

On , the facility was cited for failure to assist residents who required assistance with medications according to the requirements of 429.256 Florida Statutes. On , a revisit survey was conducted and the deficient practice previously cited was not corrected.

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.

An interview conducted with another Med Tech, Staff F, at 10:00am on revealed that Resident #2 was given the last 80mg pill on and that the Nursing Supervisor was notified to reorder the medication. Staff F also stated that the Nursing Supervisor was asked if the facility could offer the resident the discontinued medication (40mg/HCZT 12.5mg) in its place until the current order was refilled.

A review of Resident #2's medication observation records (MOR) for and indicated that the facility had given the medication 80mg, even though the medication had run out on and according to the Nursing Supervisor (in an interview at 2:00pm on), had not yet been received from the pharmacy. The review of the resident's MOR revealed that Staff D, another Med Tech, signed the MOR as if the Telmisarton 80mg dose had been at 9:00am on and Staff E, another

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Med Tech, signed the MOR that it was given at 9:00am on .

Interviews with Staff D and Staff E, at 2:00pm on , revealed both members stating they had signed that the MOR "in error" on and and that the medication in question still had not been received from the pharmacy. There was no evidence of any attempt to correct the erroneous documentation.

On , the facility was cited for failing to make every reasonable effort to ensure that prescription for residents who require assistance with medication are filled or refilled in a timely manner. On , a revisit survey was conducted and the deficient practice previously cited was not corrected.

On , a review of Resident #2's health assessment (AHCA form 1823) dated revealed that the resident required assistance with medication self-administration. A review of Resident #2's Medication Observation Record (MOR) for the month of , 2018 was reviewed. The review revealed that the resident's 10mg tablets that were due at 9:00am every day for were not given on , , , , , , or (7 days). The reason the medication was not given was written on the back of the MOR as "medication not available - back order". Photographic evidence obtained.

On , a review of Resident #1's 1823 assessment dated revealed that the resident required assistance with medication self-administration. Resident #1 had and lung issues and was retaining fluid, a condition known as and also had fluid build-up around the lungs and in the chest. For this reason, Resident #1 was prescribed , also known as , a powerful to rid the body of excess fluid. Resident #1's medication observation record (MOR) for the month of 2018 was reviewed on and it revealed that the resident should have received the prescribed 40mg tablet on at 9:00am and at 3:00pm and did not received the dose on at 9:00am. The records showed that the resident missed 3 doses of the required medication and the reason stated on the back of the MOR was "medication not available - back order". Photographic evidence obtained.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview the facility failed to ensure 1 of 3 (A) selected employee records reviewed included documentation of a negative test and a written statement from a healthcare provider documenting the individual does not have any signs or symptoms of a

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communicable .

Findings included:

During a record review on for Staff A, with a hire date of , it did not include documentation of a negative test and a written statement from a healthcare provider documenting the individual does not have any signs or symptoms of a communicable .

During an interview with the Business Office Manager (BOM) on at 1:18 PM, they confirmed Staff A's record did not include the required documentation.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview the facility failed to ensure 3 of 3 (A, B, C) selected employee records reviewed included documentation of training in elopement, control, emergency preparedness, resident rights, incident reporting, Activities of Daily Living (ADL's) and behavioral needs and , neglect and , training within 30 days of employment as required.

Findings included:

During a record review for Staff A on , with a hire date of , it did not include documentation of the following trainings: 1 hour of control, 1 hour of elopement, 1 hour of incident reporting, 1 hour of emergency preparedness, 1 hour of resident rights, 1 hour of , neglect and , and 3 hours of ADL's and behavioral needs trainings within 30 days of employment as required.

During a record review for Staff B on , with a hire date of , it did not include documentation of a 1 hour of elopement, 1 hour of emergency preparedness, 1 hour of incident reporting, 1 hour of , neglect and , and 3 hours of ADL's and behavioral needs trainings within 30 days of employment as required.

During a record review for Staff C on , with a hire date of , it did not include documentation of a 1 hour of control, 1 hour of elopement, 1 hour of incident reporting, 1 hour of emergency preparedness, 1 hour of resident rights, 1 hour of , neglect and , and 3 hours of ADL's and behavioral needs trainings within 30 days of employment as required.

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During an interview with the Business Office Manager on at 1:18 PM, they confirmed the employee records did not include documentation of the trainings.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview the facility failed to ensure 2 of 3 (A, C) selected employee records reviewed included documentation of a 1 hour ( ) training within 30 days of employment as required.

Findings Included:

During a record review for Staff A, on , with a hire date of , it did not include documentation of a 1 hour training within 30 days of employment.

During a record review for Staff C, on , with a hire date of , it did not include documentation of a 1 hour training within 30 days of employment.

During an interview with the Business Office Manger on at 1:18 PM they confirmed the documentation was not included in Staff A and Staff C's record.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the facility failed to maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. " Readily available " means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request.

Findings included:

In an interview with the Business Office Manager at 10:00 am on , they stated that the facility does not keep any paper records and that all of their resident records and staff training transcripts are kept electronically and would have to be printed out in order to be reviewed. The Business Office

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Manager also stated that in the case of a resident emergency, the facility would have to print out needed information, such as medication orders, demographic data and . . . . . status off the computer.

Although at the time of survey, partial employee records were available for review upon request, the employee training transcripts were not readily available for review and were not given to the survey team until 2.5 hours after the first request.

Class III

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on record review and interview the facility failed to ensure 1 of 3 (C) selected employee records reviewed for staff who provide direct care services to residents, had a current eligible level II background screening (BGS) following a break in direct care services employment of more than 90 days.

Findings included:

During a record review for Staff C on . . . , with a hire date of . . . , it included an application that revealed their last employment providing direct care services was dated . . . . This reveals Staff C did in fact have more than a 90 day break in employment providing direct care services.

During an interview with the Business Office Manager on . . . . at 1:18 PM, they confirmed Staff C does in fact currently provide direct care services as a Med Tech, the details of the application and last date of employment providing direct care services.

Unclassified