STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963781	**02/26/2019**
NAME OF PROVIDER OR SUPPLIER **VILLAS OF CASA CELESTE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **9225 82ND AVENUE NORTH SEMINOLE, FL 33777**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

Assisted Living Facility

A Complaint Survey (CCR#: 2010000958 and 2019001733) was conducted at The Villas of Casa Celeste Assisted Living Facility on . The Villas of Casa Celeste Assisted Living Facility had deficient practice identified at the time of the survey.

(License#: 6681)

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review and interview, the Facility failed to ensure that one Resident (#8) of one sampled resident admitted to the Facility met the Facility's admission criteria for assistance with self-administration of medication versus requiring medication administration.

Findings Included:

A record review for Resident #8, conducted on , revealed that Resident #8's Health Assessment Form dated stated that the resident required medication administration. Resident #8's Medication Observation Records signed by the Facility's unlicensed Medication Technicians as assisting the resident with self-administration of medications.
Resident #8's , and , Medication Observation Records stated that the resident "Self-Administered" the prescribed medicated , Lotion 2.5%. There were no orders in resident #8's record that stated that the resident able to self-administer any medications. There were no orders or documentation in Resident #8's record that the Resident only required assistance with self-administration of medications or any assessment that Resident #8 was able to self-administer medications versus the administration of medications required on the health assessment. Resident #8 was admitted in to the Facility on .

During an interview with the Administrator, conducted on at 11:00am, the Administrator stated that only unlicensed Medication Technicians passed medications to residents and that the Wellness Director (a Licensed Practical Nurse) supervised the Medication Technicians and did not administer medications. At 05:35pm, the Administrator acknowledged and confirmed that Resident #8 was inappropriately admitted in to the Facility due to requiring medication administration and that the resident's Medication Observation Records was signed by the Facility's unlicensed Medication Technicians. The Administrator acknowledged and confirmed that Resident #8 was self-administering

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the prescription medicated cream 2.5% Cream to affected areas.

Class III

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

Based on observation, record review, and interview, the Facility failed to:
1. Provide care and services to meet the needs for assistance with medications and medication administration
2. Maintain a written record updated with resident illnesses and notifications to the Physician and Responsible Party
3. Maintain an awareness of resident's health, safety, and emotional well-being for twelve Residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12) of twelve sampled residents residing in the Facility.

Finding Included:

During an interview with the Administrator, conducted on at 11:00am, the Administrator stated that the Facility employed unlicensed Medication Technicians to pass medication and the Medication Technicians were supervised by the Wellness Director who was a Licensed Practical Nurse. The Administrator stated that both care staff and Medication Technicians assisted the residents at the facility by going from building to building via use of a golf cart.

During an observation of Staff A with Resident #10, conducted on at 11:24am, Staff A responded to the resident's complaints of concern about possibly having a for "over a week and no one told me that the doctor was here" by stating to Resident #10, "well the doctor left".

During an interview with Resident #10, conducted on at 01:00pm, Resident #10 stated that the resident missed a medication this morning and the Medication Technician still had not gotten the medication despite that the Medication Technician told the resident that the Medication Technician would get the medication. Resident #10 stated that the medication was out for two weeks. Resident #10 stated that, "the staff do not reorder medications until the medication card was empty". Resident #10 stated that the only time staff comes to check on the resident was for giving medications to the resident and that the "new are rude". Resident #10 stated that the resident had signs and symptoms of a "over two weeks ago" and that a laboratory test was ran and the Facility kept telling the resident that "they haven't heard anything". The Facility brought a new specimen cup "today and now they are telling me that the first was contaminated".

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A record review for Resident #10, conducted on , revealed that Resident #10's Health Assessment Form dated stated that the resident required assistance with self-administration of medications and assistance with ADLs ambulation, bathing, , and toileting. Resident #10 required daily oversight for wellbeing, whereabouts, and reminders for important tasks. Resident #10's progress notes dated indicated that the resident "complained [of] , , and " and "obtain for" with ," on . According to the record, the facility provided Resident #10 with a specimen cup on the date of survey.
Resident #10's Physician Notes dated stated that the "patient appears inappropriately managed with , " medication and medication adjustments made. Resident #10's MORs had medication not documented as given to the resident and medications circled as not given to the resident due to the unavailability of the medications, which included , , , , , , , and . There was no documentation, in the resident's record, that that Facility attempted to obtain the unavailable medications or that the resident's health care provider or Responsible Party were notified of the unavailable medication.

During an observation of Staff A with Resident #12, conducted on at 11:35am, Staff A responded to the resident's unavailability of the ordered medication and stated that, "we never received it". Resident #12's was ordered to start on .

During an interview with Resident #12, conducted on at 01:20pm, Resident #12 stated that the Facility "often" out of the medications that the resident needed and that medications "sometimes" given late. Resident #12 stated that staff were "short and don't stay long" and "only come in to give me my meds (medications)".

During an interview with Resident #5, conducted on at 01:45pm, Resident #5 stated that staff "have sneaky ways of revenge if you piss them off" and "we'll just leave it at that". Resident #5 stated that the resident suspected they had "a and they were supposed to collect a but they never did".

During an interview with Staff B, conducted on at 04:32pm, Staff B stated that the Facility "don't get new orders right away" and that the "new staff don't know the resident's routine(s)". Staff B stated that the Medication Technicians were responsible for the resident's medications, laundry, and assisting with needs.

During an interview with Staff C, conducted on at 04:45pm, Staff C stated that the Medication Technicians were responsible for the reordering of medications and checking the Villas (individual apartments) at the facility.

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During an interview with Staff D, conducted on at 05:00pm, Staff D stated that, "sometimes it's happening" that the resident's medication run out. Staff D stated that the "new staff need to learn [and] they have a lot to learn [and that with the] new staff, it's a lot more difficult to give medicine".

A record review for Resident #2, conducted on , revealed that Resident #2's Health Assessment Form dated stated that the resident required assistance with self-administration of medications. Resident #2's and MORs had medications not documented as given to the resident, which included , , , , , D, , and Lubricant , , . Resident #2's progress notes dated stated that the resident refused the prescribed medication "for days now" due to "a ache after taking it". There was no documentation that the Facility notified Resident #2's health care provider or Responsible Party of the adverse effect of the medication.

A record review for Resident #7, conducted on , revealed that Resident #7's Health Assessment Form dated stated that the resident required assistance with self-administration of medications, had an unsafe gait, and required supervision with ambulation and grooming and assistance with bathing, , and transferring. Resident #7's MORs had medications not documented as given to the resident and medications circled as not given to the resident, which included Lacutlose, , Flextouch , , , , and , . There were no recorded reading in the resident's record or documentation from a Third Party provider that Resident #7 received all and testing as ordered. Resident #7 required daily oversight for wellbeing, whereabouts, and reminders for important tasks. Resident #7 resided in a Villa or individual apartment. There was no documentation, in the resident's record, that that Facility attempted to obtain the unavailable medications or that the resident's health care provider or Responsible Party notified of the unavailable medication.

A record review for Resident #8, conducted on , revealed that Resident #8's Health Assessment Form dated stated that the resident required medication administration, along with supervision with bathing and grooming, assistance with , and required precautions. Resident #8 required daily oversight with wellbeing, whereabouts, and reminders for important tasks. There were no services offered or arranged to meet the resident's needs for medication administration. Resident #8's , and , MORs were signed by unlicensed Medication Technicians. Resident #8's MORs had medications not documented as given to the resident and circled as not given to the resident due to the unavailability of the medication, which included , , , , , and . Resident #8's MORs stated that the resident self-administered the medicated cream , . There was no documentation, in the resident's record, that that Facility attempted to obtain the

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unavailable medications or that the resident's health care provider or Responsible Party was notified of the unavailable medication.

A record review for Resident #12, conducted on , revealed that Resident #12's , MORs had medications not documented as given to the resident and medications circled as not given to the resident due to the unavailability of the medication, which included , . Resident #2's MORs stated that the resident self-administered medications, which included a patch. There was no documentation, in the resident's record, that that Facility attempted to obtain the unavailable medications or that the resident's Physician or Responsible Party notified of the unavailable medication. There was no assessment or Physician's orders indicating that Resident #12 was capable of self-administering medications.

A review of the Staffing Schedule, conducted on , revealed that the Facility had 582 staffing hours per week to meet the needs of 87 in-house residents, which included 80-hours per week for the Administrator and Wellness Director. There were only 502 staffing hours per week for direct care workers which included Resident Care Aides and Medication Technicians.

During an interview with the Wellness Director, conducted on at 05:34pm, the Wellness Director confirmed that Staff A did not relay information regarding the Facility not obtaining a specimen for Resident #10 and that Staff A did not relay the information that Resident #12's , medication unavailable.

During an interview with the Administrator, conducted on at 05:35pm, the Administrator acknowledged residents MORs with medications not documented as given to the residents and medications circled as not given to the residents. The Administrator confirmed that Resident #8 required medication administration and there was no nurse for administering the resident's medication. The Administrator confirmed that there was no documentation of communication efforts to resident's health care providers and Responsible Parties of the unavailable medications. The Administrator confirmed that that Resident #5 and Resident #10's records were not updated appropriately, when both residents had signs and symptoms of , and the delay in treatment.

Class III

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

Based on record review and interview, the Facility failed to update Medication Observation Records immediately at the time a medication offered or document the resident's refusal or the reason for the

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missed medication for 12 Residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12) of 12 sampled residents who required assistance with self-administration of medications.

Findings Included:

During an observation of the medication pass with Staff A for Resident #10, conducted on at 11:24am, Resident #10 stated that, "I didn't get my pill last night". Staff A did not respond to Resident #10's concern of missing last night's medication.

During an interview with Resident #10, conducted on at 01:00pm, Resident #10 stated that the Facility's only responsibility for the resident "is for my meds (medications)". Resident #10 stated that the Physician ordered two weeks ago and the Facility had not obtained the medication.

During an interview with Resident #12, conducted on at 01:20pm, Resident #12 stated that "sometimes meds (medications) not available".

During an interview with Staff B, conducted on at 04:32pm, Staff B stated that the Facility does not "get the new orders right away [and] we have a lot of new staff [and] the new staff don't know resident's routines.

During an interview with Staff D, conducted on at 05:00pm, Staff D stated that "sometimes it's happening" that residents do not have the medications that the need and that with the "new staff a lot more difficult to give medicine".

A record review for Resident #1, conducted on , Resident #1's Health Assessment Form dated indicated that the resident required assistance with self-administration of medications.
Resident #1's Medication Observation Records (MORs) had medications not documented as given, which included the resident's prescribed:
- Lubricant , , 0.4%-0.3% Solution instill two drops in each , twice ever day not documented as given on and at 04:00pm
- Ensure Liquid Vanilla Shake dietary supplement drink one can by three time every day not documented as given from at 08:00am through at 08:00am and stated self-administers
The of Resident #1's MORs had no reason documented that the resident did not receive the medications. There were no orders to hold the medications in Resident #1's record. There were no orders or assessments that Resident #1 capable of self-administering medications.

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A record review for Resident #2, conducted on , Resident #2's Health Assessment Form dated indicated that the resident required assistance with self-administration of medications. Resident #2's , MORs had medications not documented as given. The of Resident #2's MORs had no reason documented that the resident did not receive the medications. There were no orders to hold the medications in Resident #2's record. Resident #2's , MORs had medications not documented as given, which included the resident's prescribed:
- , 81mg tablets take one tablet by every day and not documented as given on at 08:00am
- , 10mg tablets take one tablet by every day and not documented as given on at 08:00am
- 8.6mg tablets take one tablet by every day and not documented as given on at 08:00am
- D 1000 unit tablets take two tablets by every day and not documented as given on 08:00am
- Lubricant , , 0.4%-0.3% instill one drop in each , four time every day and not documented as given on at 12:00pm, at 08:00pm, and and at 12:00pm

A record review for Resident #3, conducted on , Resident #3's Health Assessment Form dated stated that the resident required assistance with self-administration of medications. Resident #3's , MORs had medication not documented as given. Resident #3's , MORs had medications not documented as given, which included the resident's prescribed:
- Spray 200/ACT one spray in alternating nostrils every day and not documented as given from at 06:00am through at 06:00am and stated self-administers; there was no indication on the Resident #3's in regards to alter alternating nostrils
The of Resident #3's MORs had no reason documented that the resident did not receive the medications. There were no orders to hold the medications in Resident #3's record. There were no orders or assessments that Resident #3 capable of self-administering medications

A record review for Resident #4, conducted on , Resident #4's Health Assessment Form dated stated that the resident required assistance with self-administration of medications. Resident #4's , MORs had medications not documented as given. The of Resident #4's MORs had no reason documented that the resident did not receive the medications. There were no orders to hold the medications in Resident #4's record.

A record review for Resident #5, conducted on , Resident #5's Health Assessment Form dated stated that the resident required assistance with self-administration of medications. The Health Assessment Form was not the required form. Resident #5's , MORs had

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medications not documented as given. Resident #5's MORS had medications not documented as given, which included the resident's prescribed:
- 80mg tablets take one-half tablet by at bedtime not documented as given on at 08:00pm
- Extended Release 500mg tablets take two tablets by at bedtime not documented as given on at 08:00pm
- 300mg tablets take one-half tablet by at bedtime not documented as given on at 08:00pm

The of Resident #5's MORs had no reason documented that the resident did not receive the medications. There were no orders to hold the medications in Resident #5's record.

A record review for Resident #6, conducted on , Resident #6's Health Assessment Form dated stated that the resident required assistance with self-administration of medications. Resident #6's MORs had medications not documented as given, which included the resident's prescribed:
- 0.005% Solution instill one drop in each at bedtime not documented from through at 08:00pm and stated and stated self-administers

The of Resident #61's MORs had no reason documented that the resident did not receive the medications. There were no orders to hold the medications in Resident #6's record. There were no orders or assessments that Resident #6 capable of self-administering medications.

A record review for Resident #7, conducted on , Resident #7's Health Assessment Form dated /1 stated that the resident required assistance with self-administration of medications. Resident #7's MORs had medications not documented as given, which included the resident's prescribed:
- 25mg tablets take one tablet by every day and not documented as given on and at 08:00am
- 5mg tablets take one tablet by every day and not documented as given on at 08:00am

The of Resident #7's MORs had no reason documented that the resident did not receive the medications. There were no orders to hold the medications in Resident #7's record.

A record review for Resident #8, conducted on , Resident #8's Health Assessment Form dated stated that the resident required medication administration. Resident #8's MORs had medication not documented as given, which included:
- Lotion 2.5% Cream to affected areas: apply moderate amount twice every day not documented as given from through and stated self-administers

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Resident #8's MORs had medications not documented as given, which included the resident's prescribed:
- Lotion 2.5% Cream to affected area: apply moderate amount , twice daily and not documented as given from at 06:00am through at 06:00am and stated self-admininsters
- 2mg/ml Concentrate give 1ml (2mg) by three time every day and not documented as given on , , , , and at 12:00pm

The of Resident #8's MORs had no reason documented that the resident did not receive the medications. There were no orders to hold the medications in Resident #8's record. There were no orders or assessments that Resident #8 capable of self-administering medications.

A record review for Resident #9, conducted on , Resident #9's Health Assessment Form dated stated that the resident required assistance with self-administration of medications. Resident #9's had medications not documented as given, which included the resident's prescribed , 20mg, 1mg, and , 40mg not documented as given on at 08:00am. The of Resident #9's MORs had no reason documented that the resident did not receive the medications. There were no orders to hold the medications in Resident #9's record.

A record review for Resident #10, conducted on , Resident #10's Health Assessment Form dated stated that the resident required assistance with self-administration of medications. Resident #10's MORs had medications not documented as given, which included the resident's prescribed:
- , 25mg tablets take one tablet by at bedtime and not documented as given on and at 08:00pm and circled as not given from at 08:00pm through at 08:00pm
- 20mg tablets take one tablet by every day at bedtime and not documented as given on at 08:00pm; of MORs on at 08:00pm stated Elavil 25mg on reorder
- 100mg tablets take one tablet by every day at bedtime and not documented as given on at 08:00pm
- 0.5mg tablets take one tablet by three times every day and not documented as given on at 12:00pm and 04:00pm
- 5mg tablets take one tablet by every day and not documented as given on at 08:00am
- 20mg tablets take one tablet by twice every for four days (at 08:00am through at 05:00pm) and not documented as given on at 08:00am and 05:00pm and at 05:00pm
- 20mg tablets take one tablet by every day starting at 08:00am and not

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documented on at 08:00am
The of Resident #10's MORs had no reason documented that the resident did not receive the medications. There were no orders to hold the medications in Resident #10's record.

A record review for Resident #11, conducted on , Resident # , MORs had medications not documented as given, which included the resident's prescribed:
- , 5mg tablets take one tablet by at bedtime not documented as given on , , and at 08:00pm
- , 25mg tablets take one tablet by twice every and day not documented as given on and at 04:00pm
The of Resident #11's MORs had no reason documented that the resident did not receive the medications. There were no orders to hold the medications in Resident #11's record.

A record review for Resident #12, conducted on , Resident #12's Health Assessment Form stated that the resident required assistance with self-administration of medications. Resident #12's , MORs had medications not documented as given, which included the resident's prescribed:
- 5% Patch apply three patches , , to skin every 12-hours apply in the morning and remove at bedtime not documented as given from at 08:00am through at 08:00am and stated self-administers
- 40mg tablets take one-half tablet by every day and not documented as given on
- , 10mg tablets take one tablet by every day and not documented as given on at 08:00pm
The of Resident #12's MORs had no reason documented that the resident did not receive the medications. There were no orders to hold the medications in Resident #12's record. There were no orders or assessments that Resident #12 capable of self-administering medications.

During an interview with the Administrator, conducted on at 11:00am, the Administrator stated the Facility hired unlicensed Medication Technicians to pass medications and that the Medication Technicians were supervised by the Wellness Director who was a Licensed Practical Nurse. At 05:35pm, the Administrator acknowledged and confirmed that Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12 had MORs with medications not documented as given.

During an interview with the Wellness Direction, conducted on at 05:15pm, the Wellness Director acknowledged and confirmed that Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, # 11, and #12 had MORs with medications not documented as given.

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Class III

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

Based on record review and interview, the Facility failed to ensure that prescription medication was filled or refilled in a timely manner and that medication ordered by a health care provider and laboratory orders were followed for seven Residents (#2, #3, #6, #7, #8, #10, and #12) of seven sampled Residents.

Findings Included:

During an observation of the medication pass with Staff A for Resident #10, conducted on at 11:24am, Resident #10 stated that, "I didn't get my pill last night". Staff A did not respond to Resident #10's concern of missing last night's medication.
At 11:35am, during observation of the medication pass, Resident #12 was missing prescribed medication 20mg. The medication was ordered to start on and was not available.

During an interview with Resident #10, conducted on at 01:00pm, Resident #10 stated that the Facility's only responsibility for the resident "is for my meds (medications)". Resident #10 stated that their health care provider ordered two weeks ago and the Facility had not obtained the medication.
A record review for Resident #10, conducted on , revealed that Resident #10 admitted in to the Facility on and had a Health Assessment Form dated that stated that the resident required assistance with self-administration of medications. Resident #10's MORs had medications circled as not available, which included the prescribed medications:
- 25mg tablets take one tablet by at bedtime and circled as not given from at 08:00pm through at 08:00pm

Resident #10's record had a Progress Note from a health care provider dated that stated that the resident "appears inappropriately managed with " and medication changes were made to the resident's prescribed to 5mg. There was no documented evidence that Resident #10's health care provider or Responsible Party was notified related to the prescribed medication not being available. The of Resident #10's MORs did not provide the dates, dates, times, and reasons for the prescribed unavailability. Resident #10 had a with ordered on for complaints of " and

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", The Facility failed to collect the before that date of survey and brought the collection cup to Resident #10 only after being questioned abou the resident's complaints.

During an interview with Resident #12, conducted on at 01:20pm, Resident #12 stated that "sometimes meds (medications) are not available".

During an interview with Staff B, conducted on at 04:32pm, Staff B stated that the Facility does not "get the new orders right away" [and] we have a lot of new staff [and] the new staff don't know resident's routines.

During an interview with Staff D, conducted on at 05:00pm, Staff D stated that "sometimes it's happening" that residents do not have the medications that they need and that with the "new staff it's a lot more difficult to give medicine".

A record review for Resident #3, conducted on , revealed that Resident #3 admitted in to the Facility on and had a Health Assessment Form dated that stated that the resident required assistance with self-administration of medications. Resident #3's and MORs had the medication circled as not given due to not available. Resident #3's , 80mg medication circled as not given from - . The medication specifically stated to take with food and the medication scheduled for 06:00am. There was no documented evidence of attempts to obtain the medication for Resident #3 in the resident's record. There was no documented evidence that Resident #3's Physician, Pharmacy, and Responsible Party notified that the resident was out of the medication. There were no orders found in Resident #3's record to hold or discontinue the medication due to the unavailability of the medication.

A record review for Resident #6, conducted on , revealed that Resident #6 was admitted in to the Facility on and had a Health Assessment Form dated that stated that the resident required assistance with self-administration of medications. Resident #6's , MORs had medications circled as not given, which included the prescribed medications:
- D 1000 unit tablets take two tablets by every day circled as not given from through due to not available
- , 400mg capsules take one capsule by three times every day circled as not given due to off premises on and at 12:00pm
There was no documented evidence that Resident #6's health care provider, Pharmacy, and Responsible Party were notified that the resident did not receive the aforementioned medication on the described dates and times. There were no orders found in Resident #6's record to hold or discontinue the medications found in the resident's record. The last communication effort documented was on

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	AL11963781	02/26/2019
NAME OF PROVIDER OR SUPPLIER **VILLAS OF CASA CELESTE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **9225 82ND AVENUE NORTH SEMINOLE, FL 33777**	

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

with a third party nurse.

A record review for Resident #7, conducted on , revealed that Resident #7 was admitted in to the Facility on and had a Health Assessment Form dated that stated that the resident required assistance with self-administration of medications. Resident #7's MORs had medications circled as not given, which included the prescribed medications:
- 10gram/15ml Solution take 15ml (10grams) by every day and circled as not given from at 08:00am through at 08:00am due to not available
There was no documented evidence of attempts to obtain the medication for Resident #7 in the resident's record. There was no documented evidence that Resident #7's Physician, Pharmacy, and Responsible Party notified that the resident was out of the medication. There were no orders found in Resident #7's record to hold or discontinue the medication due to the unavailability of the medication.

A record review for Resident #8, conducted on , revealed that Resident #8 was admitted in to the Facility on and had a Health Assessment Form dated that stated that the resident required medication administration. Resident #8's MORs had medications circled as not given, which included the prescribed medications:
- 5mg tablet take one tablet by every day circled not available from through and through
- 50mg tablets take one tablet by at bedtime circled not available from through
There was no documented evidence of attempts to obtain the medication for Resident #8 in the resident's record. There was no documented evidence that Resident #8's Physician, Pharmacy, and Responsible Party notified that the resident was out of the medication. There were no orders found in Resident #8's record to hold or discontinue the medication due to the unavailability of the medication.

A record review for Resident #12, conducted on , revealed that Resident #12's MORs had the prescribed medication 20mg circled as not given from through ; through ; and, not documented as given on .

During an interview with the Administrator at 05:35pm, the Administrator acknowledged and confirmed that Residents #2, #3, #6, #7, #8, #10, and #12 had MORs with medications not documented as given due to medications not available and that Resident #12 was currently out of .

During an interview with the Wellness Direction, conducted on at 05:15pm, the Wellness Director acknowledged and confirmed that Residents #2, #3, #6, #7, #8, #10, and #12 had MORs with

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medications not documented as given due to not available and refusals. The Wellness Director stated that the Facility had access to the Veteran's Affairs Pharmacy to access resident files for refills and that the Pharmacy of non-Veterans had a monthly cycle fill. At 05:34pm, the Wellness Director stated that Staff A never informed the Wellness Director that Resident #12 was out of the prescribed medication .

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the Facility failed to have documentation of annual negative ( ) examinations and a statement of freedom from communicable statements in the employee's records for three Staff (A, F, G) of four sampled staff.

Findings Included:

A record review for Staff A, conducted on , revealed that the last negative examination in the employee's record was dated . There was no statement from a Health Care Provider that Staff A was free from signs and symptoms of communicable . Staff A was hired at the Facility on .

A record review for Staff F, conducted on , revealed that the employee had no statement from a Health Care Provider that Staff F was free from signs and symptoms of communicable . Staff F was hired at the Facility on .

A record review for Staff G, conducted on , revealed that the last negative examination in the employee's record was dated . The only information documented on the form was the reading. There was no statement from a Health Care Provider that Staff G was free from signs and symptoms of communicable . Staff G was hired at the Facility on .

During an interview with the Administrator, conducted on at 05:35pm, the Administrator acknowledged and confirmed that Staff A and G's employee records were documentation of freedom from . The Administrator acknowledged and confirmed that Staff A, F, and G's employee records did not contain a one-time statement from a Health Care Provider that they were free from signs and symptoms of communicable .

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation, record review, and interview, the Facility failed to provide a safe living environment by failing to safely store and maintain portable tanks.

Findings Included:

A tour of the Facility, conducted on at 11:15am, revealed seven small portable tanks behind a door. The tanks were not in a secured storage rack or holder. The tanks were in the Wellness Director's office and the door was open with staff present, which included the Wellness Director. The office door remained open throughout survey and both staff and residents were in and out of the office.

A review of The National Fire and Protection Association (NFPA) and Occupational Safety and Health Administration standard for safe cylinder storage, conducted on , revealed that both agencies recommended that that "all freestanding cylinders must be stored in a rack, a cart, or another enclosure to protect them. Unsecured cylinders could , breaking the valve and possibly resulting in a rapid release of the gas, propelling the cylinder and turning it into a dangerous projectile."

During an interview with the Administrator, conducted on at 05:34pm, the Administrator acknowledged and confirmed seven small portable tanks in the Wellness Director's office were not in a secured storage rack or holder. The Administrator stated that, "a resident moved out and we found all of this in [the resident's] closet".

Class III