STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942886	**10/02/2018**
NAME OF PROVIDER OR SUPPLIER **COUNTRYSIDE HAVEN**	STREET ADDRESS, CITY, STATE, ZIP CODE **6960 CR 95 PALM HARBOR, FL 34684**	

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

0000 - Initial Comments

Assisted Living Facility

On , a biennial state relicensure survey was conducted at Countryside Haven (Lic. #5305). Deficient practice was identified during the survey.

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on observation, interview, and record review, the Facility failed to:
1. Follow safe control standards of inhalant medications;
2. Appropriately prompt or cue residents with proper administration and manufacturer's instructions of an inhaler; and,
3. Read medications labels aloud during assistance with self-administration of medication to three of three Residents sampled (#3, #12, and #13) who needed assistance with self-administration of medication.

Findings Included:

An observation of the medication pass with Resident #13, conducted on at 12:05pm, revealed that Staff B offered Resident #13 a scheduled 90mcg HFA (Hydrofluoroalkane) inhaler. Staff B handed the box containing the inhaler to Resident #13. Staff B did not read the medication label to Resident #13. Resident #13 took the inhaler out of the box and took two quick puffs and placed the inhaler back in to the box. Resident #13 handed the box back to Staff B. Staff B did not give Resident #13 any instructions for the inhaler use. Staff B did not inform the Administrator of Resident #13's incorrect use of the ordered inhaler. Staff B placed the inhaler back in to the central storage medication cart without cleansing the mouthpiece. Resident #13 required assistance with self-administration of medication.

An observation of the medication pass with Resident #3, conducted on at 12: 11pm, revealed that Staff B offered Resident #3 a scheduled 90mcg HFA inhaler. Staff B handed the box containing the inhaler to Resident #3. Staff B did not read the medication label to Resident #3. Resident #3 took the inhaler out of the box and took two quick puffs and placed the inhaler back in to the box. Resident #3 handed the box back to Staff B. Staff B did not give Resident #3 any instructions for the

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inhaler use. Staff B did not inform the Administrator of Resident #3's incorrect use of the ordered inhaler. Staff B placed the inhaler back in to the central storage medication cart without cleansing the mouthpiece. Resident #3 required assistance with self-administration of medication.

During a review of the HFA inhaler's package insert (See Photographic Evidence1), conducted on , revealed that the manufacturer's instructed on directions of used was to shake the inhaler, administer one dose, "wait one minute and shake the inhaler again" before administering a second dose.

An observation of the medication pass with Resident #12, conducted on at 12:17pm, revealed that Staff B offered Resident #12 a scheduled 0.5% , Solution. Staff B did not compare the medication label to the Medication Observation Record. Staff B did not read the medication label to Resident #12. An inspection of the 0.5% , Solution revealed that the medication label was faded and unreadable. Resident #12 required assistance with self-administration of medication.

During an interview with the Administrator, conducted on at 02:00pm, the Administrator acknowledged and confirmed that Medication Technicians should read the medication labels to residents when passing medications. The Administrator stated that Medication Technicians should cleanse the inhaler's mouthpiece before placing the inhaler back in the medication cart. The Administrator denied having a Policy and Procedure specifically for inhalers and said the Medication Technicians should follow their training.

Class III