STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910608	**05/26/2018**
NAME OF PROVIDER OR SUPPLIER **PEMBROOK PLACE II**	STREET ADDRESS, CITY, STATE, ZIP CODE **1623 ROBINHOOD LANE** **CLEARWATER, FL 33764**	

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

0000 - Initial Comments

Assisted Living Facility

A Complaint investigation (CCR#2018006215), in conjunction with a revisit survey, was conducted at Pembrooke Place II from - . Pembrooke Place II had deficiencies at the time of the investigation.

License (#7581)

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

Based on observation, record reviews and interview, the facility failed to maintain accurate and up to date daily medication observation records for 11 of 11 residents that required assistance with medication self-administration.

Findings Included:

On at 10:00 am, the Administrator was asked to provide the facility's medication observation records (MORs) for all 11 residents who resided in the facility. At that time, the Administrator was observed hastily writing in the MORs and was asked to please stop. Subsequently, the MORs for all of the residents in the facility were reviewed and they revealed that none of the 11 residents MORs had been kept up to date. All 11 residents in the facility had medications that they were ordered to take on a daily basis and all 11 required assistance with medication self-administration, according to the MORs.

At 10:10 am on , the facility MORs revealed that Resident #1's MOR was signed up to . Resident #2's MOR was signed up to . Resident #3's MOR was signed up to . Resident #4's MOR was signed up to . Resident #5's MOR was signed up to . Resident #6's MOR was signed up to . Resident #7's MOR was signed up to . Resident #8's MOR was signed up to . Resident #9's MOR was signed up to . Resident #10's MOR was signed up to . Resident #11's MOR was signed up to . Photographic evidence obtained. The MORs for Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11 were all missing entries for at least one or more full day.

In an interview with the Administrator at 11:00AM on , the Administrator said that the medications were given by herself and Staff A, an unlicensed Medication Technician (Med Tech). Both employees live on the facility premises and work every day on every shift. The Administrator could not explain why the MORs had not been kept up to date, and it was not clear from the MORs if the

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medications that should have been charted, were ever given to the residents.

Class III

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

Based on observation, records review and interview, the facility failed to ensure that resident medications on the medication cart were kept separately from other resident medications and failed to ensure that discontinued medicationswere stored separately from medications in current use, for 4 of 4 residents whose medications were observed.

Finding included:

On , at 10:15 am, an observation of Resident #3's medications on the medication cart, in Resident #3's medication compartment, revealed an medication, 500 mg with Resident #3's name on it. The label stated the order was filled on and that there were 20 tablets dispensed. On at 10:30 am, the tablets in the container were counted on and there were 20 tablets observed in the bottle. Resident #3's MOR for the month of 2018 does not list as being an ordered medication, but instead lists another mg to be given twice a day for 10 days starting on . (Photographic evidence obtained.)

On , a review of Resident #6's medication observation records (MORs), for the month of 2018, revealed that the resident only had 2 medications ordered. At 10:30 am on an audit of Resident #6's medications on the medication cart, in the resident's medication storage compartment, was conducted. One of the Resident #6's ordered medications, 50 mg tablet, was missing from the medication cart, however, the were 3 medications with the resident's name on the labels that were not listed on the resident's MORs for the month of 2018: 500 mg, and . (Photographic evidence obtained.)

At 10:40 am on , an audit was conducted of Resident #10's medication on the medication cart, in the resident's medication compartment. A medication, 0.5 mg, with another resident's name on the label (Resident #7) was found in Resident #10's medication compartment. A review of Resident #10's MORs revealed an order for 1 mg. (Photographic evidence obtained.)

In an interview with the Administrator of the facility at 11:00 am on , that Administrator claimed responsibility for keeping the medication cart up to date and organized. The Administrator offered no explanation for the discrepancies found on the medication cart.

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Class III

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

Based on observation, records review and interview, the facility failed to make every reasonable effort to ensure that prescriptions for residents, who receive assistance with medication self-administration, are filled or refilled in a timely manner for 2 of 3 residents whose medications were observed (#6 and #10).

Findings Included:

On , a review of Resident #6's medication observation records (MORs), for the month of , 2018, revealed that the resident only had 2 medications ordered. One of the medications listed on the MOR was 50 mg. At 10:30 am on an audit of Resident #6's medications on the medication cart was conducted and it revealed that Resident #6's 50 mg tablet, was missing from the medication cart. A review of the Resident #6's MORs revealed that 50 mg was ordered to be given once per day and had not been given to Resident #6 since . There was no explanation of why the medication was not given, written on the back of the MOR.

On , a review of Resident #10's MORs revealed an order for 1 mg to be given twice per day, as needed, for . At 10:40 am on , an audit was conducted of Resident #10's medication on the medication cart revealed that the Resident's 1 mg was missing from the cart, however, a medication, 0.5 mg, with another resident's name on the label (Resident #7) was found in Resident #10's medication compartment. (Photographic evidence obtained.) Resident #10's MOR for the month of , 2018 revealed that 1 mg had been given to Resident #6 twice per day, every day from to , but no 1 mg had been given to the resident after that.

In an interview with the Administrator at 11:00 am on , the Administrator could not explain why the ordered medications for Resident #6 and Resident #10 were not on the cart, if the facility had the medications or when the medications would be ordered from the pharmacy.

Class III

0163 - Records - Resident, Penalties for Alteration - 429.49 FS

Based on observations, interviews and records reviews, the facility altered or falsified medical records for 2 of 11 resident's records reviewed (#3 and #10).

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Findings Included:

A review of Resident #3's medication obserservation record (MOR) for the month of , 2018 was conducted on . The MOR revealed an listed, to be given twice a day for 10 days starting on . The facility had documented giving the resident the twice per day starting at 8:00pm on and ending on at 8:00pm, 7 pills total were documented as having been given over the course of 3 days. Photographic evidence obtained.

At 11:00am on an interview was conducted with the Administrator of the facility, who is a registered nurse (RN). The Administrator stated that the facility only gave Resident #3 the for 3 days, not 10 days. The reason the facility did not continue to give the resident all 20 doses of the , as prescribed, was because Resident #3 seemed to be feeling better.

Observations of Resident #3 throughout the day on and again on revealed that the resident was not able to make needs known, was not able to communicate in words but was capable only of making noises. A review of Resident #3's records on , revealed an 1823 assessment dated with a diagnoses of expressive aphasia, the inability to verbally communicate. The record also revealed Progress Notes, dated , which stated "noticed resident had while ambulating. given, obtained relief. At 5:00pm (same day) resident's temperature was 103 degrees, Fahrenheit. The doctor was made aware, ordered 2 times per day. Started. Progress Notes on noted that Resident #3 received Physical and that the resident seemed kind of weak. In the Progress Notes, there was no mention of the Ciprofloxin 500mg or why an order for it was filled on . Photographic evidence obtained.

An interview with Resident #3's doctor's office was conducted on at 4:00pm. The medical assistant to the doctor stated that, according to the resident's medical chart, the facility Administrator called the office on saying they thought that the resident had a . The doctor called in an order to the pharmacy for an , 1 tab 2 x day for 10 days. Then, the medical assistant stated, 2 days later, on , the facility Administrator called back to the office to say that the resident was having a . On , the doctor told the Administrator to stop the prescribed 2 days ago and start a new anti-biotic, Ciprofloxin 500mg, twice a day for 10 days.

Resident #3's MOR for the month of , 2018 was again reviewed on . Upon the 2nd review of the MOR, it was revealed that the facility never initiated the Ciprofloxin 500mg twice per day, as ordered by the doctor. The record also revealed that the facility had documented giving the resident all 20 doses of the 2 times per day from until , even though the doctor's medical assistant stated the doctor had discontinued the order for on and the Administrator had

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previously stated, on the facility stopped the resident's on because the resident seemed to be feeling better.

An audit of Resident #10's medication compartment on the facility's medication cart was conducted at 10:15am on . Among Resident #10's prescribed medications, an empty medication container was found, which the label read: Resident #10's name, , ( ) 2mg tab, 1 tablet 3 times a day, as needed for , for 7 days, dispensed 21 tablets on , must call for a refill to the prescribing doctor. The description of the medication on label stated "green rectangular pill". Photographic evidence obtained. Also within Resident #10's medication compartment was another bottle of , ( ), this one with Resident #7's name on it, the label reading Resident #7's name, , ( ) 0.5mg tab, take 1 tablet 2 times per day for , prescribed by a different doctor and filled by a different pharmacy. Photographic evidence obtained.

On , a review of Resident #10's medication observation record (MOR) for the month of , 2018 revealed there was an order for , ( ) 2 mg tablet - take 1 tablet by mouth 3 times a day as needed for , for 7 days (must call for refill, written). The MOR was prepared by a pharmacy. On , Resident #10's MOR for , of 2018 had been signed off by the facility as having given the to Resident #10 every day, 3 times per day from to . Photographic evidence obtained. A 2nd review of Resident #10's MOR for , 2018 was conducted on and it revealed the , ( ) 2 mg tablet was documented as having been given to the resident 3 times per day from to . (3 times a day x 23 days = 63 pills). Photographic evidence obtained.

In an interview with Resident #10 on / at 11:10am the resident stated that recently the resident went to a new doctor and the doctor, when asked, would not write a prescription for . Resident #3 was not able to recall the last time having been given by the facility but thought it was a few weeks or months ago.

On , at 11:30am, the Administrator of the facility presented Resident #10's medication container. The label on the container and the contents were examined. The medication label was exactly the same as the one that was observed on : , 2mg tab 1 tablet 3 times a day as needed for , for 7 days, dispensed 21 tablets, must call for a refill to (doctor). Dispensed by (pharmacy) on . 21 tablets dispensed. Description (of medication) green rectangular tablet. The contents of the container were then examined and this time there were 10 tablets inside, not empty as previous observed on , and the tablets were white in color and oblong in shape, not green and rectangular as the label specified.

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A review of Resident #10's record was conducted on . The only prescription for the record revealed was written on by a doctor at a hospital. It read " 2mg oral tablet 1 tablet PO 3 x day for 7 days PRN as needed for , . Dispense 24 tabs." The prescription had a hand written note, by an unidentified writer, which read "Do not send (resident) still has ". Photographic evidence obtained.

An interview with the pharmacy that had dispensed the for Resident #3, that was presented by the Administrator, was conducted on at 10:20am. The pharmacist confirmed that the last time the resident's prescription was filled was on , as the label of the bottle stated, 21 tablets of 2mg to be given 3 times per day as needed for , for 7 days.

The facility Administrator, who is a registered nurse (RN) was interviewed on via telephone at 2:00pm. The Administrator stated that the last time the facility filled Resident #10's prescription was in , 2018, as the prescription label said. The Administrator added that the facility was still able to supply the resident with through , of 2018, with such a limited prescription of only 21 tablets, was because the resident "had a large supply of when upon arriving at the facility about a year ago and we have been giving those pills." The Administrator did not say what "large supply" meant. The Administrator went on to add "we have been cutting the pills in half and tapering down the dose, for the resident's good."

Class III