STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968413	**10/11/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANTATION OAKS SENIOR LIVING	**9309 S ORANGE BLOSSOM TRAIL ORLANDO, FL 32837**

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

0000 - Initial Comments

Complaint Investigation 2018011138 was conducted on , , and . Plantation Oaks Senior Living, License #12300, had deficiencies at the time of the visit.

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

Based on record reviews and interviews, the facility failed to follow a health care provider's order for 4 of 19 sampled residents (#4, 12, 22 & 26), failed to notify a health care provider and family when 1 of 19 sampled residents was sent to the hospital (#10), failed to notify a health care provider when 1 of 19 sampled residents refused medications (#20), failed to document in the record of 1 of 19 sampled residents ho experienced a significant change (#19), and failed to provide adequate supervision to 1 of 19 residents who eloped from the facility (#9).

Findings:

1. Resident #22's record revealed a facility admission date of . Her most recent health assessment form (1823), dated , indicated that she had a diagnoses of (,) , , , , and Lymphedema. She required assistance with self-administered medications.

Resident #22's , Medication Observation Record (MOR) listed 650 milligram (mg.) tablet, 1 tablet by (PO) three times a day ( ) at 8 a.m., 1 p.m. and 8 p.m. The of the MOR indicated that on at 12:30 p.m., she was not given the medication because she was not in her room. The MOR and her record did not contain any documentation to indicate the facility tried to locate her to ensure she received the medication as prescribed.

On at 12 p.m., the resident care director (RCD) confirmed the findings and said prior to her arrival, it was common practice for staff to not give residents their medications if they were not in their rooms.

2. Resident #22's , MOR listed 0.125 mg. tablet, 1 tablet PO three times a week (TIW) on Monday, Wednesday and Friday, for . The medication was signed as given on Saturday , and was not signed as given on Wednesday therefore, the facility did not give the as was prescribed by a health care provider.

On at 12 p.m., the RCD confirmed the findings and did not provide an explanation.

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3. Resident #22's MOR listed Pak 3.75, mix 1 packet PO twice a day ( ) as directed for , and Welchol 625 mg. tab give 3 tablets PO . Welchol is the brand name for . Both medications were signed as given at 8 a.m. on , , , and .
Documentation on the of the MOR indicated that on at 4 p.m., the resident refused to take the Welchol tablets because she received the packets. On , a health care provider discontinued the Welchol tablets due to the resident's refusal to take them. However, documentation on the MOR revealed the facility continued to give the tablets after they were discontinued. On at 12 p.m., the RCD confirmed the findings.

4. Resident #26's record revealed a facility admission date of . Her diagnoses included , , (,) , , , , , , near , , , and , . Her most recent 1823 health assessment form, dated , indicated that she required assistance with self-administered medications and contained a health care provider's order for , 5 mg by daily.

A physician's order sheet, dated , indicated that she was to receive , 10 mg. tablet, 1 tablet PO daily.

Resident #26's , MOR listed both the , 5 mg. and 10 mg. doses, and both were signed as given daily on , and through . In addition, , 10 mg. was not signed as given after but the 5 mg. dose continued to be signed as given without an order from a health care provider until 18. , 10 mg. should have been the only dose given since the most recent order was dated . There was no documentation to indicate the facility contacted a health care provider for clarification until , when a clarification order was received.

On at 10:45 a.m., the RCD confirmed the findings.

5. On at 3:07 p.m., resident #26 said she did not receive her medications on that morning. She went on an outing to the store with activities but had not left the facility until 9 a.m., so she did not understand why she was not given her medications. She returned to the facility after 12 p.m.

Resident #26's MOR listed the following medications: , , , , , , , , , , , , and . On at 8 a.m., all of these medications were circled, and documentation on the of the MOR indicated the medications were not given because the resident was out of the facility.

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On at 10:45 a.m., the RCD said the facility's medication procedure when residents went on outings with activities was that staff reviewed the activity sign up list, and those residents listed would be given their medications either before they left or when they returned. She confirmed the findings and said the procedure she outlined was not followed.

6. Review of a facility Adverse Incident Report revealed that on resident #9 was last seen at 3:45 p.m. When the dining room opened at 4:22 p.m., resident #9 could not be located, and a room to room search began. At 5 p.m., the Florida Highway Patrol contacted the facility and reported that resident #9 was walking up the ramp to the turnpike and that he was safe. The resident said he was going to see his sister for dinner. He was returned to the facility. The report indicated that the door to the dining room was not locked, the resident always played with door handles, he went through the unlocked door, made his way through the kitchen and exited through a door.

Resident #9's record revealed a facility admission date of . His most recent 1823 health assessment form, dated , indicated that he had a diagnoses of and , he was and , and he was an elopement risk. He resided in the facility's secured memory care unit.

On at 12 p.m., observations made revealed the door to the dining room in the memory care unit where resident #9 lived was propped open with a door stopper.

On at 1:45 p.m., the memory care director said when resident #9 eloped from the facility, it was believed that the door to the dining room was left open which allowed him to walk through the dining room, into the unlocked kitchen, then exit out of an unlocked kitchen door which led to the unsecured parking lot. The memory care director said the doors to the dining room had a locking mechanism on them but staff propped them open during meals.

On at 2:25 p.m., caregiver K said on at 3:45 p.m., she saw resident #9 sitting in the dayroom. At 4:20 p.m. when the residents were called to the dining room for dinner, she noticed that he was not in the dining room. She notified the shift leader that he could not be located, and she checked every room but was unable to locate him. At 5:30 p.m., he was returned to the facility by the police. She said it was assumed that he left through the kitchen when the door to the dining room was opened for dinner.

On at 1:30 p.m., the resident care coordinator said he exhibited exit seeking behavior prior to his elopement which included trying to turn door handles.

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Resident #9 was identified as an elopement risk prior to his elopement, he had a diagnoses of , his 1823 indicated that he was and , and he exhibited exit seeking behaviors. The facility's failure to provide him with adequate supervision placed him at risk for harm.

7. Resident #4's health assessment report 1823, dated , listed diagnoses of , , - , ( ), high , , , , (device management). He needed assistance with self-administration of medications. Order dated indicated DS twice daily for 7 days and Florastor 250 mg. one twice daily for 10 days. The MOR listed DS for ( ) and Florastor 250 mg. both at 8 AM and 8 PM. DS had staff initials circled from to , Florastor 250 mg. had staff initials circled from start date of to , AM and PM. There were no notations that explained the staff initials circled for . Florastor 250 mg. was indicated as not on medication cart, not given. On , the page of the MOR indicated that the family was responsible for the Florastor. The review revealed no evidence the healthcare provider was made aware the resident did not have the medications for the . On , all morning medications were circled. The page of the MOR indicated the resident was not in his room, and medications were not given.

8. Resident #20's health assessment report 1823, dated , listed diagnoses of , , , high , , and . She needed assistance with self-administration of medications. The MOR listed , 800 mg. 4 times a day ( ) at 8AM, 12 PM, 5 PM and 8 PM, , 81 mg. daily, 40 mg., , 7.5 mg. at bedtime, and , 10 mg. daily all had staff initials circled from, to AM and PM. The page of the MOR indicated that at 5 PM and 8 PM, at 8 PM, and , the resident refused all her medications. The , MOR had staff initials for , on , and , on , , and on , , , and from to , , from to , and , on and from to . The page of the MOR at 9 AM indicated the resident did not get medications - "not in room" at 8 AM, , - not available, AM refused medications, wanted to keep them and take them later, not in apartment for 12 noon medications, refused medications and refused medications. There was no evidence the resident's healthcare provider and responsible party were notified about the resident's development of a pattern of refusing medications since , and her refusal to take all her medications for 9 days consecutively in .

In an interview on at 11:30 AM, the RCD said the med techs (medication technicians) were responsible to inform the nurse of the resident's refusal.

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9. Resident #19's 1823 Health Assessment was dated . A significant change occurred on which indicated redness to the . The facility did not have any documentation from the gap period of - , so this period of time for the resdient's condition is unknown.

On , a physician order was received for skilled nursing 2 times weekly for a , to the area but a new 1823 Health Assessment was not in the record for this significant change.

On , the Home Health form documented ; , measurements 1.5 centimeters (cm.) by 1 cm. by 0.2 cm.; selective debridement of was done by the advanced registered nurse practitioner (ARNP).

On , the home heallth notes reflected 2 both . #1 was described as a , with measurements 3.9 cm. length by 1.8 cm. width by 0.1 cm. depth with an area of 7.02 sqare cm. and a volume 0.702 cubic cm. There was a small amount of drainage. #2 was an acute moisture associated skin with no progression.

On , the home health notes reflected #1 , measurement: 2.7 cm. by 0.9 cm. by 0.2 cm. area of 2.43 square cm. and volume 0.486 with a small amount of drainage. #2, a acute, was not healed.

On , with measurements were 2.5 cm. length by 2 cm. width-superficial in depth.

On , home health notes reflected #1 as a acute , not healed with measurement 2.2 cm. by 2.1 cm. by 0.2 cm. area 4.62 square cm., volume 0.924 cubic cm., small drainage. #2, a acute was not healed, but did not have any drainage. #3 to the left lower was an acute not healed with measurement 2.7 cm. by 2.2 cm. by 0.1 cm., area 5.94 squsre cm. volume 0.594.

On , there was an open to the lower left .

On , a documented measurements of 0.5 cm. by 0.5 cm.

On , home health notes reflected #1, a acute , was not healed and measured 2.2 cm. by 1.5 cm. by 0.2 cm. area 3.3 square cm. volume 0.66 cubic cm. and small drainage noted. #2, a was acute and not healed. #3 to the left lower acute not healed measurement 3 cm. by 2.1 cm. by 0.2 cm. area 3.3 square cm.

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volume 0.86 cubic cm. #3 to the left lower acute was not healed and measured 3 cm. by 2.1 cm. by 0.1 cm. area 6.3 square cm. volume 0.63 cubic cm.

On at 11 AM, the RCD confirmed all the findings.

10. Resident #10's record revealed the resident was admitted into the hospital on and was diagnosed with exacerbation, , and active , Mycobacterium (MTB). The resident was treated and discharged on to the facility. There were no notes found in the record that documented what occurred for the hospital admission and that the health care provider and family were contacted. On at 2 PM, the RCD confirmed the findings.

11. Review of resident #12's MOR for and noted 500 mg. for , . On and at 5 PM, there was a staff initial with a circle around it. The of the MOR noted the resident did not receive the medication because she was not in the room. The facility did not follow the health care provider's orders to give the resident her medication twice a day. They did not give her the 5 PM dose because she was not in the room when they arrived to give the medication to her.

Class II

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on observations, record reviews and interview, the facility failed to make a daily effort to determine that a resident who was at risk for elopement had Identification (ID) on their person that included their name and the facility's name, address, and telephone number (#9).

Findings:

Resident #9's record revealed a facility admission date of . His most recent 1823 health assessment form, dated , indicated that he was an elopement risk.

Observations made on at 11:15 a.m. revealed he did not wear any visible ID. Caregiver I checked him to see if he had ID on his person and he did not. Caregivers I and J both said he did not have a photo ID, and he would not wear an ID bracelet.

On at 11:40 a.m., caregiver I searched his room for an ID but was unable to find one. She said it was a plastic bracelet and he broke it.

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Resident #9's Medication Observation Record (MOR) contained an entry to check his ID bracelet three times a day at 8 a.m., 4 p.m. and 12 a.m. The 8 a.m. entry was signed on . Caregiver I said she signed that entry and she did not check him for an ID but rather when she signed the MOR, she was verifying that he was the right person.

Class III

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

Based on observations, record reviews and interviews, the facility failed to ensure the Medication Observation Records (MORs) were updated for 3 of 19 sampled residents who required assistance with self-administered medications (#12, 16 & 17).

Findings:

1. Observations made on at 9:40 a.m. revealed caregiver I was standing at a medication cart in the memory care unit signing the MOR. When questioned further, she said she completed the medication pass for all of the residents. Residents #16 and 17's 8 a.m. medications were not signed as given on . Caregiver I said she already gave the residents their medications however, she did not sign any of the resident's MORs until she completed the entire medication pass. Therefore, caregiver I did not immediately update the MOR each time the medications were given, as required.

Resident #16's most recent 1823, dated , indicated that she required assistance with self-administered medications.

Resident #17's most recent 1823, dated , indicated that she also required assistance with self-administered medications.

2. Review of the MOR for for resident #12 revealed an order for , Powder, apply to for 2 times a day for 21 days-DX- . There were initials with circles on the MOR with nothing on the to indicate what the circles meant as follows:
8 AM on , 827, , and
8 PM on and
The were blank spaces at 8 PM on and .
The other days were marked as given.

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The MOR for noted the following:
Powder apply to 2 times a day for 21 days

There were initials with circles on the as follows:
8 AM and 8 PM daily, with the exception of at 8 PM on and , there were staff initials.
8 AM on through and 8 PM on through there were blank spaces.
The of the MOR noted "med circle not given, not available" at 8 AM on

On at 8 AM "med powder was refusals."
and at 8 AM noted powder was not available.
at 8 AM - powder d/c was to be given for 21 days.
There was no way to determine if the powder was provided as the MOR note it was to be provided for 21 days.

Further review of the front of the MOR revealed someone had written the words "D/C completed" over all of the spaces where the initials were listed next to the medication.

Record review for resident #12 revealed there was no order found for the Powder found.

On at 11:15 AM-the resident care director (RCD) said she had called the pharmacy to inform them that resident #12 usedthe powder, and there was no order ever provided to the pharmacy for the Powder. It never arrived to the facility. She provided a letter from the pharmacy that noted they had not received an order for the Powder. The RCD said the staff had incorrectly noted the MOR because the Powder was not for resident #12 and never provided to her.

Class III

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

Based on record reviews and interviews, the facility failed to make every reasonable effort to ensure a prescription was filled in a timely manner for 3 of 19 sampled residents who received assistance with self-administered medications (#1, 2 & 22).

Findings:

1. Resident #22's most recent 1823 health assessment form, dated , indicated that she required assistance with self-administered medications.

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Resident #22's [redacted] Medication Observation Record (MOR) listed [redacted] 30 milligram (mg) tablet, 1 tablet by [redacted] daily for [redacted]. On [redacted] and [redacted], the initials were circled and documentation on the [redacted] of the MOR indicated that the medication was not available and not given.

Resident #22's [redacted] MOR listed [redacted] D capsule 5,000 units, 1 capsule by [redacted] weekly. On [redacted] and [redacted], the initials were circled and documentation on the [redacted] of the MOR indicated that the medication was not available.

The MORs and the resident's record did not contain documentation to indicate the facility made every reasonable effort to ensure her prescription medications were filled in a timely manner.

On [redacted] at 12 p.m., the resident care director confirmed the findings and was unable to provide additional documentation.

2. Resident #1's health assessment form 1823, dated [redacted], listed diagnoses of [redacted] and [redacted]. She needed assistance with self-administration of medications. Prescription dated [redacted] indicated [redacted] 20 milligrams (mg.) daily. The [redacted] MOR listed the medication and was marked as given from [redacted] to [redacted]. The [redacted] page of the MOR indicated medication was not delivered at the time of administration from [redacted] to [redacted]. The review did not reveal any evidence the healthcare provider was made aware the resident did not have the medication and what efforts were done to obtain the medication.

3. Resident #2 had a health assessment report 1823 dated [redacted] that listed diagnoses of [redacted] due to [redacted] and [redacted]. She needed assistance with self-administration of medications. Prescription dated [redacted] (Friday) indicated Mybertiq 50 mg. daily. The [redacted] MOR listed the medication, and was started on [redacted], three days after it was prescribed. The review did not reveal any written notations to explain why the medication was not available and was not started until 3 days later.

On [redacted] at 11:30 AM, the Resident Care Director (RCD) said there was no nurse in the building after 6:45-7 PM. The medication technicians, unlicensed staff, do not make changes on the MOR. If a prescription comes after business hours on Fridays, the order is processed on Saturday. The RCD expalined that pharmacy make 2 deliveries a day, from [redacted] AM and [redacted] PM, and delivered on Saturdays, so maybe the prescription came in late.

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