STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969010	**07/03/2018**
NAME OF PROVIDER OR SUPPLIER **ELDERLY PRIDE ASSISTED LIVING LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **322 REGAL PARK DR** **VALRICO, FL 33594**	

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

0000 - Initial Comments

ASSISTED LIVING FACILITY

On , 2018, a biennial re-licensure survey with limited nursing services (LNS) and limited mental health (LMH) services in conjunction with a complaint survey (CCR#2018006044) was conducted at Elderly Pride Assisted Living. Deficient practice was identified during the surveys.

(License# 12869)

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

Based on observation, interview and records review, the facility failed to ensure that medications to be given were the the correct dose, failed to immediately update the medication records and failed to verbally prompt a resident who required assistance with medication self-administration to take medication as prescribed for 2 of 2 residents observed (Residents #1 and #2).

Findings Included:

A medication observation was conducted at the facility at 11:30am on . At 11:30am, Resident #1 went over to a table in the facility dining fetched a pill crusher, which was sitting out in the open and where other persons would have access to it. Resident #1 claimed ownership of the pill crusher. Resident #1 then asked the facility Administrator, who is also an unlicensed medication technician (Med Tech), for the resident's next dose of , a pain medication. The Administrator took the medication out of the locked medication container and, without looking at the medication observation records (MORs), popped out an pill and, without washing or sanitizing her hands, gave the pill to Resident #1. Resident #1 then put the pill into the pill crusher, crushed the pill and emptied the contents into a cup of water, mixed it up and drank it. After, drinking the medication, Resident #1 returned the pill crusher back to the dining . The Administrator/Med Tech did not immediately chart that the medication was given to resident.

A review of the MORs and Resident #1's records revealed that the resident's prescription for in the MORs does not match what the label on the medication reads, nor what the resident's doctor's orders reads. The label said " / , 7. tab take ½ tab every 3 hours as needed for pain, for 30 days" (every 3 hours would equal 8 times in a 24 hours period, 8 times ½ pill equals 4 whole pills). The MORs read " / , 7. tab take ½ tab 6 times per day. Do not take more

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969010	**07/03/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERLY PRIDE ASSISTED LIVING LLC	**322 REGAL PARK DR VALRICO, FL 33594**

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

than 3 full tablets per day." Resident #1's orders, found in the records read " [illegible] 7. [illegible] tab take ½ tab every 3 hours as needed for pain, for 30 days." A review of the resident's records also revealed that there was no order in the record for the resident to have medications crushed. The record stated that Resident #1 requires assistance with medication self-administration.

At 12:00pm on [illegible], the Administrator said it was time for Resident #2's inhaled medication. Without first reviewing Resident #2's MORs, The Administrator/Med Tech pulled out a medication from the medication storage compartment with Resident #2's name on it, there was no label on the medication. The resident's MORs read " HFA 90mcg/inhaler - inhale 2 puff by mouth every 6 hours", which was the one the Administrator/Med Tech was referring to. The orders in the resident's chart were different but did state he could have 2 puffs.

The Administrator handed the inhaler to Resident #2 and without explaining the medication to the resident, watched the resident take 2 puffs of the inhaler and then returned the inhaler back to resident's medication container box. The Administrator/Med Tech did not immediately chart that the medication was given to the resident.

In an interview with the Administrator at 12:30pm on [illegible], the Administrator denied knowledge that a resident could not crush their own medications without having an order to do so, and denied having noticed that Resident #1's [illegible] medication label and orders did not match the MORs. The Administrator also stated they were unaware that all residents' medications needed to be labeled and that the label must match the MORs and the doctor's order. The Administrator did not state why the MORs were not updated immediately after assisting the Resident #1 and Resident #2 with their medications.

Class III

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

Based on observation, record review and interview, the facility failed to ensure that medications for residents who require assistance with medication self-administration were labeled as required with the resident's name, the identification of the medicinal drug in the container, and the dosing requirements as ordered by the resident's health care provider for 3 of 3 residents (Residents #1, 2 and 4).

Findings included:

A medication review was conducted between 11:30am and 12:30pm on [illegible] and the following was

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969010	07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERLY PRIDE ASSISTED LIVING LLC	**322 REGAL PARK DR VALRICO, FL 33594**

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

found:

A review of Resident #1's medication observation records (MORs) revealed that the resident's prescription for in the MORs does not match what the label on the medication reads, nor what the resident's doctor's orders reads. The label said " / 7. tab take ½ tab every 3 hours as needed for pain, for 30 days" (every 3 hours would equal 8 times in a 24 hours period, 8 times ½ pill equals 4 whole pills). The MORs read " / 7. tab take ½ tab 6 times per day. Do not take more than 3 full tablets per day." Resident #1's orders, found in the records read " / 7. tab take ½ tab every 3 hours as needed for pain, for 30 days."

A review of Resident #1's medication observation records (MORs) revealed a prescription for a system (patch) 12mcg apply 1 patch every 12 hours . The label on the box of patches in the resident's medication compartment read " Patch 12mcg/HR patch, unwrap and apply 1 patch to skin every 72 hours for 30 days". The resident's record revealed the following orders " system 12 mcg every 72 hours ." Photographic evidence obtained.

In an interview with Resident #1 at 12:35pm on , the resident stated that the facility applies a new patch every 3 days. Resident #1 presented the resident's left arm for observation revealing a 12mcg patch.

In an Interview with the Administrator at 1:00pm, the Administrator stated that the pharmacy wrote out the MORs for the month of and failed to write the instructions for Resident #1's patch correctly. The Administrator had not noticed the error until it was pointed out. Photographic evidence obtained.

At 12:00pm on , Resident #2's medication, HFA 90mcg/inhaler, was observed to be missing a label stating the resident's name, identification of the medicinal drug in the container and the dosing requirements as ordered by the resident's health care provider. The facility Administrator was observed assisting the resident with the self-administration of this medication, based solely on what was written in the resident's MORs. Photographic evidence obtained.

At 12:15pm on Resident #4's medication, Diskus inhaler, was observed to be missing a label stating the resident's name, identification of the medicinal drug in the container, and the dosing requirements as ordered by the resident's health care provider. Photographic evidence obtained.

At 12:30pm on , the Administrator stated they were unaware that all residents' medications

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969010	**07/03/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERLY PRIDE ASSISTED LIVING LLC	**322 REGAL PARK DR VALRICO, FL 33594**

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

needed to be labeled and that the label must match the MORs and the doctor's order.

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record review and interview, the facility failed to provide a statement in the facility's contract which explained to 3 (Resident #1, Resident #2 and Resident #3) of 3 sampled residents that if there was a rate increase, the residents would be given a thirty day notice before the rate increase was implemented.

Findings included:

Record review on of the facility's contract revealed Resident #1, Resident #2 and Resident #3s' contracts did not have a statement which stated that in case of a rate increase, the facility would give the residents a thirty day notice before the rate increase was implemented.

When interviewed on at 1:15 p.m., the administrator verified the the 30 day notice of a rate increase was not in Resident #1, Resident #2 and Resident #3s' contracts.

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on records review and interview, the facility failed to ensure that facility staff, who had direct contact with residents, received 6 hours of specialized training in working with individuals with mental health diagnoses within 6 months of employment for 1 of 2 direct care staff records reviewed.

Findings Included:

During an employee records review on , it was discovered that Staff A, who provides direct care to residents, started working at the facility on and had been working there for more than 6 months. Staff A had a training certificate for 3 hours of Limited Mental Health training dated . There were no further training certificates in Staff A's records that showed that Staff A had received 6 hours of specialized training in working with individuals with mental health diagnoses, as required. It was noted on the facility's staffing schedule, Staff A was scheduled to the week of .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969010	**07/03/2018**
NAME OF PROVIDER OR SUPPLIER **ELDERLY PRIDE ASSISTED LIVING LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **322 REGAL PARK DR** **VALRICO, FL 33594**	

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

In an interview with the Administrator at 11:00am on , the Administrator stated they were not aware that Staff A was required to have 6 hours of specialized training in working with individuals with mental health diagnoses within 6 months of hire.

Class III