STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911225	**08/07/2018**
NAME OF PROVIDER OR SUPPLIER **GRAND VILLA OF ENGLEWOOD**	STREET ADDRESS, CITY, STATE, ZIP CODE **925 SOUTH RIVER ROAD** **ENGLEWOOD, FL 34223**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR# 2018006742, CCR# 2018007198 and CCR# 2018010906 was conducted through at Grand Villa of Englewood, an assisted living facility (license number #5501) in Englewood, Florida.

The complaint CCR# 2018006742 contained 3 allegations of which 1 was substantiated without citation.
The complaint CCR# 2018007198 contained 5 allegations which were unsubstantiated.
The complaint CCR# 2018010906 contained 2 allegations of which 1 was substantiated.

The following is description of the deficiencies.

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

Based on record review, staff and family interview, the facility failed to provide appropriate health care in regards to following physician medication orders for 1 (Resident #2) of 4 resident's reviewed for medications. This has the potential for adverse health and safety issues.

The findings included:

On at 12:00 p./m., the family member of Resident #2 said the health care practitioner, a physician assistant (PA), wrote an order to reduce Resident #2's from taking the medication two times per day to one time per day. The family member said the facility's medication technicians (Med Techs) continued to provide the medication two times per day.

Record review for Resident #2 found the PA wrote a prescription on to "Decrease , [ ] to 0.5 milligrams [mg] one tablet by mouth once per day."
A review of the Medication Observation Record (MOR) for , 2018 found the order was transcribed to read, " , 0.5 mg tablet (0.5 mg tablet) TAKE ONE TABLET BY MOUTH ONCE A DAY."
However, two delivery times were listed on the MOR for the : 8:00 a.m., and 5:00 p.m. The MOR documented the medication was given at both at 8:00 a.m. and 5:00 p.m. each day, until the medication ran out on .

In an interview on at 7:00 a.m., 6:00 a.m. to 2:00 p.m. shift Med Tech Staff A, working in Building E, said the techs document the medication received by the residents on an electronic MOR. The Med Tech showed when she brings up a resident's medications, the screen shows the medications the

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SUMMARY STATEMENT OF DEFICIENCIES
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resident was to take on her shift. The screen showed Resident #2 was to take 0.5 mg once per day at 8:00 a.m. The Med Tech said she initialed the box on the screen when the medication was handed to the resident and the tech observed the resident take it. The Med Tech said she does not see what medication the resident takes on other shifts.

In an interview on at 12:45 p.m., Resident Care Supervisor Staff G showed the medication, , for Resident #2 came up on both the day shift and the evening shift as ordered for once per day. Staff G acknowledged the medication order had not been properly reconciled with the electronic MOR. The Resident Care Supervisor confirmed Resident #2 received a dosage of in excess of the amount ordered on a daily bases for 20 of 22 days in , 2018 before the medication ran out. Staff G said an LPN is assigned to reconcile the medication orders so that medication errors do not occur. The Resident Care Supervisor acknowledged the error was not discovered until the medication ran out before the scheduled reorder date. Staff G said the facility did not discover the error in a timely manner.

Class III

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

Based on record review, and staff interview, the facility failed to ensure the direction for use of all medications was accurately documented on the Medication Observation Record (MOR) for 1 (Resident #2) of 4 resident's reviewed for medications. This has the potential for adverse health and safety issues.

The findings included:

On at 12:00 p./m., the family member of Resident #2 said the health care practitioner, a physician assistant (PA), wrote an order to reduce Resident #2's from taking the medication two times per day to one time per day. The family member said the facility's medication technicians (Med Techs) continued to provide the medication two times per day.

Record review for Resident #2 found the PA wrote a prescription on to "Decrease [ ] to 0.5 milligrams [mg] one tablet by mouth once per day."
A review of the Medication Observation Record (MOR) for , 2018 found the order was transcribed to read, " , 0.5 mg tablet (0.5 mg tablet) TAKE ONE TABLET BY MOUTH ONCE A DAY." However, two delivery times were listed on the MOR for the : 8:00 a.m., and 5:00 p.m. The MOR documented the medication was given at both at 8:00 a.m. and 5:00 p.m. each day, until the medication ran out on .

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SUMMARY STATEMENT OF DEFICIENCIES
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In an interview on at 7:00 a.m., 6:00 a.m. to 2:00 p.m. shift Med Tech Staff A, working in Building E, said the techs document the medication received by the residents on an electronic MOR. The Med Tech showed when she brings up a resident's medications, the screen shows the medications the resident was to take on her shift. The screen showed Resident #2 was to take 0.5 mg once per day at 8:00 a.m. The Med Tech said she initialed the box on the screen when the medication was handed to the resident and the tech observed the resident take it. The Med Tech said she does not see what medication the resident takes on other shifts.

In an interview on at 12:45 p.m., Resident Care Supervisor Staff G showed the medication, , for Resident #2 came up on both the day shift and the evening shift as ordered for once per day. Staff G acknowledged the medication order had not been properly reconciled with the electronic MOR. The Resident Care Supervisor confirmed Resident #2 received a dosage of in excess of the amount ordered on a daily bases for 20 of 22 days in , 2018 before the medication ran out. Staff G said an LPN is assigned to reconcile the medication orders so that medication errors do not occur. The Resident Care Supervisor acknowledged the error was not discovered until the medication ran out before the scheduled reorder date. Staff G said the facility did not discover the error in a timely manner.

Class III