STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967884	R 01/23/2019
NAME OF PROVIDER OR SUPPLIER **ORCHIDS HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **2960 MEADOWS OAKS DR S** **CLEARWATER, FL 33761**	

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

0000 - Initial Comments

Assisted Living Facility

A second revisit to a abbreviated biennial re-licensure survey with limited mental health (LMH) was conducted at Orchids Home on . Orchids Home had deficiencies at the time of the visit.

(License #11901)

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

Based on observation, record review, and interview, the facility failed to follow procedures for assistance with self-administration of medications as required under Section 429.256 Florida Statutes for four (Resident #1, Resident #2, Resident #3, and Resident #4) of four residents observed during a medication review.

Findings included:

A medication review was conducted on beginning at 7:36 AM with Staff A. Staff A was observed reviewing medication labels and medication observation records (MORs) for Resident #1, Resident #2, Resident #3, and Resident #4, popping each medication in to a cup at the medication cart, and immediately initialing the MORs, representing the medications as given. Staff A then brought the medications to the residents at a dining table in another room, rather than popping the pills from the original container in to a cup in front of the residents as required.

Staff A was observed assisting Resident #1, Resident #3, and Resident #4 with self-administration of their medications. Staff A attempted to assist Resident #2 with their medications by putting their medications in to a container of yogurt, explaining the medications, and spooning the medication/yogurt combination on to a spoon. Staff A asked Resident #2 to take hold of the spoon but the resident refused. Staff A then took the spoon with the medication/yogurt combination and fed it to Resident #2, without the resident assisting in the process.

The Administrator was interviewed at 9:32 AM on concerning Staff A not transferring medications from the containers in front of Resident #1, Resident #2, Resident #3, and Resident #4. The Administrator was also informed that Staff A fed medications to Resident #2 without their touching the spoon. The Administrator stated that Staff A was a home health aide and thought that they could administer medication. The Administrator acknowledged that Staff A was unlicensed personnel and was

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not qualified to administer medication to the facility's residents.

Class III

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

Based on observation, record review, and interview, the facility failed to maintain accurate medication observation records (MORs), signed immediately after medication was provided for four (Resident #1, Resident #2, Resident #3, and Resident #4) of four residents sampled.

Findings included:

A medication review was conducted on beginning at 7:36 AM with Staff A. Staff A was observed reviewing residents' MORs, reviewing residents' medication labels, transferring medication to plastic cups, then initialing the MORs, indicating that the residents' medication was already provided, prior to assisting residents with medication. Staff A was observed following these same steps when providing assistance with self-administered medication for Resident #1, Resident #2, Resident #3, and Resident #4.

The Administrator was interviewed at 9:32 AM on concerning observations that Staff A initialed MORs for Resident #1, Resident #2, Resident #3, and Resident #4 prior to assisting them with self-administration of medications.

Class III

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

Based on observation, record review, and interview, the facility failed to provide proof of a written medication order issued and signed by the resident's health care provider that showed a change in directions for a medication that the facility was providing assistance with self-administration for one (Resident #4) of four residents sampled.

Findings included:

A medication review was conducted on beginning at 7:36 AM with Staff A. A review of Resident #4's medication observation records (MORs) showed the medication Tab 30 MG, with the directions reading: Take 1 tablet by twice a day with lunch and supper from onwards. A review of the medication label showed the same instructions. Also included on the medication label

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packaging was a sticker that stated Morning and Bedtime. Staff A stated that the medication was to be given during the morning.

The Administrator was interviewed at 9:46 AM on concerning Resident #4's medication and the directions on the MORs and medication label indicating that the medication was to be provided with the lunch meal and supper meal, not the breakfast meal as observed. The Administrator did not provide any clarification or doctor's order showing a change in times for Resident #4's assistance with self-administration for their medication.

Class III

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

Based on observation, record review, and interview, the facility failed to follow procedures for assistance with self-administration of medications as required under Section 429.256 Florida Statutes for four (Resident #1, Resident #2, Resident #3, and Resident #4) of four residents observed during a medication review.

Findings included:

A medication review was conducted on beginning at 7:36 AM with Staff A. Staff A was observed reviewing medication labels and medication observation records (MORs) for Resident #1, Resident #2, Resident #3, and Resident #4, popping each medication in to a cup at the medication cart, and immediately initialing the MORs, representing the medications as given. Staff A then brought the medications to the residents at a dining table in another room, rather than popping the pills in to a cup in front of the residents as required.

Staff A was observed assisting Resident #1, Resident #3, and Resident #4 with self-administration of their medications. Staff A attempted to assist Resident #2 with their medications by putting their medications in to a container of yogurt, explaining the medications, and spooning the medication/yogurt combination on to a spoon. Staff A asked Resident #2 to take hold of the spoon but the resident refused. Staff A then took the spoon with the medication/yogurt combination and fed it to Resident #2, without the resident assisting in the process.

The Administrator was interviewed at 9:32 AM on concerning Staff A not transferring medications from the containers in front of Resident #1, Resident #2, Resident #3, and Resident #4. The Administrator was also informed that Staff A fed medications to Resident #2 without their touching the

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spoon. The Administrator stated that Staff A was a home health aide and thought that they could administer medication. The Administrator acknowledged that Staff A was unlicensed personnel and was not qualified to administer medication to the facility's residents.

Based on observation, record review, and interview, the facility failed to maintain accurate medication observation records (MORs), signed immediately after medication was provided for four (Resident #1, Resident #2, Resident #3, and Resident #4) of four residents sampled.

Findings included:

A medication review was conducted on beginning at 7:36 AM with Staff A. Staff A was observed reviewing residents' MORs, reviewing residents' medication labels, transferring medication to plastic cups, then initialing the MORs, indicating that the residents' medication was already provided. Staff A was observed following these same steps when providing assistance with self-administered medication for Resident #1, Resident #2, Resident #3, and Resident #4.

The Administrator was interviewed at 9:32 AM on concerning observations that Staff A initialed MORs for Resident #1, Resident #2, Resident #3, and Resident #4 prior to assisting them with self-administration of medications.

Due to uncorrected Class III deficiencies regarding medicinal drugs, the facility is required to employ the consultant services of a licensed pharmacist or a registered nurse.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation, interview and attempted record review, the facility failed to fully implement its emergency environmental control plan (EECP) by not storing a required amount of fuel on premises to run their alternate power source and not informing residents and responsible parties in writing of implementation of their EECP.

Findings included:

Observation of the facility during survey on beginning at 7:00 AM revealed no evidence of fuel on the premises for the facility's generator.

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The Administrator was interviewed on at 8:59 AM concerning implementing their EECP. The Administrator stated that they did not have any fuel on the premises to run their alternate power source in the event of an emergency.

Documentation of notification to residents and responsible parties was requested on . The Administrator stated that they had not yet notified residents or residents' responsible parties in writing that their EECP had been implemented.

Class III