STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964318	**10/26/2018**
NAME OF PROVIDER OR SUPPLIER **SOLARIS SENIOR LIVING STUART**	STREET ADDRESS, CITY, STATE, ZIP CODE **860 S.E. CENTRAL PARKWAY STUART, FL 34994**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR #2018011808, was conducted on and at Solaris Senior Living Stuart, License #8693. The allegation was not substantiated; however, the facility had associated but independent deficient practice at the time of the survey.

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

Based on staff interviews and resident record reviews, the facility failed to ensure medication observation records (MAR's) were accurate and consistent when staff updated these records for 4 of 5 sampled Residents (#2, 3, 8 and 9) (Photographic evidence obtained).

The findings included:

A) Review of Resident #2's medical records was conducted on at 12:14 PM with the facility's Director of Nursing (DON), a Licensed Practical Nurse, present. Her AHCA Form 1823 (health assessment) documented she requires assistance with self-administration of medications. The DON was asked and stated only licensed nurses provided to residents who were prescribed . A written Physician Order Sheet dated documented an order for R to be administered to the resident four times daily, based on the following sliding scale:

sugar	Number of units
61-150	0 units
151-200	2 units
201-250	4 units
251-300	6 units
301-350	8 units
351-400	10 units

more than 400, give 12 units plus call the resident's health care provider (HCP)

A written HCP order dated called for reduction of the doses from four to two times daily.

Review of Resident #2's 2018 Sugar Flowsheet revealed the following discrepancies:
1. On , the resident's evening sugar level was 211; staff documented administration of 2 units when 4 units were required.
2. On , the resident's evening sugar level was 387; staff documented administration of 8 units when 10 units were required.

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3. On , the resident's morning sugar level was 200; staff documented administration of 4 units when 2 units were required.
4. On , the resident's morning sugar level was 185; staff documented administration of 0 units when 2 units were required.
5. On , the resident's evening sugar level was 234; staff documented administration of 0 units when 4 units were required.
6. On , the resident's evening sugar level was 226; staff documented administration of 2 units when 4 units were required.
7. On , the resident's morning entry was left blank.
8. On , the resident's evening sugar level was 161; staff documented administration of 0 units when 2 units were required.
9. On , the resident's morning sugar level was 161; staff documented administration of 0 units when 2 units were required.
10. On , the resident's evening sugar level was 165; staff documented administration of 0 units when 2 units were required.
11. On , the resident's morning entry was left blank.
Review of Resident #2's reverse side of her 2018 MAR's, her sugar flowsheets, and her resident notes revealed nothing to explain these discrepancies. The above concerns were discussed with and acknowledged by the DON at the time of medication review.

B) Review of Resident #3's medical records was conducted on at 1:05 PM with the facility's DON present. His health assessment documented he requires assistance with self-administration of medications. A written HCP order dated called for , (, an anti- ,) 0.25 milligrams (MG) daily as needed for , . His Individual Patients Record revealed one tab was removed from the supply on , , and . Review of his MARs for , , and , 2018 revealed no corresponding entries documenting he received these four doses. Review of the reverse sides of the MARs revealed no documentation showing he received them. Also, review of his resident notes revealed no documentation showing he received the four doses; this medication was to be taken on an "as needed" basis; there was no documentation showing the reasons for receiving doses and if they were effective. The above concerns were discussed with and acknowledged by the DON at the time of medication review.

C) Review of Resident #8's medical records was conducted on at 3:00 PM with the facility's DON present. His health assessment documented, he requires assistance with self-administration of medications. A written HCP order dated called for , (anti-

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) 50 MG twice daily; the quantity on hand was documented as 24 pills. Review of her Individual Patients Record revealed no entry for the morning dose. The corresponding entry on her 2018 MAR was documented as given. Observation of the actual medication supply revealed only 23 pills were present. This concern was discussed with and acknowledged by the DON at the time of medication review.

D) Review of Resident #9's medical records was conducted on at 3:10 PM with the facility's DON present. Her health assessment documented, she requires assistance with self-administration of medications. Written HCP orders dated called for:
1. 10 MG every 12 hours. Review of her 2018 MAR revealed that out of 14 opportunities to provide this medication to the resident:
a. Seven doses were marked as refused. There was no documentation showing facility staff attempted to notify her HCP regarding her refusal of medications.
b. MAR entries for six doses were left blank. There was no documentation explaining why the dose was not received.
2. 2.5 MG three times daily at 9:00 AM, 1:00 PM and 5:00 PM, hold for , (SBP) over 110. Review of her 2018 MAR revealed the following:
a. For doses scheduled for at 9:00 AM through at 5:00 PM; at 5:00 PM; at 5:00 PM; and, at 5:00 PM, SBPs were not charted, her 2018 MAR for these doses were initialed as given.
b. The 1:00 PM SBP was 125, the dose should have been held, her MAR was initialed as given.
c. The 5:00 PM SBP was 100, the dose should have been given. The corresponding entry on her MAR was initialed and circled to show it was not given. Also, her flowsheet documented the dose was given at hour of sleep instead of 5:00 PM.
d. The 5:00 PM SBP was 120, the dose should have been held, the corresponding entry on her MAR was left blank.
e. Her MAR entries for doses scheduled for 9:00 AM through 9:00 AM were illegible.

These concerns were discussed with and acknowledged by the DON at the time of medication review; and with and by the Administrator on at 10:54 AM.

Class III

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

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Based on staff interviews and resident record reviews, the facility failed to ensure nursing staff properly stored medications, for 2 of 5 sampled Residents (#1 and #2).

The findings included:

A) Review of Resident #1's medication supplies and records was conducted on at 12:01 PM with the facility's Director of Nursing (DON), a Licensed Practical Nurse present. Resident #1's AHCA Form 1823 (health assessment) revealed she has Type II and requires assistance with self-administration of medications. Observation of her medication supply revealed a vial of stored loose in her medication basket, not in it's prescribed box, which represented potential for cross-contamination of the vial.

The medication box also present had an attached prescription label that disclosed, " ( ) 100 units per vial, inject 4 units 3 times daily with meals", and, "Discard unused portion of 28 days." The label documented the medication was filled on . The box nor the vial were labeled with the date the medication was first used. Her 2018 Medication Observation Record (MOR) documented she received the first dose on at 8:00 AM. In an interview conducted at 12:10 PM, Staff E stated the came from Resident #1's home and was already opened when received.

A loose vial (with no name or date opened) of R was observed in her medication basket. Review of her medical records revealed no written Health Care Provider (HCP) order for R. See Resident #2 below.

These concerns were discussed with and acknowledged by the DON at time of medication review.

B) Review of Resident #2's medication supplies and records was conducted on at 12.17 PM with the DON present. Her health assessment revealed she has Type II and requires assistance with self-administration of medications. Observation of her medication supply revealed an empty medication box for in her medication basket. There was no corresponding vial of . Review of her medical records revealed no written Health Care Provider (HCP) order for R.

A medication box for R stored loose was observed in her medication basket. It was not in it's prescribed box, which represented potential for cross-contamination of the vial. Also, the R medication box had a hand-written "open date" of , the box was stamped with an expiration date of . The vial of R was stamped with an expiration dated of . The box did not

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match the vial, it was not stored in it's proper medication box.

These concerns were discussed with and acknowledged by the DON at the time of medication review; and with and by the Administrator on . . . . at 10:54 AM.

Class III