STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969115	**09/25/2018**
NAME OF PROVIDER OR SUPPLIER **SYMPHONY AT ST**	STREET ADDRESS, CITY, STATE, ZIP CODE **840 STATE ROAD 16 SAINT , FL 32084**	

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

0000 - Initial Comments

An unannounced complaint survey (CCR#2018009836 and CCR#2018012991) was conducted at Symphony At St (Lic #12984) on and 25th, 2018. Deficient practice was identified during the survey.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observations, record reviews, and interviews the facility failed to provide supervision for 3 of 13 residents, evidenced by failing to update the written record following a decline in health, and failing to provide services to meet the needs of residents.

The findings include:

1. During a review of progress notes for Resident #2, a note authored by Employee C, Med Tech, entered on 9:00 PM was found. It indicated the resident was in bed all evening and has been complaining of stomach pains, she also was having loose bloody stool.

A note was entered on at 10:24 AM read that the nurse was told in report that Resident #2 was having , so a hospice nurse came out to see the resident. There was no other documentation that the loose bloody stools were addressed.

On at 2:46 PM an interview was conducted with Employee C about the note she wrote on for Resident #2. She stated that she remembered her having bloody stools and remembered writing the note, but she does not remember who she told about it. She was then asked if anything was done or if anyone had seen her about the bloody stools, and she stated, "I don't know, I can't remember, I was probably off the next day".

2. Resident #3 was observed calling out for help from her at 2:50 PM. Employee B, Licensed Practical Nurse, (LPN) was observed removing medication from her medication cart behind the desk. Employee B then walked to the residents , and entered. Upon entering the , Resident #3 was noted to be on the floor mat, on her knees. She was soiled and there was a foul odor present. She stated she was trying to get "in there", and pointed at her . Employee B then called on her radio to get resident care personnel to her , to clean her up.

On at 2:58 PM an interview was conducted with Employee B, LPN, and she stated that the

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resident had been calling out, so she got her an (anti- , medication). She then stated, "I did not realize she had , but I have called for an aide to come in and clean her up".

3. On at 11:15 AM Resident #12 was observed in the activity a dressing to left , there was not time and or date on the dressing. On at 1:10 PM, the dressing was still in place. When Employee G attempted to remove the dressing on her left , and it was stuck and would not come off. She was then asked about how long it had been on there. She then confirmed that it did not have a date and/or time, however, she saw the home health nurse do the dressing on . When asked about what the orders were for the dressing, she stated the facility doesn't have it, the home health nurse has it. She explained there is not a need to keep the order since the home health agency does the dressing. Resident #12 then stated, "I need you to look at my foot, that is what hurts". Employee F said she has a black area on her heel, and the home health agency takes care of that as well. She was asked if the facility had any orders for the foot's treatment, but there weren't any. Review of Resident #12's record found there was no paperwork in the chart under "third party providers". The entire paper chart was reviewed for orders for the treatment and/or heel and there were no orders and/or any other documentation available.

Class III

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

Based on record reviews and interview the facility failed to maintain complete and accurate medication records for 2 of 8 residents (Resident #3 and #10).

The findings include:

1. A record review was conducted of Resident #3's , 2018 Medication Administration Record (MAR), and showed an order for , - , (Sinimet/Parkinson's medication) mg (milligrams), which was ordered for three times a day. The MAR showed medication was not signed as being given on the following entries:

The 2 PM dose on , , 19th, 21st, 22nd, 23rd, 25th, and 28th.
The 8 PM dose on , , 21st, 22nd, 23rd, 24th, 25th, 26th, 27th, 28th, and 29th.

On at 2:31 PM an interview was conducted with Employee D, Licensed Practical Nurse, (LPN), regarding the MAR for Resident #3. She confirmed that they were blank, and should have been signed

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as being given. She stated that sometimes the nurses and/or med tech's will get between documenting on paper and/or in the computer, and fail to document correctly.

2. During a review of Resident #10's orders in the computer's MAR, it was discovered that she had an order for , .25mg, one tablet, twice a day.

When comparing the computer's MAR to the sign out sheet for Resident #10's , it was discovered there were doses of signed out on the sheet, but not signed as given on the MAR.

This was reviewed with Employee D on at 10:52 AM and she confirmed that the computer's MAR only allows staff to document the ordered doses which have been given, not doses that are given outside of what has been ordered. This prevents the staff from documenting they gave Resident #10 a third dose of in a day, since it was only ordered to be given twice a day. Employee D was asked if there were any other spots the third dose of could have been documented, such as another line on the MAR for an "as needed" dose, and she confirmed Resident #10 did not have an "as needed" dose prescribed.

In an interview with the facility's Administrator at 3:37 PM on , she reviewed the sign out sheet for Resident #10 and confirmed the discrepency.

Class III

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

Based on observation and interview the facility failed to ensure 1 of 3 medications observed were kept in securly in a location not readilly accessible to residents.

The findings include:

On at 12:55 PM an intact, unidentifiable, medication capsule was observed in the trash can, on the unattended medication cart in the facility's common area located in front of the private dining (photographic evidence obtained). Within 5 feet of the cart, 3 residents were observed, and one resident ambulating next to the cart.

On at 1:03 PM an interview was conducted with Employee B, Licensed Practical Nurse, (LPN), regarding the medication capsule in the trash can. She stated, "I do not know what that is, I did not put

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that in there". She then stated that another employee was helping her earlier, and she must have put it in there. When asked about the facility's policy for disposing of medications, she stated, "If it is a we flush it or something, but if it is just a regular medication, we don't do anything special with it".

She was asked for more information about how the facility ensures medications are disposed of properly. She explained there was no issue with throwing the medication away in the garbage can, as was observed. She was asked if she knew the facility's policy and procedure for proper disposal of medications, and she did not know.

Class III

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

Based on record reviews and interviews the facility failed to ensure that medications were accurately labeled, and available for resident use, for 3 of 8 residents reviewed for medications (Residents #5, #3, and #8).

The findings include:

A record review was conducted for Resident #5 and revealed that he had a current order for , (anti- , medication), 1 mg (milligram), with instructions to give one tablet, by mouth, one time a day at 5 PM for agitation.

A review was conducted of the medication card for Resident #5's and it revealed a different order on the label: , take one tablet, by mouth, two times a day for agitation.

On at 11:39 AM an interview was conducted with Employee E, Medication Tech, regarding the label on the medication card for Resident #5's , . She stated that they should have placed a change alert sticker on the card, so everyone would know the order was changed.

The facility policy and procedure for medicaion administration was reviewed. It repeats twice, under #4 and #8, that part of the process includes ensuring the label matches the current order for resident's medication.

2. On at 12:50 PM an observation was conducted of Employee B, Licensed Practical Nurse, (LPN), assisting Resident #3 with medications. Employee B dispensed one tablet of milligrams (Sinimet/Parkinson's Medication) to Resident #3. The label on

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the package read to give 1 tablet by mouth three times a day (photographic evidenmce obtained).

A review was conducted of the computer screen which contained the Medication Observation Record (MOR), and it revealed an order for the following; , - , mg (milligrams) give one and a half tablets, by mouth, four times a day. A record review was conducted for Resident #3 and revealed her neurologist increased the medication on , 2018, from her neurologist.

On at 12:52 PM an interview was conducted with Employee B, LPN. She reviewed the label and the MOR for Resident #3's , - , , and confirmed that it did not match. She then looked in the medication cart, and stated, "I am looking for a card with ½ tablet in it, but there is not one".

On at 3:39 PM an interview was conducted with the Administrator, and she confirmed that the order for one and a half tabs, four times a day, was the correct current order.

3. A review of the mediaction orders was conducted for Resident #8. The orders, listed in the computer's MOR, revealed that he had an order for , 150mg one tablet by mouth twice a day, however the medication was not available.

On at 10:52 AM an interview was conducted with Employee D. She stated that Resident #8 had missed doses of his , because the other nurses could not find the medication. She stated that it was in the wrong place, but she put it back where it belonged. During this interview Employee D was told Resident #8 was out of this medication, to which she replied, "Oh I did not know he was out, I will have to call his pharmacy".

Class III