STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969091	**07/10/2018**
NAME OF PROVIDER OR SUPPLIER **TUSCAN GARDENS OF VENETIA BAY**	STREET ADDRESS, CITY, STATE, ZIP CODE **841 VENETIA BAY BLVD** **VENICE, FL 34285**	

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

0000 - Initial Comments

An unannounced relicensure survey was conducted . . . . through . . . . at Tuscan Gardens of Venetia Bay, an assisted living facility (license #12918) in Venice, Florida.

The following is description of the deficiencies.

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

Based on observation and interview, the facility failed to ensure medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, ... area at all times.

The findings included:

On . . . . at 2:10 p.m., Licensed Practical Nurse (LPN) Staff D was observed preparing medications. Staff D was called away by another staff person into the hallway. Staff D left the medication walked down the hallway. Staff D could not see the medication cart from where she was in the hallway. Staff D left the medication cart with the key still in the lock, the bottom drawer open with multiple medications exposed and the door to the medication . . . . . left open. When Staff D re-entered the medication , she expressed a sound of frustration at having left the medications unattended.

On at 2:40 p.m., the wellness director admitted this was not proper procedure.

Class III

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

Based on observation, record review and interview, the facility failed to ensure new directions for the use of a medication were reflected on the medication container or obtain a revised label from the pharmacist for 1 (Resident #1) of 3 resident medication observations.

The findings included:

On . . . . at 2:10 p.m., Licensed Practical Nurse (LPN) Staff D was observed assisting Resident #1 with medications. The Medication Observation Record indicated , /Levadopa mgs (a medicine for . . . . .) 2 tablets by . . . tube 3 times daily. The medication container indicated , /Levadopa mgs take 2.5 tablets via tube 3 times daily. An order was

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produced dated . . indicating wean . . . . . (brand name for . . . . . , /Levadopa) down to 2 tablets 3 times daily for 1 week, then 1.5 tablets for 3 days, then 1 tablet times three days then stop.

On . . . . at 2:15 p.m., Staff D said the process when an order changes is to place a sticker on the medication container indicating the change. Staff D said she had no stickers and would have to obtain them from the memory care unit.

0n . . . . at 2:40 p.m., the wellness director said they had been having a problem with the pharmacy.

Class III

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

Based on record review and interview the facility failed to ensure evidence of a negative examination is documented on an annual basis for 3 (Administrator, Staff A, Staff E) of 4 employee records reviewed.

The findings included:

The Administrators' personnel file revealed a hire date of . . . . . . The Administrators' personnel file revealed a negative . . . . . exam dated . . . . . . There were no further . . . . . exams in the file.

Staff A's personnel file revealed a hire date of . . . . . . Staff A's personnel file revealed a negative . . . . . exam dated . . . . . . There were no further . . . . . exams in the file.

Staff E's personnel file revealed a hire date of . . . . . . Staff E's personnel file revealed a negative . . . . . exam dated . . . . . .
There were no further . . . . . exams in the file.

On . . . . at 11:00 a.m., the Administrator agreed the . . . . . exams hadn't been updated and they would be working on a better tracking system.

Class III