| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11964280 | 04/23/2019 |
| NAME OF PROVIDER OR SUPPLIER<br>**MAGNOLIA MANOR AT DAYTONA BEACH, LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**252 FOREST LAKE BLVD**<br>**DAYTONA BEACH, FL 32119** | |

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

**0000 - Initial Comments**

A complaint investigation (CCR# 2019000624) was conducted at Magnolia Manor on . Deficiencies were identified at the time of the survey.

**0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC**

Based on record review and staff interview, the facility failed to obtain a complete AHCA 1823 Health Assessment based on a health examination no more than 60 days before admission or 30 days after for 1 of 3 sampled residents, Resident #7.

The findings include:

Record review for Resident #7 found she was admitted to the facility on . Record review of the AHCA 1823 Health Assessment found in the resident record found the physician signed it was based on a health examination. (Photographic evidence obtained)

The findings were confirmed during an interview on at 2:48 PM with the Corporate Director of Operations and she confirmed a new AHCA 1823 was needed.

Class III

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

Based on observation, interview and record review, the facility failed assist with self-administration of medications for 1 of 3 residents, Resident #3, and failed to provide timely assistance with self-administration of medications for 8 of 14 sampled residents, Resident #4, #8, #9, #10, # 11, #12, #13 and #14.

The findings include:

On at 8:00 AM, Employee A, a Med Tech, was observed trying to get into her computer to give medications. She was asked if the facility had a backup plan and she stated she was new and did not know one.

An interview was held with the Wellness Director when she arrived at the facility on at around 8:50 AM. She was informed that Employee A was having trouble getting into her computer to give

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medication. She stated was going to reset the employee password for the computer.

On at 9:08 AM, Employee A was observed at her medication cart beginning her medication observation pass. She started with Resident #3. She brought a bottle of into the resident's room. The bottle ( AC 1%) did not have the residents name, date opened or directions for use. The Employee A put one drop in the left and missed. She then tried again. She stated the drop went in and the resident confirmed it. She left and went to her cart. She was asked if the bottle of had a box and she looked and could not find it. She was asked when she last assisted the resident with medication. She stated she worked the previous Saturday training and she did not see a box at that time. (Photographic evidence obtained)

Employee A was asked on at 9:20 AM, if any of the residents she was going to assist with medications scheduled for 8:00 AM. She stated, she could not give the 8:00 AM medications as it was now too late. She was asked if she had notified anyone. She stated she had not but would tell the nurse. The Employee A was asked for the resident names and pulled up the resident names and rooms up in the computer. Record review and interview with Employee A at the 9:20 AM confirmed Resident #4, #8, #9, #10, #11, #12, #13 and #14 had medications schedule for 8:00 AM that they did not receive.

During an interview with the Wellness Director on at 9:24 AM, she stated Employee A should have contacted her when she first discovered she could not log in. She was notified that the Med Tech did not give out her 8:00 AM medications. She stated she would check the orders to see if they could be given, and contact the physicians.

During an interview with the Director of Operations on at 1:48 PM, she stated the process for the medication system being down is to use the paper MORs that are in the nursing office. She stated that the staff did not have the key to the nursing office. She stated she had reset Employee A's password twice and this AM she was driving to the facility when she was notified and could not reset it.

An interview was held with the Resident #14 on at 3:20 PM. She stated she left the facility around noon and had just returned from her . She stated she did not have her 8:00 AM medication before she left and needed them.

Class III

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

Based on observation and staff and resident interviews, the facility failed to properly label medications

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for Residents #3 and failed to refill medications in a timely manner for Resident #3 and #14 in a sample of 14 residents.

The findings include:

On at 9:08 AM, a Med Tech (Employee A) was observed at her medication cart beginning her medication observation pass. She brought a bottle of AC 1% into the Resident #3's room. The bottle did not have the resident's name, date opened or directions for use. The Med Tech (Employee A) returned to her cart and was asked if the medication had a box. She looked through the cart and could not find it. (Photographic evidence obtained) She was asked when she last assisted the resident with medication. She stated she worked the previous Saturday. She stated she was in training and she did not see a box at that time. She was asked if there were any other medications for Resident #3. A review of the computer system was done with Employee A. The review revealed Resident #3 had an order for 20 MG take two tablets by once daily that should have also been given. Employee A stated the medication had not come from the pharmacy.

The findings were confirmed during an interview with the Wellness Director on at 9:24 AM. She was notified that the in the med cart did not have a box and the bottle itself was not labeled. She confirmed the bottle did not have the residents name or directions for use and added that it needed to be dated when opened.

Record review of the medication observation record (MOR) for Resident #3 revealed she did not have her 20 MG on and . She did not have her ordered for twice a day 25 times in with each time "Not Delivered form Pharmacy yet" documented as the reason.

During an interview with the Wellness Director on at 1:20 PM AM, she stated the pharmacy wants all the physician orders done quarterly and sent to them. She stated Resident #3's last physician order sheet was sent to the pharmacy in and another should have been sent the end of . She stated she discovered the problem last Friday and got all the physician orders but still needed to fax the orders to their pharmacy. She could not explain why there were days in the were given between days they were not given as they were not delivered by the pharmacy.

Record review of the MOR for Resident #14 revealed she had not received her 9:00 AM dose of Metropol 25 milligram (MG) tablet twice a day for high since . The

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notes on the MOR documented the medication was not yet delivered from the pharmacy. Further review of the MOR found Resident #14 did not have her 125 micrograms (MCG) since and did not have her 150 MG 1 tablet ordered for twice a day at 5:00 PM on , , and and the 9:00 AM and 5:00 PM dose on and . The notes in the medication system documented the medication was not delivered from the pharmacy on , and .

The MOR for Resident #14 was reviewed with the Wellness Director on at 10:11 AM and she confirmed the findings.

Class III