STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965334	11/13/2018
NAME OF PROVIDER OR SUPPLIER **ARDEN COURTS OF WINTER SPRINGS**	STREET ADDRESS, CITY, STATE, ZIP CODE **1057 WILLA SPRINGS DRIVE** **WINTER SPRINGS, FL 32708**	

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

0000 - Initial Comments

A Complaint investigation # 2018012260 was conducted on , and . Arden Courts of Winter Springs Assisted Living Facility license #9733 had deficiencies at the time of the visit.

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

Based on medication observations, medication observation record (MOR) review, record review and interview, the facility did not provide care and services to meet the needs of 1 of 6 sampled residents (#2) by not following the physician's orders for medication administration.

Findings:

Observations during the medication administrator pass on at 11:45 AM, revealed the Licensed Practical Nurse went to the locked medication cart, removed the MOR and reviewed it she removed the medication from their bubbly packs and placed the pills in a small cup. She went to the table where resident #2 was sitting and handed her the cup and explained to her what the medications were Acidophilus 3 times daily for 21 days and , 0.25 mg 1 3 times daily.

A review of the MOR for 11/2018 revealed it noted the Acidophilus 3 times daily for 21 days (at 8 AM, 12 PM and 4 PM) was given from through . The LPN was asked at the time how would the nurses know to stop the medication after the 21st day because the MOR was not numbered. She said they would not and she would check the MOR for .

Review of the MOR revealed the medication was marked as given 19 days (from through), the medication was administered a total of 25 days based on the MOR and also on at 8 AM and the LPN was observed administering the medication at 12 PM.

Review of the medication packages of the Acidophilus revealed there was 2 full bubble packs of 28 pills that equaled 56 and 1 package that came with 26 pills and only 21 pills were missing (5 remained). 61 pills remained.

Interview with the LPN who said she had the pharmacy receipt and 18 pills were sent as a backorder on and on -2 packages of 28 and 1 package 26 was sent for a total of 100 pills. She confirmed the 18 were given and the 21 which was a total of 39, the resident should have received 63 pills. She confirmed the MOR was marked as given for 25 days and 2 pills on (77 pills) when the resident did not actually receive that amount of medication.

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Record review for resident #2 revealed a resident health assessment form 1823 dated . . . . . that noted the resident was to have her medications administered, there was an order dated for . . . . . 875 mg take one twice daily and Acidophilus 1 three times daily for 21 days.

On . . . . . the administrator and the director of nursing confirmed the findings.

On . . . . . an email was received from the facility administrator who stated according to the pharmacy, there was an error on their end, an additional 30 pills were sent to the facility and they did not have a copy of the delivery receipt. She stated a total of 130 pills was delivered instead of the 100.

A review of an email sent from the pharmacy representative on 11/13/18 confirmed what the administrator stated.

After review the facility was sent a total 130 pills, the physician ordered the resident to have the medication for only 21 days which would have been 63 pills. There was actually a total of 69 pills given (39 +30 that were not on the receipt).

According to the MOR for and resident #2 was administered the 3 pills daily for 25 days instead of 21 as ordered. Also on . . . . . she was administered 1 pill at 8 AM and 1 pill at 12 PM which would have been a total of 77 pills. She should have only received 63. Resident #2 actually received 69 based on the amount of pills that were left over.

Class III

0163 - Records - Resident, Penalties for Alteration - 429.49 FS

Based on medication observations, medication observation record (MOR) review, record review and interview, the facility staff falsified medication observations records for 1 of 6 sampled residents (#2).

Findings:

Observations during the medication administrator pass on . . . . . at 11:45 AM, revealed the Licensed Practical Nurse went to the locked medication cart, removed the MOR and reviewed it she removed the medication from their bubbly paced and placed the pills in a small cup. She went to the table where resident#2 was sitting and handed her the cup and explained to her what they were for the medications were Acidophilus 3 times daily for 21 days and , ... 0.25 mg 1 3 times daily.

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A review of the MOR for 11/2018 revealed it noted the Acidophilus 3 times daily for 21 days (at 8 AM, 12 PM and 4 PM) was given from through . The LPN was asked at the time how would the nurses know to stop the medication on after the 21st day because the MOR was not numbered. She said they would not and she would check the MOR for .

Review of the MOR revealed the medication was marked as given 19 days (from through), the medication was administered a total of 25 days based on the MOR and also on at 8 AM and the LPN was observed administering the medication at 12 PM.

Review of the medication packages of the Acidophilus revealed there was 2 full bubble packs of 28 pills that equaled 56 and 1 package that came with 26 pills and only 21 pills were missing (5 remained). 61 pills remained.
Interview with the LPN who said she had the pharmacy receipt and 18 pills were sent as a backorder on and on -2 packages of 28 and 1 package 26 was sent for a total of 100 pills. She confirmed the 18 were given and the 21 which was a total of 39, the resident should have received 63 pills. She confirmed the MOR was marked as given for 25 days and 2 pills on (77 pills) when the resident did not actually received that amount of medication.

Record review for resident #2 revealed a resident health assessment form 1823 dated that noted the resident was to have her medications administered, there was an order dated for 875 mg take one twice daily and Acidophilus 1 three times daily for 21 days.

On the administrator and the director of nursing confirmed the findings.

On an email was received from the facility administrator who stated according to the pharmacy, there was an error on their end, an additional 30 pills were sent to the facility and they did not have a copy of the delivery receipt. She stated a total of 130 pills delivered instead of the 100.

A review of an email sent from the pharmacy representative on 11/13/18 confirmed what the administrator stated.
After review the facility was sent a total 130 pills, the physician ordered the resident to have the medication for only 21 days which would have been 63 pills. There was actually a total of 69 pills given (39 +30 that were not on the receipt).

According to the MOR for and resident #2 was administered the 3 pills daily for 25 days instead of 21 as ordered. Also on she was administered 1 pill at 8 AM and 1 pill at 12 PM

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which would have been a total of 77 pills. She should have only received 63. Resident #2 actually received 69 based on the amount of pills that were left over. The facility staff falsified the medications observations record, the resident did not receive 77 pills as note on the MORs based on the amount of pills that the facility had left over.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on review of the Florida health finder.gov and interview, the facility did not within five (5) business days, notify in writing, each resident and the resident's legal representative upon submission of the emergency power plan to the local emergency management agency that the plan had been submitted for review and approval and did not develop written policies to ensure that the assisted living facility could effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source, that also included procedures to ensure residents would not experience complications from fluctuations in air temperatures inside the facility.

Findings:

Review of the Florida health finder.gov website revealed the facility reported to the agency that their emergency power plan was approved on .

Review of the facility's emergency power plan documentation revealed there were no written policies and procedures that included:

How the facility would immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source.

The care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including:

1. The use of cooling devices and equipment;
2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration;
3. Wellness checks by assisted living facility staff to monitor for signs of and heat injury;

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and,
4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy.

On at 2 PM, the administrator said the facility had provided a letter to the resident's or the resident's legal representative upon submission of the plan to the local emergency management agency. She provided a copy of the letter and the letter did not indicate that the facility had submitted their Plan for review as required. She was not aware that their written policies and procedures were to include the above information.

Class III