STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	**03/08/2019**
NAME OF PROVIDER OR SUPPLIER **LAMPLIGHT INN**	STREET ADDRESS, CITY, STATE, ZIP CODE **1896 PARK MEADOW DRIVE** **FORT MYERS, FL 33907**	

SUMMARY STATEMENT OF DEFICIENCIES
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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, the facility failed to ensure staff who had a break in service of 90 days or more completed a new background screening prior to beginning or returning to work for 3 (Administrator, Staff D, and S) of 10 staff records reviewed for background screening.

The findings included:

1. A review of the Administrator's personnel record revealed a background screening dated . The record showed a break in service from to , greater than 90 days.

2. A review of Med Tech Staff D's personnel record revealed a background screening dated . The record showed a break in service from to .

3. A review of Resident Aide Staff S's personnel record revealed a break in service from to , while Staff S had private sector jobs.

4. In an interview on at 12:45 p.m., the Administrator acknowledged her break in service.

In an interview on at 1:45 p.m., Business Manager Staff C said all personnel information was filed in the charts. A handfull of un-filed information was presented and filed in the charts that were being reviewed. Additiobnal background screening for the Administrator, Staff D, Staff N, or Staff S was not found.

Unclassified

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on record review and interview, the facility failed to ensure all staff completed a Attestation of Compliance with Background Screening Requirements for 1 (Staff W) of 10 staff reviewed for background screening compliance.

The findings included:

1. Personnel record review revealed Resident Aide Staff W had not signed the Attestation of Compliance with Background Screening Requirements (form #3100-0008) as required.

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2. On at 1:45 p.m., Business Manager Staff C said all personnel information was filed in the chart. A full of un-filed information was presented and filed in the charts being reviewed. An Attestation of Compliance for Resident Aide Staff W was not found.

Unclassified

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0000 - Initial Comments

An unannounced complaints survey CCR #2018017821, CCR #2019000934, CCR #2019001528, CCR #2019002603, CCR #2019002741, CCR #2019002833, CCR #2019003014 was completed on through at Lamplight Inn, an assisted living facility (license #5096) in Fort Myers, Florida.

Complaint # 2018017821 contained 2 allegations which were both substantiated without citation.
Complaint # 2019000934 contained 1 allegation which was substantiated.
Complaint # 2019001528 contained 3 allegations of which all were substantiated.
Complaint # 2019002603 contained 2 allegation of which both were substantiated.
Complaint # 2019002741 contained 3 allegations of which 3 were unsubstantiated.
Complaint # 2019002833 contained 1 allegation which was substantiated.
Complaint # 2019003014 contained 2 allegations of which 2 were substantiated.

On at 5:18 p.m. the Administrator and Corporate Nurse were notified of Class I deficiencies at A025, A030, A052, and A056.

The following is a description of the deficiencies.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review, staff and resident interview, the facility failed to issue a 45-day discharge notice to a resident with a pressure injury/ when the facility became aware of the having (tissue) for 1 (Resident #38) of 2 residents reviewed for pressure injury/ . Resident #38 no longer met the criteria for continued residency.

The findings included:

The National Advisory Panel (NPUAP) is a multidisciplinary group of experts in pressure injury and serves as the authoritative voice for improved patient outcomes in pressure injury prevention and treatment through public policy, education and research. The NPUAP defines a pressure injury as-full-thickness loss of skin, in which adipose (fat) is visible in the and tissue is often present. and/or eschar (scab) may be visible. The depth of tissue damage varies by anatomical location. (Source:
https://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/)

In an interview on at 2:30 p.m., Resident #38 said he had an area on his left a few months

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ago, but healed it up himself. Now he said he has an area on his right that he had been trying to take care of himself.

Review of Resident #38's record revealed on , the previous Director of Nursing (DON) noted the resident came to the nurses station to have his looked at. The resident reported he had on his for "about a week or so." She noted the resident had an open reddened area to right 2nd , and it looked like pressure from his shoe. The DON noted the resident had a soiled (with drainage) bandage in place that the resident said he put on himself.
On an initial assessment was done by the Home Health Registered Nurse (RN). The RN noted a pressure injury on Resident #38's right second as 1.2 centimeters (cm) by 1.2 cm in size and 0.2 cm in depth with "yellow stringy ". The RN noted she gave report given to the current DON and Licensed Practical Nurse Staff L.
A report on noted Resident #38's had increased in size to 2.3 cm (almost 1 inch) by 2.3 cm with 0.3 in depth.
On , the Advanced Registered Nurse Practitioner noted Resident #38's was reddened and ordered an and consult with the care center.

Observation on at 4:21 p.m., Home Health RN performed care on Resident #38' . A 1.5 cm by 1.5 cm, , full thickness with was noted on the top of the right second . The depth was not determined due to a crevice in the front part of bed near , of the . The RN said had been present in the crevice and confirmed was present during her initial assessment on .

In an interview on at 5:04 p.m., the Administrator said she was not aware Resident #38 had a pressure injury/ on his . She acknowledged she would be the one to issue him a discharge notice and confirmed this has not been done.

Photos on file.

Class II

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

Based on observation, record review, and staff interviews, the facility failed to ensure a safe environment to meet the resident's needs for 2 (Resident #7 and #49) of 3 residents reviewed in the Memory Care unit. The facility failed to address violent resident behaviors until after Resident #49 was injured. The facility failed to provide adequate supervision that lead to an alleged assault which sent Resident

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#7 to the emergency room for examination. The lack investigation, documentation, and in-servicing of key staff, allowed Resident #7 to remain with his abuser for 5 weeks after the reported assault. These systemic failures put these and other residents in imminent danger and may allow other residents to be injured in the same way.

The findings included:

1. Review of resident records noted Resident #49 was a female with , and Resident #50 was a male. Both residents resided on the memory care unit.

Review of Incident Report showed on Resident #50 severely injured Resident #49, after he pushed her to the floor and kicked her multiple time in the side and torso area. Staff ran to intervene and told him to stop, but he continued the assault. Resident #49 was sent to the emergency room (ER) and found to have a closed of her left .

Resident record review showed Resident #50 was admitted to the facility with the diagnoses including (a progressive breakdown of cells affecting movement, thinking, and behavior), , and . The Advanced Registered Nurse Practitioner (ARNP) visits noted the following:
On - resident has been having aggression lately, hitting staff and other residence. Resident was sent to ER due to violent behaviors.
On - resident was recently in hospital due to violent outburst, aggression. Resident went to hospital and was sent to facility. No changes to medication per facility. Resident having multiple issues with aggression. Today resident is impulsive, tremors.
On - resident was having violent outbursts and aggression lately, his dad wanted him sent to , but insurance was not accepted.
On - resident has been having violent outbursts and aggression lately, consulted to see patient, was apparently seen last week and she ordered Austedo [a drug to treat], but it was denied for coverage through insurance, facility called me, but I advised them to discuss with .
On - resident has been having violent outburst and aggression lately; history of and is very impulsive.
On - Resident still having aggression at times.
On - resident continues to have violent outburst and aggression. Currently facility asked me to see due to resident pushing another resident and she broke her arm. Resident seems aware of what he has been doing and informed me today that medication are not working. Advised that I will discuss with psych nurse practitioner and see what the best treatment plan for him will be. Medication changes made

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on (day after incident) was to discontinue resident , and start him on [2 , , medications].
On - resident been on new medication for 3 days and seems to be feeling better no issues with pushing or harming other residents. Modified medications again today. Increase , [a drug used to treat] to 500 mg twice a day.

Review of Resident #50's service notes included the following:
On memory care director was by the resident, he was swinging, hitting and cussing at her. She tried to redirect him three times with very little effect. Police were called and resident was taken to hospital.
On resident was observed attempting to hurt other resident when staff held him and went to get the administrator. When resident saw the administrator, he got a hold of her , after multiple attempts to disengage resident from the administrator's , -1 was called and resident sent to hospital.
On resident had altercation with his roommate on night shift, room change made.
On resident had an altercation with physical behavior towards another resident this afternoon with which the other resident sustained a arm.

In a phone interview on at 8:20 a.m., Med Tech/Caregiver Staff X reported that she had work at the facility for 3 weeks in the memory care unit. She said that she only worked on Sundays p.m.. She said she observed 3 different incidents while she was on duty and she reported each but was never given an incident report to write her statement. Staff X said on she saw a male resident push a female resident up against the wall and put his on her . The next Sunday I was on I saw the same man push a woman in the hall and hurt her arm the lady had to go to the hospital and came with her arm all bandaged up and I don't know if it was broken. She then said "I then quit because it was too much for me."

In an interview on at 8:30 a.m., Med Tech/Caregiver Staff U said she was aware of Resident #50's behaviors and knew that resident often got upset and agitated when he was not allowed to drink all he wanted from the juice machine. She said he was hard to redirect when he was upset and mad.

In an interview on at 8:40 a.m., Med Tech/Caregiver Staff Q said Resident #50 could become aggressive and violent when he did not get his way. She said, one time he chased her around the table in the dining room trying to get her because he was mad. She said she was scared and the other residents were trying to protect her. She said that she was on duty the day Resident #50 pushed Resident #49 and kicked her multiple times while she was on the floor. She reported this was not unusual for him.

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In an interview on at 8:50 a.m., Med Tech/Caregiver Staff V said she was aware of Resident #50's aggressive behavior. She said he has multiple staff and other residents. She said he wants to do what he wants to do and if you try to redirect him, he becomes violent. She said she was on duty the day Resident #50 pushed Resident #49 and he kicked her while she was on the floor.

In an interview on at 9:05 a.m. Memory Care Coordinator said Resident #50 was aggressive and violent at times. She said she was by the resident herself once, and it scared her. She acknowledged the resident has behaviors, he wants to do what he wants, and staff have to try to redirect him, but he gets mad. She said resident has had altercations with staff and residents, and once he had to be moved because he got in fight with his roommate. She confirmed the incident when Resident #50 got aggressive with the Administrator, grabbed her around the , and she had to try to pull him off her. The Memory Care Coordinator said she reported Resident #50's behaviors to Administrator, the Director of Nursing (DON), and the nurse every time.

In an interview on at 2:30 p.m., Licensed Practical Nurse (LPN) Staff L said she was aware of Resident #50's behavior and said she was the nurse who sent Resident #49 to the hospital after the altercation with Resident #50. She said Resident #50 had a history of aggressive behavior against staff and residents. She said she was unaware of any changes in his medication until after Resident #49 was hurt and her arm .

In an interview on at 3:30 p.m., the Administrator acknowledged she was aware of Resident #50's behaviors and confirmed that in one incident the resident had grabbed her around the and staff had to physically remove him from her. She said that the police were called and resident was taken to the hospital. She also acknowledged the resident remained in the memory care unit after this incident and no medication changes were made after this incident.

2. Review of resident records noted Resident #7 was a mute male with , and Resident #50 was a male. Both residents resided on the memory care unit. The records returned with resident from the ER documented that on Resident #7 was sent to the ER for examination after an alleged assault by bodily force by Resident #50. Resident #7 too remained on the memory care unit with his abuser for 5 weeks after the reported alleged assault. There was no evidence of staff training or interventions to ensure Resident #7's safety.

In a phone interview on at 8:20 a.m., Med Tech/Caregiver Staff X reported she had worked at the facility for 3 weeks in the memory care unit. She said that she only worked on Sundays p.m.. She said she observed 3 different incidents while on duty and reported each but was never given an incident

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report to write her statement. The first time she worked on , she came into a room and found two men naked in the room, one man was on his in front of the other man and it looked like he was going to do oral on the other man. She yelled, because she did not know their names at that time, because she was just hired, and then the other staff member came in and said, "Oh that's Resident #50, he is gay." The next time she was on, , she saw a male resident push a female resident up against the wall and put his on her . "The next Sunday I was on I saw the same man push a woman in the hall and hurt her arm. The lady had to go to the hospital and came with her arm all bandaged up, and I don't know if it was broken.

In an interview on at 9:20 a.m., the Memory Care Coordinator said she was aware of the 2 incidents that happened in her unit. She said she was made aware of a resident-to-resident interaction between Resident #7 and a Resident #50 that was of the nature. She said that Administrator told her she had gotten a call about an alleged event that happened. The Memory Care Coordinator said they sent Resident #7 to the ER to have him checked out to see if he had any evidence of damage of a nature. She was unaware if any incident report was filled out on the incident or if it was investigated. She said Resident #50 remained on the unit after that even though they knew Resident #50 was gay and would always follow Resident #7 around. She said she tried to keep an on Resident #50 to make sure he did not go after Resident #7. She said that Resident #7 does not speak so he is unable to tell what is happening.

Review of the Agency's Incident Reporting System (AIRS) revealed as of the survey date, no AIRS report was filed with the state agency related to the assault of Resident #7.

In an interview on at 2:35 p.m., LPN Staff L said she overheard other staff say Resident #50 had been in Resident #7's room at night. She overheard the night shift laughing about it. She asked them what was so funny about that. LPN Staff L said it was known by staff that Resident #50 was gay, he told people that.

In an interview on at 8:30 a.m., Staff U, Med tech/caregiver on memory care unit, said she had only work there for a month but she knew about Resident #50 liking Resident #7 and he was seen going into his room.

In an interview on at 8:40 a.m., Med Tech/Caregiver Staff Q said she was aware of Resident #7 going to the hospital after an incident with Resident #50. She said Resident #50 liked Resident #7 and acknowledged this was not allowed because Resident #7 could not talk and he did not want Resident #50 by him; he would push Resident #50 out of his room when he tried to come in. Staff Q said Resident #7 did not like males in his room. He would get upset and his would shake.

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In an interview on at 8:58 a.m., Med Tech/Caregiver Staff V said that she saw Resident #50 coming out of Resident #7's room before. Once she came in Resident #7's room and saw Resident #50 in his bed. Resident #50 told her more than once that Resident #7 was his boyfriend, and she said she told him that is not true and he should not say that.

In an interview on at 5:30 p.m., Administrator acknowledged there was an incident involving Resident #7 in early . She said she got a phone call from the previous DON and from an employee who told her about a possible incident involving Resident #7. The Administrator said she went to the memory care unit and told them to send Resident #7 to the ER to be checked over from to to see that he was ok. She said the incident had something to do with Resident #7 being touched inappropriately by Resident #50. The Administrator said the previous DON told her it happened that day about 2 or 3 in the afternoon. The Administrator said that she did not have an incident report or investigation. The Administrator acknowledged she did not report it to the Hot Line or file a one-day report for Resident #7 being transferred to the hospital for a possible assault. She acknowledged she had not investigated the incident because the DON did everything. The Administrator looked through the incident reports and could not find any report or documentation. She said the previous DON may have taken it with her when she left. The Administrator said she notified the doctor and had an order to transfer to the hospital but could not find the order. The Administrator denied knowledge of other incidents of the nature between these two residents. She admitted not interviewing the staff in the memory care about Resident #50 stalking Resident #7 or meeting with staff about keeping the two residents apart while in the same unit.

In a phone interview on at 10:15 a.m., the sister and power of attorney for Resident #7 said that the Administrator had called her about an incident in the beginning of . She said the Administrator told her a caregiver may have touched her brother inappropriately and she sent him to the hospital to get checked out. She said the Administrator said the ER reported Resident #7 was ok, and that was it. The sister said she was not aware of anything else or that it involved another resident. She repeated the Administrator said it was a caregiver.

In a phone interview on at 11:15 a.m., the prior DON said she remembered in early , when she was off, the Administrator called and told her about a call that came in to the corporate office regarding an allegation of misconduct between Resident #50 and Resident #7. The Administrator told her she was sending Resident #7 to the hospital to get looked over. The prior DON said that when she got to work, she looked at the ER report and noticed it said that it was assault by bodily force by caregiver. She said that she brought this to the Administrator's attention that it was wrong and it was a incident between residents. The prior DON said that she was not involved at all, the

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Administrator did everything and it was between the Administrator and corporate office. She said the Administrator told her told her corporate told her what to do about the situation.

In an interview on at 12:45 p.m., the Administrator now said that she had forgotten that she had done the incident report after the incident between Resident #50 and #7. She said she found the incident report in a box of papers in the DON's office. The Administrator now said she was informed of the incident by the prior DON who called her and told her she had received an anonymous call about it.

Class I

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on record review, resident and staff interview, the facility failed to provide adequate and appropriate health care for 2 (Resident #37 and #16) of 3 residents reviewed for medications. Resident #37 did not receive her medications as ordered from through As a result the resident had a on requiring extended hospitalization. Resident #16 had history of and did not receive her medications as ordered and was hospitalized.
The facility failed to protect 2 (Resident #15 and #51) of 2 residents observed for assistance from potential exposure to borne when assisting with obtaining samples.
The facility failed to protect from physical and assaults, 2 (Resident #49 and #7) of 3 residents reviewed on the secured unit.
The facility failed to protect 2 (Residents #44 and #46) of 2 residents from restriction to a secured unit without assessment or documentation of legal authority for the residents.
The facility failed to assist 1 (Resident #44) when her glasses were lost.
These failures to implement systemic approaches to ensure a safe environment places all residents in imminent danger of neglect or loss of personal rights.

The findings include;

1. In an interview on at 9:35 a.m., Resident #37 said on she had a (a that causes a loss of and violent) in the bathroom. She was on floor "for hours" before someone found her. Resident #37 said the hospital increased her medications because they wanted her level up but she had no issues with before on previous dose. Resident #37 said they were out of her medication for 3 to 4 days before and that was reason she had a . The resident said she kept asking staff every morning if they had gotten her medication in yet.

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Review of Resident #37's record revealed a diagnosis of , , , and recurrent . On the physician ordered , , (an medication) 500 milligrams (mg) twice a day. The Residents Medication Observation Record (MOR) for , indicated the resident did not receive her 8:00 a.m. dose of , , on . The MOR was circled as not being given. The 4 p.m. dose was initialed as being given. On , , and the MOR showed , , was circled as not given for a total of 7 missed doses. A nursing note on at 8:30 a.m. indicated the "Resident was observed on the bathroom floor with multiple ones in 5 minutes", -1 called and "while there she has 2 more .", then was transported to the hospital.

Hospital records revealed Resident #37 was admitted on for , was nonverbal, arousable to painful stimuli, and had a hematoma (a solid ˘ of clotted) on the right forehead. After admission, the physician was notified the resident began actively ˘ and , , was administered , (into the). The physician noted critical care was required due to the high probability of sudden, clinically significant deterioration in the patient's condition and required the highest level of preparedness to intervene urgently. Services provided were to treat and clinically prevent significant deterioration that could result in . The final admitting diagnosis was with hematoma of , , and . Resident #37 was intubated (tube inserted into airway for placement on a) and admitted to ( ). While in , she was started on a ˘ and treated with for possible , , . The resident's symptoms improved and the ˘ was removed. On , Resident #37 was discharged to a skilled nursing facility.

Resident #37's record showed she returned to the facility more than a month later on .

In an interview on at 1:20 p.m., the Pharmacy Technician said Resident #37's family member called him and was upset saying the pharmacy let his sister run out of her medication. The Pharmacy Technician told him they send 30-day supply, she should have had plenty, and were never notified she ran out. The pharmacy would have sent meds to cover until the next 30-day supply. He sent run sheets to Resident #37's brother to prove the facility should have had plenty of medication on . The delivery log was reviewed and verified sufficient supply had been provided by the pharmacy well in advance of when the resident would have run out of her medication. Sixty tabs of , , were delivered on . Resident #37 was due to run out on and had enough medication to last until . The pharmacy delivery receipt was signed by previous Director of Nursing (DON).

In an interview on at 2:35 p.m., Licensed Practical Nurse (LPN) Staff L said she was called to Resident #37's room by staff on the morning of and saw the resident laying on the floor. LPN Staff L told staff not to touch her and called -1. The resident's brother called right after that and said

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the had not been given was reason for her . LPN Staff L said the pharmacy was good about bringing medication right away and usually send a 30-day supply. She said staff never made her aware of the not being available to give to the resident.

In an interview on at 10:30 a.m., Medication Technician Staff M said she noted on the morning of that Resident #37 was out of her medication . She said the medication was not available and she circled the MOR as not being given. Staff M said she told the nurse and also the previous DON. Staff M said she mentioned it more than once as she was concerned over this as resident needed her medication.

In an interview on at 10:49 a.m., Advanced Registered Nurse Practitioner (ARNP) said he was the clinician for Resident #37 and was not aware she had been without her for several days prior to her having a . He said Resident #37 was very aware of her medications and would be able to say if she got them or not. The ARNP said Resident #37 has a low threshold for and without her medication, she could have an which may lead to . He said after 24 hours 87% of the medication would be out of her system is why he orders it to be given twice a day. The ARNP confirmed he was never contacted by facility staff to alert him of the resident being without her medication.

2. Resident #16's record revealed on , the resident was observed with activity and -1 was called. The resident was admitted to the hospital and did not return until . On at 7:00 p.m., Resident #16 was again observed with , -1 was called and the resident was transported to the hospital. On the resident returned to the facility with an order to decrease the , (an medication) from 800 mg to 600 mg three times a day for and a new order for , (another medication) 50 mg twice daily for .
The MOR for showed the was circled as not given and they continued to give , 800 mg and not the 600 mg that was ordered.
In an interview on at 11:30 a.m., the providing Pharmacist said on new orders were received for Resident #16. The was decreased to 600 mg and a 30-day supply of the new dosage was sent to the facility. A new order for was also received and on , the facility and the physician were notified of the need for pre-authorization to pay for the . The Pharmacist said she never heard anything from facility or the physician on this.

Hospital records for Resident #16 revealed she was admitted . The record noted Patient presents to the emergency department reporting status post two witnessed . Per staff, patient had a at lunch and another immediately prior to arrival. was called, as the duration of the was longer than usual. She was discharged to the facility . Discharge instructions

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included to stop , , take , 600 mg 3 times daily, and start (carbamazene) 200 mg 3 times daily.

The MOR for , showed the was circled as not given, and they continued to give , 800 mg and not the 600 mg that was ordered. The MOR for indicated , 600 mg but no indication the resident received the noon dose on and . On , the , was rewritten for 800 mg three times a day and a dose given at 5:00 p.m.

In an interview on at 2:30 p.m., the Director of Nursing (DON) said she was approached by a med tech on about Resident #16's MOR indicating , 600 mg but the medication label was for 800 mg. The DON said she changed the MOR but was unable to locate a physician's order for the dose being changed to 800 mg. The DON did not contact the pharmacy or resident's physician for clarification.

In an interview on at 8:36 a.m., Resident #16 said she had concerns with not getting her medication and missed 2 doses over the weekend. She did not want to go to the hospital again and told the Administrator about it on .
In an interview on at 2:30 p.m., the DON said Resident #16 reported on , she had not been getting her medication on time. The DON said she was unaware of the missed doses on and .
3. Observation on at 4:20 p.m., Med Tech Staff Y prepared to perform monitoring for Resident #51. Staff Y took the from the medication cart and placed a test strip into the machine. She took the lancing device, removed the end cap, placed a new lancet into the device, and replaced the end cap. She donned gloves, cleaned the resident's , and lanced it. She completed the process to wick a drop of on to the test strip in the and placed it on her medication cart. She informed the resident of the results. She removed the test strip from the , removed the end cap and lancet from the lancing device, and disposed of the test strip and used lancet in the sharps container. The was not after use.

Observation on at 4:30 p.m., Resident #15 came to the medication room right after the previous resident. Med Tech Staff Y again prepared to perform monitoring for Resident #15. Staff Y took the lancing device, placed a new lancet into the device, and placed the same used end cap on the device. She took the same (that had not been cleaned or sanitized) from the medication cart and placed a test strip into the machine. She donned gloves, cleaned the resident's , placed the lancing device against the and lanced it. She completed the process to wick a drop of on to the test strip in the and placed it on her medication cart. She informed the resident of the results. The was not after use.

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In an interview on at 4:38 p.m., Med Tech Staff Y explained she used the same lancing device for the all the residents who have monitoring. She said that they just change the lancet inside. She was unaware the must be between residents and an end cap should not be used for more than one resident.

In an interview on at 4:40 p.m., Licensed Practical Nurse (LPN) Staff L said she unaware the must be between residents and an end cap should not be used for more than one resident.

In an interview on at 4:41 p.m., DON said she was unaware the must be between residents and an end cap should not be used for more than one resident.

4. Review of resident records noted Resident #49 was a female with , and Resident #50 was a male. Both residents resided on the memory care unit. Review of Incident Report showed on Resident #50 severely injured Resident #49, after he pushed her to the floor and kicked her multiple time in the side and torso area. Staff ran to intervene and told him to stop, but he continued the assault. Resident #49 was sent to the emergency room (ER) and found to have a closed of her left .

Resident record review showed Resident #50 was admitted to the facility with the diagnoses including (a progressive breakdown of cells affecting movement, thinking, and behavior), , and . The Advanced Registered Nurse Practitioner (ARNP) visits noted the following:
On - resident has been having aggression lately, hitting staff and other residence. Resident was sent to ER due to violent behaviors.
On - resident was recently in hospital due to violent outburst, aggression. Resident went to hospital and was sent to facility. No changes to medication per facility. Resident having multiple issues with aggression. Today resident is impulsive, tremors.
On - resident was having violent outbursts and aggression lately, his dad wanted him sent to , but insurance was not accepted.
On - resident has been having violent outbursts and aggression lately, consulted to see patient, was apparently seen last week and she ordered Austedo [a drug to treat], but it was denied for coverage through insurance, facility called me, but I advised them to discuss with .
On - resident has been having violent outburst and aggression lately; history of and is very impulsive.

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On - Resident still having aggression at times.
On - resident continues to have violent outburst and aggression. Currently facility asked me to see due to resident pushing another resident and she broke her arm. Resident seems aware of what he has been doing and informed me today that medication are not working. Advised that I will discuss with psych nurse practitioner and see what the best treatment plan for him will be. Medication changes made on (day after incident) was to discontinue resident and start him on [2 medications].
On - resident been on new medication for 3 days and seems to be feeling better no issues with pushing or harming other residents. Modified medications again today. Increase [a drug used to treat] to 500 mg twice a day.

Review of Resident #50's service notes included the following:
On memory care director was by the resident, he was swinging, hitting and cussing at her. She tried to redirect him three times with very little effect. Police were called and resident was taken to hospital.
On resident was observed attempting to hurt other resident when staff held him and went to get the administrator. When resident saw the administrator, he got a hold of her , after multiple attempts to disengage resident from the administrator's -1 was called and resident sent to hospital.
On resident had altercation with his roommate on night shift, room change made.
On resident had an altercation with physical behavior towards another resident this afternoon with which the other resident sustained a arm.

In an interview on at 8:30 a.m., Med Tech/Caregiver Staff U said she was aware of Resident #50's behaviors and knew that resident often got upset and agitated when he was not allowed to drink all he wanted from the juice machine. She said he was hard to redirect when he was upset and mad.

In an interview on at 8:40 a.m., Med Tech/Caregiver Staff Q said Resident #50 could become aggressive and violent when he did not get his way. She said, one time he chased her around the table in the dining room trying to get her because he was mad. She said she was scared and the other residents were trying to protect her. She said that she was on duty the day Resident #50 pushed Resident #49 and kicked her multiple times while she was on the floor. She reported this was not unusual for him.

In an interview on at 8:50 a.m., Med Tech/Caregiver Staff V said she was aware of Resident #50's aggressive behavior. She said he has multiple staff and other residents. She said he wants to do what he wants to do and if you try to redirect him, he becomes violent. She said she was on duty the

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day Resident #50 pushed Resident #49 and he kicked her while she was on the floor.

In an interview on at 9:05 a.m. Memory Care Coordinator said Resident #50 was aggressive and violent at times. She said she was by the resident herself once, and it scared her. She acknowledged the resident has behaviors, he wants to do what he wants, and staff have to try to redirect him, but he gets mad. She said resident has had altercations with staff and residents, and once he had to be moved because he got in fight with his roommate. She confirmed the incident when Resident #50 got aggressive with the Administrator, grabbed her around the , and she had to try to pull him off her. The Memory Care Coordinator said she reported Resident #50's behaviors to Administrator, the Director of Nursing (DON), and the nurse every time.

In an interview on at 2:30 p.m., Licensed Practical Nurse (LPN) Staff L said she was aware of Resident #50's behavior and said she was the nurse who sent Resident #49 to the hospital after the altercation with Resident #50. She said Resident #50 had a history of aggressive behavior against staff and residents. She said she was unaware of any changes in his medication until after Resident #4 9 was hurt and her arm .

In an interview on at 3:30 p.m., the Administrator acknowledged she was aware of Resident #50's behaviors and confirmed that in one incident the resident had grabbed her around the and staff had to physically remove him from her. She said that the police were called and resident was taken to the hospital. She also acknowledged the resident remained in the memory care unit after this incident and no medication changes were made after this incident.

5. Review of resident records noted Resident #7 was a mute male with , , and Resident #50 was a male. Both residents resided on the memory care unit. The records returned with resident from the ER documented that on Resident #7 was sent to the ER for examination after an alleged assault by bodily force by Resident #50. Resident #7 too remained on the memory care unit with his abuser for 5 weeks after the reported alleged assault. There was no evidence of staff training or interventions to ensure Resident #7's safety.

In a phone interview on at 8:20 a.m., Med Tech/Caregiver Staff X reported she had worked at the facility for 3 weeks in the Memory Care unit. She said that she only worked on Sundays p.m.. She said she observed 3 different incidents while on duty and reported each but was never given an incident report to write her statement. The first time she worked on , she came into a room and found two men naked in the room, one man was on his in front of the other man and it looked like he was going to do oral on the other man. She yelled because she did not know their names at that time because she was just hired. Then the other staff member came in and said, "Oh that's Resident

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#50, he is gay." The next time she was on, , she saw a male resident push a female resident up against the wall and put his on her . "The next Sunday I was on, I saw the same man push a woman in the hall and hurt her arm. The lady had to go to the hospital and came with her arm all bandaged up. I don't know if it was broken. I then quit because it was too much for me."

In an interview on at 9:20 a.m., the Memory Care Coordinator said she was aware of the 2 incidents that happened in her unit. She said she was made aware of a resident-to-resident interaction between Resident #7 and a Resident #50 that was of the nature. She said that Administrator told her she had gotten a call about an alleged event that happened. The Memory Care Coordinator said they sent Resident #7 to the ER to have him checked out to see if he had any evidence of damage of a nature. She was unaware if any incident report was filled out on the incident or if it was investigated. She said Resident #50 remained on the unit after that even though they knew Resident #50 was gay and would always follow Resident #7 around. She said she tried to keep an on Resident #50 to make sure he did not go after Resident #7. She said that Resident #7 does not speak so he is unable to tell what is happening.

In an interview on at 2:35 p.m., LPN Staff L said she overheard other staff say Resident #50 had been in Resident #7's room at night. She overheard the night shift laughing about it. She asked them what was so funny about that. LPN Staff L said it was known by staff that Resident #50 was gay, he told people that.

In an interview on at 8:30 a.m., Staff U, Med tech/caregiver on memory care unit, said she had only work there for a month but she knew about Resident #50 liking Resident #7 and he was seen going into Resident #7's room.

In an interview on at 8:40 a.m., Med Tech/Caregiver Staff Q said she was aware of Resident #7 going to the hospital after an incident with Resident #50. She said Resident #50 liked Resident #7 and acknowledged this was not allowed because Resident #7 could not talk and he did not want Resident #50 by him; he would push Resident #50 out of his room when he tried to come in. Staff Q said Resident #7 did not like males in his room. He would get upset and his would shake.

In an interview on at 8:58 a.m., Med Tech/Caregiver Staff V said that she saw Resident #50 coming out of Resident #7's room before. Once she came in Resident #7's room and saw Resident #50 in his bed. Resident #50 told her more than once that Resident #7 was his boyfriend, and she said she told him that is not true and he should not say that.

In an interview on at 5:30 p.m., Administrator acknowledged there was an incident involving

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Resident #7 in early . She said she got a phone call from the previous DON and from an employee who told her about a possible incident involving Resident #7. The Administrator said she went to the memory care unit and told them to send Resident #7 to the ER to be checked over from to to see that he was ok. She said the incident had something to do with Resident #7 being touched inappropriately by Resident #50. The Administrator said the previous DON told her it happened that day about 2 or 3 in the afternoon. The Administrator said that she did not have an incident report or investigation. The Administrator acknowledged she did not report it to the Hot Line or file a one-day report for Resident #7 being transferred to the hospital for a possible assault. She acknowledged she had not investigated the incident because the DON did everything. The Administrator looked through the incident reports and could not find any report or documentation. She said the previous DON may have taken it with her when she left. The Administrator said she notified the doctor and had an order to transfer to the hospital but could not find the order. The Administrator denied knowledge of other incidents of the nature between these two residents. She admitted not interviewing the staff in the memory care about Resident #50 stalking Resident #7 or meeting with staff about keeping the two residents apart while in the same unit.

In a phone interview on at 10:15 a.m., the sister and power of attorney for Resident #7 said that the Administrator had called her about an incident in the beginning of . She said the Administrator told her a caregiver may have touched her brother inappropriately and she sent him to the hospital to get checked out. She said the Administrator said the ER reported Resident #7 was ok, and that was it. The sister said she was not aware of anything else or that it involved another resident. She repeated the Administrator said it was a caregiver.

In a phone interview on at 11:15 a.m., the prior DON said she remembered in early , when she was off, the Administrator called and told her about a call that came in to the corporate office regarding an allegation of misconduct between Resident #50 and Resident #7. The Administrator told her she was sending Resident #7 to the hospital to get looked over. The prior DON said that when she got to work, she looked at the ER report and noticed it said that it was assault by bodily force by caregiver. She said that she brought this to the Administrator's attention that it was wrong and it was a incident between residents. The prior DON said that she was not involved at all, the Administrator did everything and it was between the Administrator and corporate office. She said the Administrator told her told her corporate told her what to do about the situation.

In an interview on at 12:45 p.m., the Administrator now said that she had forgotten that she had done the incident report after the incident between Resident #50 and #7. She said she found the incident report in a box of papers in the DON's office. The Administrator now said she was informed of the incident by the prior DON who called her and told her she had received an anonymous call about it.

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6. In an interview on at 1: 45 p.m., Resident #44 said she is locked in this unit and has not been off the unit, even for activities, since she was placed in the unit. She said she was moved to the unit because she was a "bad girl." Resident #44 said she would like to come off the unit sometimes and join the friends she has for activities, but she is not allowed out. Resident #44 said she told them where she wanted to go (down the to a bar/restaurant) but was told they felt she could not get there safely.

A review of Resident #44's record revealed she was relocated to the Memory Care unit on after she left the facility and wanted to visit with friends. She was brought to the facility and placed on the unit at 6:15 p.m. The record showed the resident signed herself into the facility on . She has no signed advance directives, power of attorney, or health care surrogate. She had no documentation of incapacity.

In an interview on at 2:39 a.m., the Administrator said the Memory Care residents do get to come off the unit for special activities several times a week. She also said Resident #44's son lives in Japan, and they contact him if they need permission for anything. She said the advanced directives were in the record. After looking, she said she did not realize the papers in the record had never been signed by the resident and were therefore not valid.

7. Records showed Resident #46 was admitted to the Memory Care unit on . She was signed in by her spouse. Her diagnoses included major , , generalized , and with behavioral disturbance. The record did not contain power of attorney, guardianship, or healthcare surrogate paperwork providing the right of placement to her husband.

In an interview on at 2:39 p.m., the Administrator said she though the paperwork for Resident #46's guardianship was in the record. She said she knew the husband had gone to court to be able to provide for his spouse. She reviewed the record, but found not paperwork.

8. In an interview on at 1: 45 p.m., Resident #44 said she lost her glasses. She thought they were here, but could not find them. She has looked everywhere. She is locked up so someone is going to have to help her get new glasses. During the interview the resident was observed wearing a pair glasses with tiger stripe pattern frames. She said this is a pair someone gave her that are close to her prescription, but are not hers.

In an interview on at 2:23 p.m., Med Tech Staff N said Resident #44 never gives her an problem. She is usually in her room or out in the common area. Whatever you ask her to do, she'll do it. Staff N said she asked the resident on Tuesday night about her glasses, but could not find them. Her glasses

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have red frames. Staff N said Resident #44 thought she put them in a shoe, but they were not in her shoes, dresser drawers, etc. She could not find them.

In an interview on at 1:50 p.m., the Administrator and Director of Nursing was told of the missing glasses. They immediately said Resident #44 is wearing glasses. When told those were not hers, the Administrator said they were, that Resident #44 was . She pulled the record and the photo within was not showing glasses. A look in the receptionist book found a picture of the resident wearing the red glasses. The Administrator acknowledged the red glasses in the photo. The Administrator dismissed the resident's concern about her glasses without investigating the lost or assisting to make an for new glasses.

Class I

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

Based on observation and interview, the facility failed to provide safe and sanitary assistance with self-administration of medication for 2 (Resident #51 and #15) of 2 residents observed for monitoring and . The facility put the resident at risk for by the use of devices for more than one person and not monitoring devices ( ). These systemic failures put resident at risk for exposure to borne , such as , ( ).

The findings included:

The Centers for and Control and Prevention (CDC) guidance regarding monitoring includes the following:
If reusable devices are used for assisted monitoring of then they should be treated in a manner similar to other personal care items (e.g., razors and toothbrushes) and must never be shared. Facilities must take steps to assure that devices are clearly labeled and stored in a manner to prevent inadvertent use for the wrong patient and cross-contamination from the surface of one device to another ...
Transmission of has been described in residential settings when individuals shared their personal monitoring equipment with friends or family ...
has been demonstrated to remain in dried on environmental surfaces for at least 7 days. For these reasons, meters should be cleaned and after each use, unless they are dedicated to a single patient and appropriately stored to prevent inadvertent contamination.

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Source: Frequently Asked Questions (FAQs) regarding Assisted Monitoring and Administration at https://www.cdc.gov/injectionsafety/providers/-monitoring_faqs.html

1. Observation on at 4:20 p.m., Med Tech Staff Y prepared to perform monitoring for Resident #51. Staff Y took the from the medication cart and placed a test strip into the machine. She took the lancing device, removed the end cap, placed a new lancet into the device, and replaced the end cap. She donned gloves, cleaned the resident's , and lanced it. She completed the process to wick a drop of on to the test strip in the and placed it on her medication cart. The indicated a reading of 118 and she informed the resident. She removed the test strip from the , removed the end cap and lancet from the lancing device, and disposed of the test strip and used lancet in the sharps container. Staff Y removed the resident's , from the med cart and dialed the pen to 10 units. She then stated the resident gets 10 units and showed the pen was dialed to 10 units. Staff Y handed the pen to the resident and she injected it into her lower abdomen. She then placed the into the cart and resident left. At the time of administration, the medication observation (MOR) record was not on the med cart Staff Y did not look at the MOR. The MOR remained closed on the counter. The was not after use.

Review of the order for Resident #51's order (on the MOR and prescription on the bag) directed the resident to have 13 units of . She received 3 units less than ordered. The package noted the , 's expiration date of .

2. Observation on at 4:30 p.m., Resident #15 came to the medication room right after the previous resident. Med Tech Staff Y again prepared to preform monitoring for Resident #15. Staff Y took the lancing device, placed a new lancet into the device, and placed the same used end cap on the device. She took the same (that had not been cleaned or sanitized) from the medication cart and placed a test strip into the machine. She donned gloves, cleaned the resident's , placed the lancing device against the and lanced it. She completed the process to wick a drop of on to the test strip in the and placed it on her medication cart. The indicated a reading of 274 and she informed the resident. Staff Y said he would be getting 4 units of . She proceeded to dial Resident #15's , up to 4 units and handed it to the resident. The resident injected it into his and handed the pen to Staff Y.

In an interview on at 4:38 p.m., Med Tech Staff Y explained she used the same lancing device for the all the residents who have monitoring. She said that they just change the lancet inside. She was unaware unlicensed staff should not do testing or dial , . She was

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unaware the ... must be ... between residents and an end cap should not be used for more than one resident. She acknowledged she set the wrong amount of ... for Resident #51 and realized she did not check the order on the MOR.

In an interview on ... at 4:40 p.m., Licensed Practical Nurse (LPN) Staff L said she was not aware unlicensed staff should not do ... testing or dial ... She said the lead med techs on day and evening shift have been doing them for a few days now. She said the pharmacy had taught them. LPN Staff L said she is the one who signs off on the ... and ... in the MOR. She said the med techs write the ... results on a piece of paper for her. LPN Staff L was unaware the ... must be ... between residents and an end cap should not be used for more than one resident.

In an interview on ... at 4:41 p.m., DON also said she was not aware unlicensed staff should not do ... testing or dial ... She was unaware the ... must be ... between residents and an end cap should not be used for more than one resident.

In an interview on ... at 5:10 p.m., Administrator said she was unaware unlicensed staff should not do ... testing or dial ... She said the state should send an e-mail or update when they decide not to do something. She said the pharmacy has been teaching the med techs how to do it so they must not be aware either.

Class I

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

Based on record review, resident and staff interview, the facility failed to ensure residents received medications as ordered for 3 (Resident #37, #16, and #41) of 3 residents sampled for medication refills. Resident #37 did not receive her ... medication as ordered for 4 days resulting in the resident having a ... on ... requiring extended hospitalization. The facility failed ensure Resident #16 received her ... medications as ordered and was hospitalized. The facility failed to ensure Resident #41 received a ... patch as ordered. These failures to implement systemic approaches to ensure appropriate medication places residents in imminent danger to their health.

The findings included:

1. In an interview on ... at 9:35 a.m., Resident #37 said on ... she had a ... (causes a loss of ... and violent ...) in the bathroom. She was on floor "for

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hours" before someone found her. Resident #37 said the hospital increased her medications as they wanted her level up, but she had no issues with before on previous dose. Resident #37 said they were out of her medication 3 to 4 days before she had a . The resident said she kept asking staff every morning if they had gotten her medication in yet.

Review of Resident #37's record revealed diagnoses of , , and recurrent . On the physician ordered , (an medication) 500 milligrams (mg) twice a day. The Medication Observation Record (MOR) for indicated the resident did not receive her 8:00 a.m. dose of , on . The MOR was circled as not being given. The 4 p.m. dose was initialed as being given. On , , and the MOR indicated the , was circled as not given for a total of 7 missed doses. A nursing note on at 8:30 a.m. indicated the "Resident was observed on the bathroom floor with multiple ones in 5 minutes", -1 called and "while there she has 2 more ", then was transported to the hospital.

Hospital records revealed Resident #37 was admitted on for , was nonverbal, arousable to painful stimuli, and had a hematoma (a solid of clotted) on the right forehead. After admission, the physician was notified the resident began actively and , was administered (into the). The physician noted critical care was required due to the high probability of sudden, clinically significant deterioration in the patient's condition and required the highest level of preparedness to intervene urgently. Services were provided to treat and clinically prevent significant deterioration that could result in . The final admitting diagnoses were with hematoma of , , and . Resident #37 was intubated (tube inserted into airway for placement on a) and admitted to ( ). While in , she was started on a and treated with for possible , , . The resident's symptoms improved and the was removed. On , Resident #37 was discharged to a skilled nursing facility.
Resident #37's record showed she returned to the facility more than a month later on .

In an interview on at 1:20 p.m., the Pharmacy Technician said Resident #37's family member called him and was upset saying the pharmacy let his sister run out of her medication. The Pharmacy Technician told him they send a 30-day supply, she should have had plenty, and were never notified she ran out. They would have sent meds to cover until next 30-day supply. The Pharmacy Technician sent run sheets to prove the facility should have had plenty of medication on . The delivery log verified sufficient supply had been provided by the pharmacy well in advance of when the resident would have run out of medication. Sixty tabs of , were delivered on . The resident was due to run out on and had enough medication to last until . The pharmacy delivery receipt was signed by previous Director of Nursing (DON).

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In an interview on at 2:35 p.m., Licensed Practical Nurse (LPN) Staff L said she was called to Resident #37's room by staff on the morning of and saw the resident laying on the floor. LPN Staff L told staff not to touch her and called -1. The resident's brother called right after that and said the reason for her was the , , had not been given. LPN Staff L said the pharmacy was good about bringing medication right away and usually send a 30-day supply. She said staff never made her aware the , , not being available to give to the resident.

In an interview on at 10:30 a.m., Med Tech Staff M said she noted on the morning of that Resident #37 was out of her medication , , . She said the medication was not available and she circled on the MOR as not being given. Staff M said she told the nurse and the previous DON. Staff M said she mentioned it more than once as she was concerned as this resident needed her medication.

In an interview on at 10:49 a.m., Advanced Registered Nurse Practitioner (ARNP) said he was the clinician for Resident #37 and was not aware she had been without her , , for several days prior to her having a . He said Resident #37 was very aware of her medications and would be able to say if she got them or not. The ARNP said Resident #37 has a low threshold for and without her medication, could have an which may lead to . He said after 24 hours 87 percent of the medication would be out of her system; that is why he orders it to be given twice a day. The ARNP confirmed he was never contacted by the facility staff to alert him of the resident being without her medication. He said he would have called the pharmacy himself if necessary.

2. Resident #16's record revealed on , the staff observed the resident with activity and called -1. The resident was admitted to the hospital and did not return until . On at 7:00 p.m., Resident #16 was again observed with , -1 was called and the resident was transported to the hospital. On the resident returned to the facility with an order to decrease the , (an medication) from 800 mg to 600 mg three times a day for and a new order for , (another medication) 50 mg twice daily for .
The MOR for showed the was circled as not given and they continued to give , 800 mg and not the 600 mg that was ordered.
In an interview on at 11:30 a.m., the providing Pharmacist said on new orders were received for Resident #16. The , was decreased to 600 mg and a 30-day supply of the new dosage was sent to the facility. A new order for , was also received and on , the facility and the physician were notified of the need for pre-authorization to pay for the , . The Pharmacist said she never heard anything from facility or the physician on this.

Hospital records for Resident #16 revealed she was admitted . The record noted Patient

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presents to the emergency department reporting status post two witnessed . Per staff, patient had a at lunch and another immediately prior to arrival. was called, as the duration of the was longer than usual. She was discharged to the facility . Discharge instructions included to stop , take , 600 mg 3 times daily, and start (carbamazene) 200 mg 3 times daily.

The MOR for showed the was circled as not given, and they continued to give 800 mg and not the 600 mg that was ordered. The MOR for indicated 600 mg but no indication the resident received the noon dose on and . On , the was rewritten for 800 mg three times a day and a dose given at 5:00 p.m.

In an interview on at 2:30 p.m., the Director of Nursing (DON) said she was approached by a med tech on about Resident #37's MOR indicating 600 mg but the medication label was for 800 mg. The DON said she changed the MOR but was unable to locate a physician's order for the dose being changed to 800 mg. The DON did not contact the pharmacy or resident's physician for clarification.

In an interview on at 8:36 a.m., Resident #16 said she had concerns with not getting her medication and missed 2 doses over the weekend. She did not want to go to the hospital again and told the Administrator about it on .
During the interview on at 2:30 p.m., the DON said Resident #16 reported on , she had not been getting her medication on time. The DON said she was unaware of the missed doses on and .

3. In an interview on at 2:50 p.m., Resident #41 said before coming to the facility she was on a patch for . She had found this was effective in controlling her upper , and arrived with a supply from the prior facility. When her supply ran out, the facility did not get the patch for her. Resident #41 said when she is having too much , she has to lie down or ask for a medication. She said the patches help her , and the oral , medication makes her sick so doesn't want to take it.

Resident #41's record revealed an order dated for patch daily for . The MOR indicated Resident #41 ran out of her supply on . On , Pharmacy notified facility and physician of need for pre-authorization on the patches. The MORs showed the patch as not being available nearly 2 months, from until .

In an interview on at 10:30 a.m., Med Tech Staff M said Resident #41 had patches

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when first admitted and when she ran out never got any from the pharmacy. The resident kept asking about them and she would let the nurse know. She told the nurses and DON about the patches not being available. Staff M said the resident doesn't like the , meds that were ordered for her and wants the patch as she says it relieves her . , .

Class I

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

Based on record review and interview, the facility failed to ensure, within 30 days after beginning employment, newly hired staff provided documentation from a health care practitioner that the individual did not have any signs or symptoms of communicable within 60 days pre-hire or 30 days post-hire for 13 (Staff D, N, O, P, Q, T, V, W, Z, AA, BB, CC, and DD) of 18 staff personnel files reviewed for communicable / statements. The required documents were falsified by photocopy or absent.

The findings included:

1. Personnel record review revealed Med Tech Staff D was hired on . A freedom from communicable statement was signed by the Advance Registered Nurse Practitioner (ARNP) on . The ARNP's signature, licence number, address and phone number exactly matched and appeared photocopied on Staff Q's, Staff N's, Staff W's, and Staff AA's when laid over each other.

Personnel record review revealed Resident Aide Staff Q was hired on . The photocopied statement was dated .

Personnel record review revealed Med Tech Staff N was hired on . The photocopied statement was dated .

Personnel record review revealed Resident Aide Staff W was hired on . The photocopied statement was dated .

Personnel record review revealed Med Tech Staff AA was hired on . The photocopied statement was dated . Staff AA's personnel record also contained blank photocopies of the communicable and the documents with the ARNP's signature and license number.

2. Personnel record review revealed Med Tech Staff P was hired on . A freedom from

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communicable statement was signed by the Advance Registered Nurse Practitioner (ARNP) on . The ARNP's signature, license number, address and phone number exactly matched and appeared photocopied on Staff V's when laid over each other.

Personnel record review revealed Resident Aide Staff V was hired on 11/23/18. The photocopied statement was dated .

3. Personnel record review revealed Med Tech Staff O was hired on . There was no freedom from communicable nor test in the personnel record.

4. Personnel record review revealed Resident Aide Staff T was hired on . There was no freedom from communicable nor test in the personnel record.

5. Personnel record review revealed Resident Aide Staff CC was hired on . There was no freedom from communicable nor test in the personnel record.

6. Personnel record review revealed Licensed Practical Nurse Staff Z was hired on . There was no freedom from communicable nor test in the personnel record.

7. Personnel record review revealed Med Tech Staff DD was hired on . There was no freedom from communicable nor test in the personnel record.

8. In an interview on at 10:49 a.m., the ARNP whose signature appeared on the form said he had no faith in any system in this facility. He said knowing about the forged signatures, so he does not trust anything signed here.
In a second interview, on at 9:06 a.m., the ARNP said the copied forms were found when a staff cleaned the Director of Nursing (DON) Office. When presented to him, he immediately shredded the forged copies. The ARNP said in another folder they found an orders for , , and , . Those forms had a different ARNP's signature copied on them. He said there were 5 copies of those forms which he also shredded. He said he would not trust anything with his signature on it in this facility since he saw the forged documents.

On at 12:45 p.m., the Administrator admitted she had heard last week there were forgeries. She said she made everyone come in and get a new tests. She said they started last week. The Administrator said a box was found in the DON's office which had forgeries in it, so she decided to do everyone again.

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Class III

0080 - Training - Core & Competency Test - 429.52( ) FS; 58A-5.0191(1) FAC

Based on record review and interview, the facility failed to ensure the Administrator obtained and maintained 12 hours of continuing education in topics related to assisted living every 2 years as required by Chapter 429.52 Florida Statutes:
"(c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years as provided under Section 429.52, F.S.
(d) .... An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must: 1. Retake the assisted living facility core training; and 2. Retake and pass the competency test."

The findings included:

1. Record review revealed the Administrator was hired on . Her resume showed under Education and Training, "State of Florida Dept. of Elder Affairs - Assisted Living CORE trained, and South Florida College - Marketing." It also showed she had worked in marketing for 2 skilled nursing facilities from to coming to work at the facility. Record review revealed the Administrator completed the CORE competency test in 2005.
In an interview on at 1:30 a.m., while employed at the facility as marketing and admissions staff, she said she had completed Assisted Living Facility CORE training and passed the test. She asked why she would have maintained her continuing education when she was not an administrator?

A review of the the Administrator's last 5 years of continuing education (CE) revealed in 2014 and 2015 the Administrator only had 9 hours total for both years of CE.

On at 2:30 p.m., the Administrator said she had maintained her CE, but could only provide 9 hours of CE for 2014 and 2015.

Class III

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on record review and interviews, the facility failed to ensure all direct care staff were trained in Control, Sanitation, and Universal Precautions prior to providing care and within 30 days for Activities of Daily Living (ADL) and Behavioral Needs, Elopement Response, Incident Reporting and

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Emergency Procedures, Resident Rights and , Neglect and , (ANE), and Nutrition and Safe Food Handling for 9 (Staff D, N, O, P, Q, R, S, U, and V) of 10 staff personnel records reviewed. Untrained staff put residents at risk.

The findings included:

On at 1:45 p.m., Business Manager Staff C said all training was filed in the personnel records. She said the training times did not show on the Individual Timecards, but was written and submitted separately for pay.
Personnel record reviewed for required training found:

1. Med Tech Staff D was hired on . Training certificates included:
Control and Universal Precautions for 1 hour on ,
Sanitation for 1 hour on ,
ADL and Behavioral Needs for 3 hour on ,
Elopement Response for 1 hour on ,
Incident Reporting for 1 hour on ,
Emergency Response for 1 hour on ,
ANE for 1 hour on ,
Resident Rights for 1 hour on , and
Nutrition and Safe Food Handling for 1 hour on ,
None of these trainings were provided within 30 days of hire.

2. Med Tech Staff N was hired on . Training certificates included:
Elopement Response for 1 hour on and ,
Nutrition and Safe Food Handling for 1 hour on , (2 hours), and .
None of the trainings were provided within 30 days of hire.

In an interview on qt 2:23 p.m., Med Tech Staff N said she worked here over a year in . She said she started in the kitchen before she became a med tech over a month ago. She said none of the / , trainings were true.

3. Med Tech Staff O was hired on . Med Tech Staff O had none of the required trainings within 30 days of hire.

4. Med Tech Staff P was hired on . Training certificates included:
Control and Universal Precautions for 1 hour on ,

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ADL and Behavioral Needs for 3 hours on ,
Elopement Response for 1 hour on ,
Incident Reporting for 1 hour on ,
Emergency Procedures for 1 hour on ,
ANE for 1 hour on ,
Resident Rights for 1 hour on , and
Nutrition and Safe Food Handling for 1 hour on .
There was no training for Sanitation.

In an interview on at 2:36 p.m., Med Tech Staff P said she started here in . She trained for about days on-the-job -on training on the med cart at first. She said she also did resident care on A and B halls. She said her only trainings were safe food handling and the med class. She said none of the other trainings documented for her were given to her. She said she would remember if she had to sit in a class or on the computer to study.

5. Resident Aide Staff Q was hired on . Training certificates included:
Control and Universal Precautions for 1 hour on and ,
Sanitation for 1 hour on ,
ADL and Behavioral Needs for 3 hours on and ,
Elopement Response for 1 hour on ,
Incident Reporting for 1 hour on ,
ANE for 1 hour on and ,
Resident Rights for 1 hour on , and
Nutrition and Safe Food Handling for 1 hour on and .
The trainings were not provided within 30 days of hire.

In an interview on at 12:51 p.m., Resident Aide Staff Q said she only took 2 classes in as she was on leave.

6. Med Tech Staff R was hired on . Training certificates included 15 hours of training all provided on , including:
Control and Universal Precautions for 1 hour on ,
Sanitation for 1 hour on ,
ADL and Behavioral Needs for 3 hours on ,
Elopement Response for 1 hour on ,
Incident Reporting for 1 hour on ,
Emergency Response for 1 hour on ,

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ANE for 1 hour on ,
Resident Rights for 1 hour on , and
Nutrition and Safe Food Handling for 1 hour on .
A review of Med Tech Staff R's Individual Timecard showed he worked on 11/11/18 from "12:00 AM - 6:45 AM" and "10:00 PM - 12:00 AM" a total of 8.25 hours of floor work plus the 15 hours of training which would equal 23.25 hours in a 24 hour period.
A call was placed to Staff R on , but no return call was received.

7. Resident Aide Staff S was hired on . There were no training certificates in her file. More than 30 days had passed since her hire.

8. Med Tech Staff U was hired on . There were no training certificates in her file. More than 30 days had passed since her hire.

In an interview on at 7:15 a.m., Med Tech Staff U said she has worked here about a month now. Her only training class has been the 6-hour medication course. She said all other training has been on-the-job, -on training with another staff person.

9. Resident Aide Staff V was hired on 11/23/18. Training certificates included 14 hours of training all provided on (her first day), including:
Control and Universal Precautions for 1 hour on ,
Sanitation for 1 hour on ,
ADL and Behavioral Needs for 3 hour on ,
Elopement Response for 1 hour on ,
Incident Reporting for 1 hour on ,
Emergency Response for 1 hour on ,
ANE for 1 hour on ,
Resident Rights for 1 hour on , and
Nutrition and Safe Food Handling for 1 hour on .
Review of Med Tech Staff V's Individual Timecard showed no work hours for Staff V.
A call was made to Staff V on , but no return call was received.

Class III

0082 - Training - / - 58A-5.0191(4) FAC

Based on record review and interview, the facility failed to ensure all staff have training on Human

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/ , (/) within 30 days of hire for 6 (Staff D, N, O, P, S, and U) of 10 staff reviewed for / training. Employees are required to have training that includes transmission of , prevention and control of / , behavior, and workplace and legal issues.

The findings included:

1. Record review revealed Med Tech Staff D was hired on . The certificate for the / training showed it was completed on . More than 30 days after hire.

2. Record review revealed Med Tech Staff N was hired on The certificate for the / training showed it was completed on . More than 30 days after hire.

In an interview on at 2:23 p.m., Med Tech Staff N said she worked here over a year in . She said she started in dietary and moved into caregiving 1 month ago. She said none of the / training documentation was true.

3. Record review revealed Med Tech Staff O was hired on . The file had no certificate of training for / . Staff O was hired more than 30 days ago.

4. Record review revealed Med Tech Staff P was hired on . The certificate for the / training showed it was completed on .

In an interview on at 2:36 p.m., Med Tech Staff P said she started here in . She said she trained for about day on the medication cart. She said she was also doing care and was always on A or B hall. She said the only training she got was safe food handling and the med class. She confirmed none of the other trainings were given to her. She said she would remember if she had to sit in a class or on the computer to study.

5. Record review revealed Med Tech Staff S was hired on . The file had no certificate of training for / . Staff S was hired more than 30 days ago.

6. Record review revealed Med Tech Staff U was hired on . The file had no certificate of training for / . Staff U was hired more than 30 days ago.

In an interview on at 7:15 a.m., Med Tech Staff U said she took a medication course in Port Charlotte. Then she came here for 2 days of on-the-job, -on training on the floor and on a med

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cart with another caregiver. She said she had never worked in assisted living before and this was new to her.

Class III

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

Based on record review and interview, the facility failed to ensure that staff who assist with medications complete the 6 hour training including competency demonstration with a Consultant Pharmacist or Registered Nurse prior to assisting with medications for 1 (Staff P) of 6 med tech personnel files reviewed.

The findings included:

Med Tech Staff P was hired on . Med Tech Staff P's personnel file had a certificate for the 6-hour medication course taken on . This was 15 days after starting as a med tech.

On at 7:15 a.m., Med Tech Staff P said she started here in . She trained on-the job for about days, then as of the second day she was on the med cart with someone watching her. They left her on the med cart and doing personal care on the A and B halls. She said she took the med class about 1 month ago.

Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(7) FAC

Based on record review and interview, the facility failed to ensure direct care staff are trained in safe food handling within 30 days of hire for 8 (Staff D, N, O, Q, R, S, U, and V) of 10 staff reviewed for training. Knowledge of safe food handling is key to prevention of foodborne illness.

The findings included:

1. Med Tech Staff D was hired on . Record review revealed the certificate for safe food handling was dated , more than 30 days after hire.

2. Med Tech Staff N was hired on . Record review revealed the certificates for safe food handling were dated and , more than 30 days after hire.

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In an interview on at 2:23 p.m.., Med Tech Staff N said she worked here over a year in . She said she started in dietary and moved into caregiving 1 month ago. She said none of the / training documentation was true.

3. Med Tech Staff O was hired on . Record review revealed no certificate for safe food handling. Staff O was hired more than 30 days ago.

4. Resident Assistant Staff Q was hired on . Record review revealed the certificates for safe food handling were dated and , more than 30 days after hire.

A review of the Individual Timecard for Staff Q showed from through the staff had no work hours. On from "08:00 AM - 2:35 PM", a total of 8 hours floor work. On from "5:56 AM to 2:17 PM", a total of 7.73 hours floor work. On from "6:04 AM - 12:32 PM" and "01:26 PM - 02:38 PM", a total of 7.75 hours floor work.

In an interview on at 12:51 p.m., Resident Assistant Staff Q said she had on-the job, -on training and only 1 hour on the computer when she was first hired. Staff Q said she only took 2 classes in as she was out the rest of the time on leave.

5. Med Tech Staff R was hired on . Record review revealed Med Tech Staff R had the / certificate: dated .

The personnel record showed Med Tech Staff R had 15 hours of training on .
The computer printout "individual timecard" showed the staff worked on 11/11/18 from "12:00 AM to 06:46 AM and from 10:00 PM to 12:00 AM." Training and work hours for 11/11/18 would equal a total of 23.25 hours.
A call to Med Tech Staff R was attempted on and a message left. No return call was received.

In an interview on at 1:45 p.m., Business Manager Staff C said the time sheets do not show the training hours.

6. Resident Aide Staff S was hired on . Record review revealed no certificate for safe food handling more than 30 days after hire.

7. Med Tech Staff U was hired on . Record review revealed no certificate for safe food handling. Staff O was hired more than 30 days ago.

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8. Resident Aide Staff V was hired on 11/23/18. Record review revealed the certificates included Nutrition and Safe Food Handling 1 hour on . Documentation showed 14 hours of training on for this staff person.
A telephone call was made to Staff V on at 12:20 p.m. and message left. No return call was received.

Class III

0086 - Training - ADRD - 58A-5.0191(10) FAC

Based on record review, and interview, the facility failed to ensure all staff who interact on a daily basis or provide direct care to residents with are trained in 's and Related Level I Training within 3 months of hire for 1 (Staff V) of 3 staff reviewed for 's training. The facility has a secured memory care unit and numerous residents who suffer from and related .

The findings included:

1. Resident Aide Staff V was hired on 11/23/18. Record review revealed the 's training certificate was not in the personnel file. The personnel file showed Staff V had 14 hours of training on , but did not include the 's training.

In an interview on at 1:45 p.m., Business Manager Staff C said all training certificates were filed in the personnel records.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview, the facility failed to ensure direct care staff are trained in the facility's ( ) policy and procedure within 30 days of hire for 8 (Staff D, O, Q, R, S, T, U, and V) of 10 staff reviewed for trainings. Florida laws are very specific about and staff need to be aware to ensure residents' wishes are honored.

The findings included:

1. Med Tech Staff D was hired on . Record review revealed Med Tech Staff D had no training in until , more than 30 days after hire.

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2. Med Tech Staff O was hired on . Record review revealed Med Tech Staff D had no training in .

3. Resident Aide Staff Q was hired on . Record review revealed Resident Aide Staff Q had no training in until , more than 30 days after hire.

4. Med Tech Staff R was hired on . Record review revealed Med Tech Staff R had 15 hours of training including training on .

A review of the Individual Timecard revealed on 11/11/18 Staff R worked, "12:00 AM - 6:45 AM" and "10:00 PM - 12:00 AM" for a total of 8.25 hours of floor work. The 8.25 hours plus 15 hours would equal a total of 23.25 hours in a 24-hour period.
A call was placed to Staff R on and message left. No return call was received.

5. Resident Aide Staff S was hired on . Record review revealed Resident Aide Staff S had no training in . Staff S was hired more than 30 days ago.

6. Resident Aide Staff T was hired on . Record review revealed Resident Aide Staff T had no training in . Staff T was hired more than 30 days ago.

7. Med Tech Staff U was hired on . Record review revealed Med Tech Staff U had no training in . Staff U was hired more than 30 days ago.

8. Resident Aide Staff V was hired on 11/23/18. Record review revealed Resident Aide Staff V had 14 hours of training on (same date as hired) including training.

9. In an interview on at 1:45 p.m., Business Manager Staff C said all training was filed in the personnel records. She also said the training time did not show on the Individual Timecard, but was written and submitted separately for pay.

Class III
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0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(&) FS; 58A-5.0241 FAC

Based on record review and staff interviews, the facility failed to file 1-day or 15-day Adverse Incident

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Reports as required or call the 1-800- hotline for 3 (Resident #7, #37, and #16) of 4 residents reviewed for adverse incidents. Resident #7 was allegedly assaulted by another resident in the memory care unit of the facility. Resident #37 did not receive her medication as ordered for 4 days resulting in the resident having a on requiring extended hospitalization. Resident #16 did not received her medications as ordered and was hospitalized after a .

Failure to report adverse incidents impedes the facility's ability to respond to adverse events affecting the residents and obstruct the Agency's oversight.

The findings included:

1. Review of resident records noted Resident #7 was a mute male with , and Resident #50 was a male. Both residents resided on the memory care unit. Records documented that on Resident #7 was sent to the emergency room (ER) for examination after an alleged assault by Resident #50. Both residents remained on the memory care unit for 5 weeks after the alleged assault.

In an interview on at 9:20 a.m., the Memory Care Coordinator said she was aware of the 2 incidents that happened in her unit. She said she was made aware of a resident-to-resident interaction between Resident #7 and a Resident #50 that was of the nature. She said that Administrator told her she had gotten a call about an alleged event that happened. The Memory Care Coordinator said they sent Resident #7 to the ER to have him checked out to see if he had any evidence of damage of a nature. She was unaware if any incident report was filled out on the incident or if it was investigated. She said that Resident #7 does not speak so he is unable to tell what is happening.

Review of the Agency's Incident Reporting System (AIRS) revealed as of the survey date, no AIRS report was filed with the state agency related to the assault of Resident #7.

In an interview on at 8:40 a.m., Med Tech/Caregiver Staff Q said she was aware of Resident #7 going to the hospital after an incident with Resident #50.

In an interview on at 5:30 p.m., Administrator acknowledged there was an incident involving Resident #7 in early . She said she got a phone call from the former DON and from an employee who told her about a possible incident involving Resident #7. The Administrator said she went to the memory care unit and told them to send Resident #7 to the ER to be checked over from to to see that he was ok. She said the incident had something to do with Resident #7 being touched inappropriately by Resident #50. The Administrator said the former DON told her it happened

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that day about 2 or 3 in the afternoon. The Administrator said that she did not have an incident report or investigation. The Administrator acknowledged she did not report it to the Hot Line or file a one-day report for Resident #7 being sent to the hospital for a possible assault. She acknowledged she had not investigated the incident because the former DON did everything. The Administrator looked through the incident reports and could not find any report or documentation. She said the former DON may have taken it with her when she left. The Administrator said she notified the doctor and had an order to transfer to the hospital but could not find the order. She admitted she did not interview the staff in the memory care about the issues or meeting with staff about keeping the two residents apart while in the same unit.

In a phone interview on at 10:15 a.m., the sister and power of attorney for Resident #7 said that the Administrator had called her about an incident in the beginning of . She said the Administrator told her a caregiver may have touched her brother inappropriately and she sent him to the hospital to get checked out. She said the Administrator said the ER reported Resident #7 was ok, and that was it. The sister said she was not aware of anything else or that it involved another resident. She repeated the Administrator said it was a caregiver.

In a phone interview on at 11:15 a.m., the prior DON said she remembered in early , when she was off, the Administrator called and told her about a call that came in to the corporate office regarding an allegation of misconduct between Resident #50 and Resident #7. The Administrator told her she was sending Resident #7 to the hospital to get looked over. The prior DON said that when she got to work, she looked at the ER report and noticed it said that it was assault by bodily force by caregiver. She said that she brought this to the Administrator's attention that it was wrong and it was a incident between residents. The prior DON said that she was not involved at all, the Administrator did everything and it was between the Administrator and corporate office. She said the Administrator told her told her corporate told her what to do about the situation.

In an interview on at 12:45 p.m., the Administrator now said that she had forgotten that she had done the incident report after the incident between Resident #50 and #7. She said she found the incident report in a box of papers in the DON's office. The Administrator now said she was informed of the incident by the former DON who called her and told her she had received an anonymous call about it.

2. In an interview on at 9:35 a.m., Resident #37 said on she had a (causes a loss of and violent) in the bathroom. She was on floor "for hours" before someone found her. Resident #37 said the hospital increased her medications as they wanted her level up, but she had no issues with before on previous dose.

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Resident #37 said they were out of her medication 3 to 4 days before she had a . The resident said she kept asking staff every morning if they had gotten her medication in yet.

Review of Resident #37's record revealed diagnoses of , , and recurrent . On the physician ordered , , (an medication) 500 milligrams (mg) twice a day. The Medication Observation Record (MOR) for indicated the resident did not receive her 8:00 a.m. dose of , , on . The MOR was circled as not being given. The 4 p.m. dose was initialed as being given. On , , and the MOR indicated the , , was circled as not given for a total of 7 missed doses. A nursing note on at 8:30 a.m. indicated the "Resident was observed on the bathroom floor with multiple ones in 5 minutes", -1 called and "while there she has 2 more ", then was transported to the hospital.

Hospital records revealed Resident #37 was admitted on for , was nonverbal, arousable to painful stimuli, and had a hematoma (a solid of clotted) on the right forehead. After admission, the physician was notified the resident began actively and , , was administered , (into the). The physician noted critical care was required due to the high probability of sudden, clinically significant deterioration in the patient's condition and required the highest level of preparedness to intervene urgently. Services were provided to treat and clinically prevent significant deterioration that could result in . The final admitting diagnoses were with hematoma of , , , and . Resident #37 was intubated (tube inserted into airway for placement on a) and admitted to ( ). While in , she was started on a and treated with for possible , , . The resident's symptoms improved and the was removed. On , Resident #37 was discharged to a skilled nursing facility.
Resident #37's record showed she returned to the facility more than a month later on .

In an interview on at 1:20 p.m., the Pharmacy Technician explained the facility should have had plenty of medication on . The delivery log verified sufficient supply had been provided by the pharmacy well in advance. The pharmacy delivery receipt was signed by previous Director of Nursing (DON).

In an interview on at 2:35 p.m., Licensed Practical Nurse (LPN) Staff L said she was called to Resident #37's room by staff on the morning of and saw the resident laying on the floor. LPN Staff L told staff not to touch her and called -1. The resident's brother called right after that and said the reason for her was the , , had not been given. LPN Staff L said the pharmacy was good about bringing medication right away and usually send a 30-day supply. She said staff never made her aware the , , not being available to give to the resident.

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In an interview on at 10:30 a.m., Med Tech Staff M said she noted on the morning of that Resident #37 was out of her medication . She said the medication was not available and she circled on the MOR as not being given. Staff M said she told the nurse and the previous DON. Staff M said she mentioned it more than once as she was concerned as this resident needed her medication.

In an interview on at 10:49 a.m., Advanced Registered Nurse Practitioner (ARNP) said he was the clinician for Resident #37 and was not aware she had been without her for several days prior to her having a . He said Resident #37 was very aware of her medications and would be able to say if she got them or not. The ARNP said Resident #37 has a low threshold for and without her medication, could have an which may lead to . He said after 24 hours 87 percent of the medication would be out of her system; that is why he orders it to be given twice a day. The ARNP confirmed he was never contacted by the facility staff to alert him of the resident being without her medication. He said he would have called the pharmacy himself if necessary.

Review of the Agency's Incident Reporting System (AIRS) revealed as of the survey date, no AIRS report was filed with the state agency related to the hospitalization of Resident #37.

3. Resident #16's record revealed on , the staff observed the resident with activity and called -1. The resident was admitted to the hospital and did not return until . On at 7:00 p.m., Resident #16 was again observed with , -1 was called and the resident was transported to the hospital. On the resident returned to the facility with an order to decrease the , (an medication) from 800 mg to 600 mg three times a day for and a new order for , (another medication) 50 mg twice daily for .
The MOR for showed the , was circled as not given and they continued to give , 800 mg and not the 600 mg that was ordered.
In an interview on at 11:30 a.m., the providing Pharmacist said on new orders were received for Resident #16. The , was decreased to 600 mg and a 30-day supply of the new dosage was sent to the facility. A new order for , was also received and on , the facility and the physician were notified of the need for pre-authorization to pay for the , . The Pharmacist said she never heard anything from facility or the physician on this.

Hospital records for Resident #16 revealed she was admitted . The record noted Patient presents to the emergency department reporting status post two witnessed . Per staff, patient had a at lunch and another immediately prior to arrival. was called, as the duration of the was longer than usual. She was discharged to the facility . Discharge instructions included to stop , , take , 600 mg 3 times daily, and start (carbamazene) 200

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mg 3 times daily.

The MOR for showed the was circled as not given, and they continued to give 800 mg and not the 600 mg that was ordered. The MOR for indicated 600 mg but no indication the resident received the noon dose on and . On , the was rewritten for 800 mg three times a day and a dose given at 5:00 p.m.

In an interview on at 2:30 p.m., the Director of Nursing (DON) said she was approached by a med tech on about Resident #37's MOR indicating 600 mg but the medication label was for 800 mg. The DON said she changed the MOR but was unable to locate a physician's order for the dose being changed to 800 mg. The DON did not contact the pharmacy or resident's physician for clarification.

In an interview on at 8:36 a.m., Resident #16 said she had concerns with not getting her medication and missed 2 doses over the weekend. She did not want to go to the hospital again and told the Administrator about it on .
During the interview on at 2:30 p.m., the DON said Resident #16 reported on , she had not been getting her medication on time. The DON said she was unaware of the missed doses on and .

Review of the Agency's Incident Reporting System (AIRS) revealed as of the survey date, no AIRS report was filed with the state agency related to the hospitalization of Resident #16.

Class III