| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11968449 | 06/08/2018 |
| NAME OF PROVIDER OR SUPPLIER<br>**INSPIRED LIVING AT HIDDEN LAKES** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**1200 54TH AVE W, BRADENTON**<br>**BRADENTON, FL 34207** | |

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

**0000 - Initial Comments**

Assisted Living Facility

A Complaint investigation (CCR#2018005099) was conducted at Inspired Living at Hidden Lakes on . . . . . Inspired Living at Hidden Lakes had deficiencies at the time of the investigation.

License (#12337)

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

Based on record reviews, observations and interviews, the facility failed to make every reasonable effort to ensure that prescriptions for residents who required assistance with medication self-administration are filled or refilled in a timely manner for 4 out of 5 residents reviewed (#1, #2, #3 and #4).

Findings Included:

On , Resident #1's records were reviewed and they revealed that the resident required assistance with medication self-administration. A record review of Resident #1's medication observation records (MORs) for the months of , , , and of 2018 revealed that the resident missed 32 doses of medications that were due to be given, all with the reason code of "waiting on pharmacy".

In , , the medication doses Resident #1 went without were eye drops, medication for high , , a treatment, a supplement, a supplement, an anti-depressant, a medication to treat and an ointment.
In , the resident went without a supplement, a treatment, a medication to treat high , and a supplement.
In , from through , the resident went without a supplement and a treatment for over-active .

On , Resident #2's records were reviewed and they revealed that the resident required assistance with medication self-administration. A record review of Resident #2's medication observation records (MORs) for the months of , , , and of 2018 revealed that the resident missed 18 doses of medications that were due to be given, all with the reason code of "waiting on pharmacy".
In , , the medication doses Resident #2 went without were an anti- , medication and a stool

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SUMMARY STATEMENT OF DEFICIENCIES
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softener.
In , the resident went without pain medications and an anti- medication.
In , from through , the resident went without a pro-biotic.

On , Resident #3's records were reviewed and they revealed that the resident required assistance with medication self-administration. A record review of Resident #3's medication observation records (MORs) for the months of , , and of 2018 revealed that the resident missed 16 doses of medications that were due to be given, all with the reason code of "waiting on pharmacy".
In , the medications the resident went without were a pain medication, a medication for the treatment of and an anti-depressant. In , the resident went without a pain medication.

At 1:10pm on , Staff B was observed assisting Resident #4 with medication self-administration. Resident #4 was supposed to receive eye drops and Staff B stated they were not on the medication cart and that the facility was waiting for them to be delivered from the pharmacy. The resident went without the ordered dose of eye drops on . Staff B did not know when the pharmacy would be delivering the needed eye drops.

At 1:50pm on , an interview was conducted with the facility Administrator. The Administrator stated that the facility would be conducting an investigation regarding the numerous missed medications. Facility nursing staff are responsible for ensuring medications are refilled in a timely manner

Class III