STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967913	**01/23/2019**
NAME OF PROVIDER OR SUPPLIER **CAPE WEST**	STREET ADDRESS, CITY, STATE, ZIP CODE **4616-4614 SW 7 PL** **CAPE CORAL, FL 33914**	

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

0000 - Initial Comments

An unannounced monitoring visit was conducted on at Cape West, an assisted living facility (license #12694) in Cape Coral, Florida.

The following is description of the deficiencies.

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

Based on record review and interview, the facility failed to maintain written record of an illness resulting in medical attention for 1 (Resident #2) of 6 residents reviewed. This has the potential for residents with an illness needing medical attentions to not receive the care timely or have their physician or representative informed of the illness.

The findings included:

Record review for Resident #2 found she had an order dated for . The resident's record had no written record of why she needed the or how she came to receive the order.

On at 11:15 a.m., the facility manager said that on around noon, the resident was noticed to have a change in mental status and was sent to the hospital for evaluation. She said no written record was completed related to the incident.

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 ensure the appropriate assistance was provided for 1 (Resident #4) of 1 resident observed being assisted with their medication. The facility failed to ensure that 3 (Resident #1, #2, and #6) of 6 residents reviewed were competent to understand the need for and request the as needed medications. This has the potential for residents to experience adverse side effects from medications.

The findings included:

On at 12:15 p.m., Staff A was observed assisting Resident #4 with the self administration of her medications. He was observed removing the resident's pre-packaged medications from the cart. He

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opened the packages and poured the pills into a pill cup. He took them to the resident. He encouraged her to take them. He did not explain what pills they were. The resident was unable to get all of the medications out of the cup. One pill was observed falling from her to the floor. She was having a difficult time swallowing the pills. After she swallowed several times he handed her a cup of water and helped her drink it. She was able to swallow the remaining pills in her . He picked the pill up off the floor and deposed it with the packaging. He went to the cart and initialed all the morning medications as being taken. This included the pill that on the floor and was disposed.

A review of the Medication Observation Record (MOR) found all the morning pills were noted as taken. This included the pill the had been disposed and the medication ProMod a liquid protein that was not given.

Record review for Resident #1 found she has a medication order for to be taken at bed time if needed. A physician's record dated for Resident #1 said the resident is mentally

Record review for Resident #2 found she has an order for to be taken every 8 hours as needed. It did not says as needed for what. The MOR documented this medication is being given daily. It did not note at what time the medication is given. The resident's health assessment (1823) dated noted the resident has advanced .

Record review for Resident #6 found she has an order for to be taken as needed every 4 hours. It did not note what the medication is to be taken for. The MOR documented the resident is given the medication daily. It did not note why or at what time it is given.

On at 1:30 p.m., the facility manager said Resident #1, #2, and #6 are not competent to understand the need for their as needed medications or to be able to ask for them.

Class III

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

Based on record review, observation and interview the facility failed to ensure the Medication Observation Records (MORs) for 5 (Residents #1, #2, #4, #5, and #6) of 6 residents reviewed were accurate. This has the potential for severe adverse effects from medications.

The finding included:

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Resident #1's MOR documented she is receiving an as needed (PRN) medication daily. The record did not note why the medication is being given or at what time.

Resident #2's MOR documented she is receiving a PRN medication daily. The record did not note why the medication is being given or at what time. The record showed the resident received an order for an medication to be given three times a day for 7 days. The MOR documented the medication was given three times a day for 7 days plus two times a day for an additional 7 days.

Observation of Staff A assisting Resident #4 with her medication on at 12:00 p.m., found the medication was dropped on the floor and was not taken by the resident. The observation found Staff A did not assist the resident with an ordered liquid protein. Staff A was observed initialing on the MOR that both of these medications were taken.

Resident #5's MOR noted the resident is receiving a PRN medication daily. The MOR did not document why or at what time the medication is taken.

Resident #6 has an order for a patch to be applied once every 3 days. On at 1:20 p.m., the pharmacist said 10 patches were delivered on . The last patch should currently be in place on the resident. It was noted that one patch remained in the package of . The resident's MOR for did not document any patches being applied to the resident.

On at 1:30 p.m., the facility's manager said staff should be noting on the page of the MOR the time and reason for any PRN medications being provided to the residents. She said staff must have just continued to note on the MOR that the was being given to Resident #2. There were only 21 doses of the medication which when given 3 tines a day would last 7 days. She said staff are not noting on the MOR when they assist with Resident #6's patch

Class III

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

Based on record review and interview the facility failed to ensure that as needed (PRN) medications had the circumstances under which it would be appropriate for the resident to request the medication and any limitations for 4 (Residents #1, #2, #3, and #6) of 6 residents reviewed. They failed to ensure 1 (Resident #2) of 6 residents had a medication order filled timely. They failed to ensure 1 (Resident#4) of 6 residents had a physician's order before changing the direction for using a medication. This has the

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potential for residents to experience adverse effects of the medication regiments.

The findings included:

Record review for Resident #1 found she had a medication for to be taken at bed time if needed. The order did not say needed for what.

Record review for Resident #2 found she has an order for to be taken every 8 hours as needed. It did not say as needed for what.

Record review for Resident #3 found he had an order for Sod 1% gel apply , , to three to four times daily, It was not noted where the gel is to be applied or why.

Record review for Resident #6 found she has an order for to be taken as needed every 4 hours. It did not note what the medication is to be taken for.

Record review found that Resident #2 had an order dated for an . The medication was documented as being first given on in the evening.

Record review for Resident #4 found she had an order for ProMod liquid protein.

On at 1:430 p.m., the facility's manager said the PRN medications for Resident #1, #2, #3, and #6 does not note circumstances under which it would be appropriate for the resident to request the medication and any limitations for them. She said Resident #2 went to the hospital at noon on . She returned later that day with the prescription for the . The 4th was a Friday. When she came in on Monday she had the order filled. Resident #4 has an order for the ProMod liquid protein. It was ordered as the resident had some skin issues. She does not have the skin problem now so she quit providing the liquid protein to the resident. She did not get an order from the physician to stop giving the liquid protein.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on observation, record review and interview, the facility failed to ensure staff assisting residents with self administration of medication received appropriate training for 1(Staff #A) of one staff reviewed. This has potential for residents not to be properly assisted in their self administration of medications.

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The findings included:

On at 12:15 p.m., Staff A was observed assisting Resident #4 with the self administrations of medication.

Record review for Staff A found the most current training for assisting with the self administrations of medications was completed on .

On at 12:30 p.m., the facility manger said Staff A has not had the required annual training on assisting with the self administrations of medications. The last training for Staff A was completed on .

Class III