STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968848	**06/20/2018**
NAME OF PROVIDER OR SUPPLIER **MORSELIFE MEMORY CARE RESIDENCE**	STREET ADDRESS, CITY, STATE, ZIP CODE **4847 FRED GLADSTONE DR** **WEST PALM BEACH, FL 33417**	

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

0000 - Initial Comments

An unannounced Extended Congregate Care Survey was conducted on . . . . at Morse Life Memory Care, License #12684. The facility had deficiencies at the time of the visit.

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

Based on observation and interview, the facility failed to ensure that medications intended for residents were poured/prepared in a sanitary manner, for 3 of 5 sampled residents (Resident #1,#2 & #3)

Findings include:

During observation of Medication Pass was conducted on . . . . starting at 9:00 am. The Nurse popped each medication from the . . . . card package directly into uncovered left hand and then poured the medication from her hand into the medication cup. The nurse poured a total of 5 medications for Resident # 1 in this manner. The nurse then placed the cup of medications in front of Resident # 1 who consumed the medications.

Nurse A returned to the Medication cart and removed the . . . . card medications for Resident # 2 from the cart and again poured each of the medications directly into her left hand and then poured them from her hand into the medication cup. The nurse poured a total of 5 medications in this manner. The nurse again placed the medication filled cup in front of Resident # 2 who the consumed them.

Nurse A at 9:24 AM, returned to the Medication cart and again poured each medication into her ungloved hand and then into the medication cup. Then, the Nurse crushed each medication . The nurse poured a total of 6 medications in this manner. After spoon feeding each medication to Resident # 3, the Nurse returned to the cart.

The Nurse Manager was standing to the left of the nurse approximately 4 feet away and observing Nurse A, the entire time. The surveyor asked the Nurse Manager on at 9:38 AM, what she had observed. She confirmed that the nurse failed to compare the medications to the Medication Record and should not have poured each medication directly into her hand. She confirmed that medications should be poured directly into the medication cup to avoid possible contamination.

During an interview with Nurse A on . . . . at 09:41 AM. She confirmed that she poured each medication directly into her hand and that she did not follow the training procedure she was taught in Nursing School and/or follow the facility policy. The nurse confirmed that medications should be

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poured in a clean and sanitary manner and that she failed to do so.

Class III

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

Based on observation, record review and interview, the facility failed to ensure medications were poured and administered in accordance with Physician orders, for 4 of 5 sampled residents (Resident #1,#3, #4 & #5).

Findings include:

1) A Medication Pass observations was conducted from 9 am to 10:30 am on . . . . . Nurse A poured each medication and then handed the . . card of the medications to the surveyor. A comparison of the medications poured for Resident #1 compared to the Medication Administration Record revealed that the Nurse failed to follow the order to administer Gavalax powder 17 gm to be mixed in water or juice once daily at 9 AM.
A review of the Medication Administration record was conducted and Nurse A confirmed that she failed to administer the . . . . powder as ordered. Although, she documented that she had done so. The Nurse Manager was present and also confirmed that the Nurse documented that she administered the . . . . but did not do so.

2) Nurse A on . . . . . at 9:24 AM, poured the medications for Resident # 3 into her hand, from her hand into a cup and then she put each medication into a plastic crush bag and crushed each of the five medications. One of the medications was . , 81 mg . . . . It was noted that . . . . . medications should not be crushed. The Nurse Manager was present and after reviewing the Medication Administration Record confirmed that the nurse should not have crushed the dose of . . . . . , . The Manager should have notified the physician that the resident required her medications to be crushed . When asked if . . . . . medications should be crushed, Nurse A stated that she was unaware of this.

3) At 9:38 AM, a Medication Pass Observation was conducted with Nurse B. The nurse poured a total of 8 medications without comparing the medications to the Medication Administration Record . The nurse was asked how many medications he had poured and he confirmed that it was a total of 8 medications. A comparison of the poured medications to the Physician orders and the Medication Administration Record revealed that Nurse B failed to administer the following ordered medications:
1) . . . . , . . 5 mg

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SUMMARY STATEMENT OF DEFICIENCIES
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2) cream apply to stomach
3) D 3 1000 units
This surveyor observed that the nurse poured each medication without referring to the Medication Administration Record (MAR).
During an interview with the Nurse Manager on at 10:00 AM(who also observed the Medication Pass Procedure with the Surveyor), confirmed that the nurse did not compare the cards of medications to the MAR as he poured each medication and failed to administer the 3 ordered medications listed above.

4) An observation of the Medication Pass procedure was conducted on with Resident # 5 by Nurse B. The nurse poured a total of 5 medications including 7.5 mg. The card that contained the had an orange sticker which stated "bedtime medication ". The surveyor handed the card to the Nurse and pointed out the orange sticker warning that the medication was to be given at bedtime. A comparison of the MAR to the card also confirmed that the medication was only to be administered at bedtime. The Nurse confirmed that he failed to read the label warning and the order before pouring the medication. The Nurse Manager was present and confirmed that the nurse poured a medication ( ) which was ordered for bedtime in error and that he failed to compare the order to the card label.

Class III

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

Based on observation, record review and interviews, the facility failed to ensure that medications that were and were not administered, were documented appropriately, for 2 of 5 sampled residents (Resident #1 & #4).

Findings include:

1) A Medication Pass observations was conducted from 9 am to 10:30 am on Nurse A poured each medication and then handed the card of the medications to the surveyor. A comparison of the medications poured for Resident #1 compared to the Medication Administration Record revealed that the Nurse failed to follow the order to administer Gavalax powder 17 gm to be mixed in water or juice once daily at 9 AM.
A review of the Medication Administration record was conducted and Nurse A confirmed that she failed to administer the powder as ordered. Although, she documented that she had done so. The

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Nurse Manager was present and also confirmed that the Nurse documented that she administered the [redacted] but did not do so.

2) At 9:38 AM, a Medication Pass Observation was conducted with Nurse B. The nurse poured a total of 8 medications without comparing the medications to the Medication Administration Record. The nurse was asked how many medications he had poured and he confirmed that it was a total of 8 medications. A comparison of the poured medications to the Physician orders and the Medication Administration Record revealed that Nurse B failed to administer the following ordered medications:

1) [redacted] 5 mg
2) [redacted] cream apply to stomach
3) [redacted] D 3 1000 units

This surveyor observed that the nurse poured each medication without referring to the Medication Administration Record (MAR).

During an interview with the Nurse Manager on [redacted] at 10:00 AM(who also observed the Medication Pass Procedure with the Surveyor), confirmed that the nurse did not compare the [redacted] cards of medications to the MAR as he poured each medication and failed to administer the 3 ordered medications listed above.

Class III