STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942886	R 12/04/2018
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

A Revisit Survey to a 10/02/18 Biennial Survey was conducted at Countryside Haven Assisted Living Facility on 12/04/18. Countryside Haven Assisted Living Facility had deficient practice identified at the time of the survey.

(License#: 5305)

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

Based on observation, record review, and interview, the Facility failed to prompt or cue residents to assist with the administration according to manufacturer's instruction of inhaler use for three Residents (#2, #4, and #6) of six sampled residents who required assistance with self-administration of medication. The facility also failed to follow control standards when unlicensed staff assisted with self-administration of medication.

Findings Included:

An observation of the medication pass with Resident #2, conducted on at 12:21pm, revealed that Staff A offered Resident #2 a scheduled 90mcg Hydrofluoroalkane (HFA) inhaler. Staff A told Resident #2 to take two puffs. Resident #2 took two quick puffs of the inhaler. Staff A did not inform Resident #2 that the manufacturer's instructions stated to wait one minute between puffs. Staff A did not inform the Administrator or Resident #2's Physician that the resident was not self-administering the HFA inhaler appropriately.

An observation of the medication pass with Resident #4, conducted on at 12:28pm, revealed that Staff A did not follow safe control standards or use Universal Precautions while assisting Resident #4 with a test. Staff A placed the machine on the dining table in front of Resident #4 with no barrier between the machine and the dining table. Resident #4 continued with the testing by pricking a with a lancet and placing the used lancet on the dining table. After Resident #4 drew up the in the test strip and obtained the reading, the resident removed the test strip from the machine, placed it in the package, and folded the package in half. Resident #4 left the -filled test strip on top of the dining table. Resident #4 was sitting at the dining table with three other residents. Resident #4 handed the used lancet to Staff A to dispose of in the sharps container in the bottom drawer of the medication cart. Staff A was not wearing

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gloves.

An observation of the medication pass with Resident #6, conducted on at 12:36pm, revealed that Staff A offered Resident #6 a scheduled 90mcg HFA inhaler. Staff A told Resident #6 to take two puffs.
Resident #6 took two quick puffs of the inhaler. Staff A did not inform Resident #6 that the manufacturer's instructions stated to wait one minute between puffs. Record review on revealed no documentation that Resident #6's Physician was informed that the resident was not self-administering the HFA inhaler appropriately. Record review also revealed that Resident #6 required assistance with self-administration of medication.

A review of the facility's Medication Technician training revealed that item #12 instructed the Medication Technicians to "follow safe control standards"; #13 instructed Medication Technicians to "prompt each resident with proper manufacturer's instructions" and to wait one minute between puffs of an inhaler (See Photographic Evidence POC2).

During an interview with the Administrator, conducted on at 01:15pm, the Administrator stated that the Facility notified Resident #6's Physician of the improper inhaler use but not Resident #2's Physician. The Administrator was unable to provide documentation of Resident #6's Physician notification. The Administrator stated that "we spoke with the residents and they are like we will take our inhaler how we want to take our inhaler."

Class III

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

Based on record review and interview, the Facility failed to update the Medication Observation Records (MORs) immediately when medications were offered to one Resident (#3) of five sampled residents who needed assistance with self-administration of medication.

Findings Included:

During a medication pass with Staff A, conducted on at 12:23pm, Staff A pulled up Resident #3's MORs on the computer screen. Resident #3's MORs indicated that mediations were due. Staff A stated Staff B gave these medications to Resident #3 at 11:00am and confirmed that Staff B did not sign for the medications. When Staff A told Staff B that the medications were not signed as given, Staff B stated to Staff A that Staff A should "sign them." The medications given to Resident #3 at 11:00am by

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Staff B included the resident's prescribed [redacted] 25mg, [redacted] 8mg, [redacted] 20mg, [redacted] 20meq, [redacted] 150mg, and Trintellix 10mg.

During an interview with the Administrator, conducted on [redacted] at 01:15pm, the Administrator acknowledged and confirmed that the Facility's expectation was for medications to be documented as given to the resident by the person giving the medication to the resident.

Class III

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

Based on observation, record review, and interview, the Facility failed to maintain centrally stored medications in a locked medication cart at all times.

Findings Included:

Observation of the medication pass with Staff A, conducted on [redacted] at 12:26pm, revealed that Staff A walked out of the dining room to retrieve a requested walker for Resident #4 and left the medication cart unsecured/unlocked for two minutes. At 12:36pm, Staff A walked out of the dining room to take Resident #6 their prescribed Hydrofluoroalkane inhaler and left the medication cart unsecured/unlocked for three minutes. There was no other staff present in the dining room each time the medication cart was left unsecured/unlocked. Most of the Facility's residents were present in the dining room eating the lunch meal each time the medication cart was left nsecured/unlocked.

A review of the Facility's [redacted] Medication Technician training and policy, conducted on [redacted], revealed that the Facility's expectation #17 (See Photographic Evidence POC2) was to return medications to proper storage and lock the medication cart.

In an interview with the Administrator, conducted on [redacted] at 01:15pm, the Administrator stated that the Facility's expectation was for the Medication Technicians keep the medication cart locked when out-of-sight from the cart.

Class III

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

Based on observation, record review, and interview, the Facility failed to ensure that medications for which the facility staff were assisting with self-administration were in a container with a clear, legible

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label containing directions for use.

Findings Included:

An observation of Resident #5's prescribed , conducted on at 12:30pm, revealed that Resident
#5's prescribed and solutions had labels that were faded and unreadable.

During an interview with Staff A, conducted on at 12:31pm, Staff A confirmed they were unable to read Resident #5's prescribed and solution labels.

A review of the Medication Technician training, conducted on , revealed that item #10 instructed the Medication Technicians that, "if a medication label is difficult to read due to fading, contact the resident's Pharmacy for a new label."
The Medication Technician did not call Resident #5's Pharmacy during survey (See Photographic Evidence POC2).

During an interview with the Administrator, conducted on at 01:15pm, the Administrator stated that the Pharmacy was notified and they sent a new bottle with a new label. The Administrator demonstrated that Resident #5 had a new bottle with a new label for the prescribed solution but not for the solution.

Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42( ) FS; 58A-5.033(3)(a) FAC

Based on record review, observation, and interview the Facility failed to demonstrate compliance for class III deficiencies regarding medication.

Findings Included:

Review of the Class III deficiencies cited during the Biennial Survey, conducted on , revealed one (A0052) Class III medication deficiency cited.

Observation of a medication pass, conducted on , revealed that the Facility did not correct the

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previously cited Class III deficiency (A0052) and had two new Class III medication deficiencies (A0055 and A0056).

During an interview with the Administrator, conducted on . . . . . at 01:15pm, the Administrator acknowledged and confirmed the requirement to employ or contract with the consultant services of a licensed Pharmacist or a licensed Registered Nurse. The Consultant services must provide at a minimum onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. This statement serves as notification of the aforementioned requirement.

Class III