STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969078	**12/13/2018**
NAME OF PROVIDER OR SUPPLIER **ANGELS SENIOR LIVING AT THE LODGES AT IDLEWILD**	STREET ADDRESS, CITY, STATE, ZIP CODE **18440 EXCITING IDLEWILD BLVD LUTZ, FL 33548**	

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

0000 - Initial Comments

Assisted Living Facility

On [redacted], a complaint survey (CCR#2018015497) was conducted at Angels Senior Living at Idlewild. Deficiencies were identified during the visit.

(License #12899)

0050 - Medication - Self Administered Medications - 429.256(2) FS;58A-5.0185(1) FAC

Based on record review and interview the facility failed to follow-up on or address an observed health status change that could attribute to improper self-administration of medication of one Resident (#1) of three sampled residents.

Findings Included:

During a record review for Resident #1 conducted on their current Resident Health Assessment (1823) revealed that the resident is capable of self-administering their own medication.

During an interview with the administrator conducted on at 3:09 PM they stated that Resident #1 does need assistance with self-administration due to a health status change. They confirmed that the facility did not document the health status change in the resident's chart and that the resident's health care provider was not contacted.

Class III

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

Based on observation, record review and interview the facility failed to follow required steps for assisting with self-administration of medications for five Resident's (#2, #3, #4, #5, and #6) of five sampled residents. Unlicensed staff failed to read the medication label aloud and failed to compare the medication label to the Medication Observation Record.

Findings Included:

During a medication pass observation conducted on , Staff A, an unlicensed staff, was

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observed failing to compare the medication labels to the medication observation record (MOR) and not reading the labels in the presence of Resident's #2, #3, #4, #5 and #6.

In an observation of Staff A, unlicensed staff, conducted on at 12:36 PM assisting Resident #2 with a treatment. Staff A poured the measured dose into the dispensing cup of machine and placed the machine on the table by the resident. Staff A then left the room and did not observe Resident #2 during the treatment. At 1:00 PM Staff A had not returned to the room to check if the resident had finished the treatment.

A record review of the facility's Assistance with the Self-Administration of Medication Process, policy not dated, reveals

2. Right Medication
   a. Check medication label and order three times. Check MOR, Check label, then Check MOR with label. Read the label to the resident and verify the resident understands the drug dosage and reason for use, if known.

Staff A did not follow facility's policy and procedure.

In an interview with the administrator during exit conference they confirmed that the facility's policy and procedure for medication self-administration should be followed and that Staff A should have stayed with the resident during the treatment.

Class III

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

Based on observation, interview and record review the facility failed to ensure medication was stored in a safe manner and in a locked cart or cabinet for one (Resident #6) of one sampled residents.

Findings Included:

During an observation conducted on at 12:25 PM, Resident #6 approached Staff A and handed them a small white souffle cup with one pill in it. The resident stated that they found the pill on the counter top in their bathroom and stated that the pill is not a medication they take.

During an interview with the Administrator conducted on at 3:38 PM, the Administrator stated that the pill found was an and at this time there are no current residents on that medication. They stated that they cannot explain what happened or where the medication came from.

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During an interview with the Resident #6 conducted on at 4:00 PM, the resident stated that they found the medication sitting on the counter in their bathroom and that it was not a pill they take.

During a medication observation record (MOR) review conducted on for Resident#6, it was confirmed that the resident was not on an .

Class III

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

Based on observation, record review and interview, the facility failed to follow physician's orders for one (Resident #4) of five residents sampled and failed to ensure that medication was properly labeled for one (Resident #2) of five residents sampled, who require assistance with self-administration of medication.

Findings Included:

During a medication pass observation conducted on for Resident #4, a note on the medication observation record (MOR) indicated that the resident's ordered fish oil was not available and had been on order since .

During a MOR review conducted on , the order for fish oil had been discontinued on .

In an interview with the Administrator conducted on at 4:10 PM, they confirmed that the order for fish oil had been discontinued on the and MORs and reappeared on the MOR. Documentation on the MOR revealed that Resident #4 was given the fish oil the first five days in and then the fish oil went on order.

During a medication pass observation conducted on the label for Resident #2's treatment did not match the MOR. The label on the box read "to be given as needed" and the MOR read "to be given every six hours."

During a MOR review conducted on , the MOR revealed that Resident #2 had an order for a scheduled treatment to be given every six hours and a treatment to be given as needed for . There was no documentation indicating if the facility clarified which

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order was to be followed, no direction for circumstances for use of "as needed" medications and no alert label indicating any changes to the label or MOR.

In an interview with the Administrator conducted on , they confirmed that the label on the box in the medication cart read "as needed" and did not match the order that the med tech was following, to be given every six hours.

Class III