STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968608	R 06/12/2018
NAME OF PROVIDER OR SUPPLIER **FLORIDIAN GARDENS ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **17250 SW 137 AVENUE MIAMI, FL 33177**	

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

0000 - Initial Comments

A Standard Biennial Survey Second revisit was conducted on [redacted] through [redacted] at Floridian Gardens Assisted Living Facility with Limited Mental Health, Limited Nursing Services and Extended Congregate Care Services Components (License # AL 12489), had the following deficiencies identified at the time of the visit:

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

Base on observation, record review and interview, the facility failed to maintain a written record, updated as needed, of any significant changes in the method of medication administration, or other changes that resulted in the provision of additional services fort 3 out of 101 sampled residents (Resident # 53, # 54 and #55).

Findings included:

On [redacted] at 7:40 AM, observed that Staff O crushed Resident #53's medications, placed them in applesauce, and administered the mixture to Resident # 53.

A review of Resident #53's health assessments and Medication Observation Records showed that she needed assistance with self-administration of medication. Further record review revealed that Resident # 53, #54, and # 55 had no physician's order for crushed medication and administration of medication. There was no documentation that the residents' health conditions had changed, and that they were no longer able to take the medications as prescribed.

On [redacted] at 8:07 AM, Staff O stated he knew that there was no "crush" order for Residents #53, # 54 and #55. Staff O stated he was instructed by his [redacted] and nurses to crush and administer the medications. Staff O stated he explained this to the nurses on staff and said that he was not licensed to administer medication, but they told him he had to do it. Staff O stated he crushed the medications for Residents #53, #54, and #55.

Uncorrected
Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review, and interview, the facility failed to treat three of 101 residents with

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dignity and respect. The facility used full bed rails as physical for 3 out of 101 sampled residents who were not under hospice care (Resident # 55, # 56, and # 57).

Findings included:

On at 6:30 AM, observed in # that Resident # 55 was in bed with full bed rails up. The resident was unable to remove the full bed rails. The strong smell. Further observation showed # was occupied by Resident #58 and the a strong smell, Staff NN stated, " smell is strong because sometimes we change their adult brief and at the same moment they ."

A review of Resident # 55's health assessment dated showed known to shellfish and , with medical history and diagnoses of: , , ( ), and Failure. The resident had physical or sensory limitations including a left eye, ambulation with assistance/wheelchair. The resident needed and universal precautions. The resident was independent with eating, needed supervision with transferring and assistance with ambulation, bathing, dressing, self-care and toileting. Resident # 55 had full bed rails order by a physician on and a consent to the use of full bed rails was signed by him. Further review of files of residents with full bed rails that they couldn't remove without staff assistance, but for whom there was a physician's order for the full bed rails found Residents #56 and # 57 were not under hospice care.

A review of facility records showing a list of the resident's that had been receiving hospice care revealed that Resident's #55, #56 and #57's names were not listed.

On at 8:45 AM, the Administrator stated that she doesn't know why Resident #55 had full bed rails and confirmed that the resident was not under hospice care. She stated "I don't know why they put the full bed rails."

Uncorrected
Class III

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

Surveyor: Gonzalez, Yarine

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Based on observation, interview and record review, the facility failed to follow the correct procedure as outlined by the state when assisting out of 1 out of 101 sampled resident with self-administration of medications (Resident # 53, #54 and #55). Staff O crushed medications without having a crush order.

Findings included:

On at 7:40 AM, observed that Staff O (Medication tech) pre-poured medications, crushed all but one of the medications (he opened a capsule and sprinkled the last medication into the crushed mixture), placed them in applesauce, administered the medicines to Resident # 53. He did not identify the medications to the resident.

On at 8:07 AM, Staff O stated he knows that there is no "crush" order for Residents #53, #54, and #55. Staff O stated he was instructed by his , and nurses to do so. Staff O stated he knows what he can and cannot do because he is not licensed by the State of Florida to administer medication. Staff O stated he explained this to the nurses on staff, but they told him he has to do it. Staff O stated he crushed medications for Residents #53, #54, and #55.

Review medication observation record (MOR) for Residents #53, #54 and #55 revealed that none of the Residents had crushed order.

Review of Residents #53, #54 and #55s' files showed no crushed order in their files or medication observation recordss (MORs).

Uncorrected
Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview and record review, the facility failed to follow the correct procedure as outlined by the state when assisting out of 1 out of 101 sampled resident with self-administration of medications (Resident # 53). Staff O administered medications to the resident.

Findings included:

On at 7:40 AM, observed that Staff O (unlicensed medication techician) pre-poured medications, crushed all but one of the medications (he opened a capsule and sprinkled the last

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medication into the crushed mixture), placed them in applesauce, administered the medicines to Resident # 53.

On [redacted] at 8:07 AM, Staff O stated he knows what he can and cannot do because he is not licensed by the State of Florida to administer medication. Staff O stated he explained this to the nurses on staff, but they told him he has to do it.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to maintain an accurate daily medication observation record (MOR) for each resident who received assistance with self-administration of medications or medication administration for two out of 102 sampled resident (Residents # 53, #56).

Findings included:

A review of the resident records and MORs for Resident #53 showed that none of medications listed for 7:00 pm on [redacted] ([redacted] 40mg, [redacted], 5mg, [redacted], 0.5 mg, [redacted], 2.5 mg, Polyeth Glyc Pow 3350) were initialed by staff on [redacted]. A review of Resident #56's MOR showed that [redacted] 20mg; [redacted], 5mg; [redacted], 0.25 mg; and [redacted] 01 were not initialed by staff on [redacted] for the 8:00 pm and 9:00 pm medication times.

On [redacted] at 1:43 PM, Staff DD (administrator assistant) stated by phone "I'm here with Staff P (nurse) that assisted residents with medication on [redacted]." Staff P stated, "I forgot to initial the MOR."

Class III

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

Based on observation and interview, the facility failed to keep over-the-counter and prescription medications in a secure place.

Findings included:

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On at 8:51 AM observed the nursing office unlocked. Prescription medications located on the nursing desk, table, and in a box on the floor. A cabinet which was also unlocked and contained a variety of over-the-counter medication.

On at 8:56 AM, observed the Administrator close the Nurse's Office door.

On at 8:58 AM, observed the nursing office unlocked. Contacted Staff N (Registered Nurse) to close and locked the office door. Staff N stated his office is always locked when he is not in it.

Uncorrected
Class III

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

Based on observation, interview and record review, the facility failed to ensure that medications were labeled with resident names and instructions for use. The facility failed to have a physician's order for crushed medications on file for 3 out of 101 sampled residents. (Residents #53, #54 and #55).

Findings included:

On at 7:40 AM, observed that Staff O (med tech) crushed all medicine for Resident # 53 except one that he opened a capsule and sprinkled the last medication into the crushed mixture. Further observation at 8:51 AM showed that the nursing office was unlocked, and the nurse's desk counter contained over-the-counter medication (OTC) throat spray which had no resident name labels or instructions for use. A mini refrigerator which was also unlocked contained a variety of over-the-counter medications without residents names, the list of (OTC) medication were: , Muscle Rub and others.

On at 8:07 AM, Staff O stated he knew that there was no "crush" order for Residents #53, #54, and #55. Staff O stated he was instructed by his , and nurses to do so. Staff O stated he knew what he could and could not do because he was not licensed by the State of Florida to administer medication. Staff O stated he explained this to the nurses on staff, but they told him he had to do it. Staff O stated he crushed medications for Residents #53, #54, and #55.

A review of the medication observation record (MOR) for Residents #53, #54 and #55 revealed that none of the Residents had crush orders.

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Uncorrected
Class III

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

Based on observation, interview and record review, the facility failed to correct deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, deliver, or administration during a survey. The facility is required to employ the consultant services of a licensed pharmacist or a licensed registered nurse who will, at a minimum, provide onsite quarterly consultation until an inspection by the Agency's personnel determines that such consultation services are no longer required.

Findings included:

On at 7:40 AM, the facility had deficient practice in the areas of: assistance with self administration of medication when Staff O (unlicensed medication technician) pre-poured and crushed the medications for Resident #53. There was no documentation of a health care provider's order or prescription label to crush the medication. The medications were placed in a dirty crusher which contained the residue of past medications. Observed that Staff O placed the medicines in applesauce and administered them to Resident # 53.

On , the nursing office was found unlocked and revealed over the counter medication without labeling residents names and directions for use.

Uncorrected
Class III

0076 - ( ) - 58A-5.0186 FAC

Base on record review and interview, the assisted living facility failed to have currently employed administrators, managers, direct care staff and staff involved in resident admissions receive at least one hour of training in the facility ' s policies and procedures regarding ( ) for 10 out of 41 sampled employee. Staff A, O, S, , , V, M, Q, T, Y, did not know what was and did not receive a new training.

Findings included:

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Review of the policy on and Advance Directives of the facility showed "it's the policy of the assisted living facility (ALF) to honor and to honor advance directives." The facility may call 911 to control pain and to make sure the resident is comfortable.

Review of the staffing scheduled showed that Staff A, O, S, , , V, M, Q, T, Y were scheduled to work for the month of , 2018.

Facility record review showed that Staff A, O, S, , , V, M, Q, T, Y did not receive a one hour of training in the facility ' s policies and procedures regarding .

On at 10:41 AM, the Administrator stated that the in-service was provided to the staff that needed it but stated "I do not have the documentation at this moment in the facility." She stated Staff DD had the documentation with her and was on vacation.

Uncorrected
Class III

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

Based on observation, record review, and interview, the facility also failed to ensure that staff were retrained and qualified to perform their assigned duties, and failed to ensure that staff exercised their responsibilities for resident care. Staff failed to use control, sanitation, and universal precautions methods for three out of 101 sampled residents that received crushed medications without physicians' orders. The device used to crush the medications was not cleaned using sanitary techniques, leaving the three residents at risk of ingesting medications not prescribed for their use (Resident #53, 54 and 29). The facility also failed to provide documentation that the four staff who were observed on video in , 2018, failing to provide access to medical care or perform , , for Resident #37, who became unresponsive and then , were retrained and/or qualified to perform their assigned duties (Staff K, L, OO, GG).

Findings:
1)
On at 7:02 AM, observed Staff O (medication technician), crushing medications for two different residents, attempted to clean a pill crusher with a bit of hand sanitizer and a paper towel. The container had a thick crust of medications left over from a previous use on the outside of the crush container. This medication was not removed before Resident #53's medication was placed in the

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crusher. The medicine from the contaminated container was administered to Resident #53 in applesauce by Staff O, who was not a nurse or other licensed health care provider.

On at 7:02 AM, Staff O stated three residents required crushed medications (Residents #54, #53 and #29). He further stated that he used the same medication crusher for all residents, and that he did have a second crusher, but that he only used it when he had pills that were difficult to crush. Staff O stated that he was not a nurse. He further stated that he knew that he should not administer medications, and that he hadn't ever seen the crush medication orders, but that he crushed and administered the medications because the nurses said he had to.

A review of the medication observation record (MOR) for resident #53 showed that 81 mg, 20 mg; 40 mg; 500mg; Levetiraceta 500 mg; 50 mg; 1000, were prescribed to her. Medication 500 mg was not to be given crushed, according to the Physician's Desk Reference.

A review of the resident records and MORs for Residents #54, #53 and #29 showed that none of them had a physician's order for crushed medications.

On at 7:40 am, Staff N (nurse) stated that he didn't know where the crush medication orders were but that he was sure they had them. The crush orders were not found during the inspection.

On at 7:10 am, attempted to interview Resident #53, and she was unable to respond.

2)
Review of the staffing scheduled showed that Staff K, L, OO, GG were scheduled to work for the month of , 2018.

Facility record review showed that Staff K, L, OO, GG were not listed on the document showing staff who were retrained regarding . Further review of the facility record showed that the day and evening shift staff had been retrained by the assistant administrator. No other documentation of interventions by the facility management to show that Staff K, L, OO, GG would respond differently to an unresponsive resident was provided.

On at 10:41 AM, the Administrator stated that the in-service was provided to the staff that needed it but stated "I do not have the documentation at this moment in the facility." She stated Staff DD had the documentation with her and was on vacation.

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Class II