STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969410	**05/21/2019**
NAME OF PROVIDER OR SUPPLIER **KEYSTONE PLACE AT TERRA BELLA**	STREET ADDRESS, CITY, STATE, ZIP CODE **2200 LIVINGSTON ROAD** **LAND O LAKES, FL 34639**	

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0000 - Initial Comments

Assisted Living

A complaint investigation (Complaint Number: 2019004161) was conducted at Keystone Place at Terre Bella Assisted Living Facility on 05/21/19. Deficiencies were identified at the time of survey.

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on observation and interview, the Facility failed to assist with and administer medication (med) pursuant to the training requirement of a licensed practical nurse; failed to follow their policy and procedure for suspicion of diversion; and, and failed to follow their medication policy and procedure for one Resident (#21) of one resident that received a medicated treatment.

Findings Included:

During an interview with Staff D, conducted on 05/21/19 at 06:46am, Staff D stated that there were "a lot of refusal of meds when I am off" [and Staff E was] slow [and Staff N had] a lot of discrepancies in [the staff's] med pass". Staff D stated that the staff informed management of the med pass issues which included the Director of Nursing and the Interim Administrator. Staff D stated that the Facility had "a lot of issues [and] since th there have been so many off [count]". Staff D stated that there was an incident in which a was popped out of the med pack and Staff A (the Director of Nursing) told the staff to put it back in the med pack and tape it into place. The was found at a later time that "it wasn't the pill it was a , (med)". and med issues had been brought to the attention of Staff A and that the staff says that it will be taken care of but "never does".

During an interview with Staff E, conducted on 05/21/19 at 07:42am, staff E stated that once the count was off for the staff back "in March".

During an observation of the med pass with Staff E for Resident #21, conducted on at 08:00am in the Unit, Staff E gave Resident #21 the residents prescribed 08:00am meds which included an 0.083% 3milliliter (ml) and 0.25milligram (mg)/2ml solution. Staff E set up Resident #21's solution and handed it to the resident and cued the resident on and Staff E stayed within eyesight of the resident continuing to cue the resident on taking the treatment until 08:18am when Staff E walked away to attempt meds with another resident sitting at the dining table. Staff E returned to Resident #21 at 08:21am. Resident #21 gotten out

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of the chair and walking around the room. The had popped off the and the resident was not receiving any med. Staff E turned the machine off and took the from the resident and started toward the bathroom to empty the The Surveyor stopped Staff E and observed that Resident #21 had approximately one quarter of the solution left in the Staff E stated, "that is more than usual". Staff E exited the Unit without giving the other two residents residing on their meds. Staff E took thirty-one minutes to give Residents #16, #21, and #22 their meds and had thirty-two residents that still needed their 08:00am meds.

During an interview with Residents #1, conducted on 05/21/19 at 08:35am, Resident #1 stated that the resident had not received meds yet this morning and never received the meds yesterday morning.

During an interview with Staff F (Assistant Director of Nursing), conducted on 05/21/19 at 11:08am, Staff F stated that, "around mid-March the count was off; the nurses were arguing". Staff A was called due to Staff E "popped a out for a resident and tossed it and did not dispose of it properly and the count was off all weekend". Staff F stated that there was another incident in which Staff N was told by Staff A to put a back in the blister med pack and Staff O found that "it was not the ". According to Staff F, Staff A did not come in to the Facility; and, to the staff's knowledge, no investigation was performed for either incident.

During interviews with Residents #4 and #8, conducted on 05/21/19 at 12:42pm, Resident #4 and #8 stated that neither resident received their 08:00am meds this morning.

During an interview with Resident #18, conducted on 05/21/19 at 01:00pm, Resident #18 stated that the Facility sometimes provided the meds late.

A review of Medication Observation Records with the Interim Director and the Assistant Director of Nursing for Residents #1, #19, and #20, conducted on 05/21/9, revealed that Residents #1 and #19 did not have their 08:00am meds documented as given and Resident #20 had 08:00am meds documented as given at 11:21am.

A review of the Facility's Medication Administration Policy and Procedure (P&P), conducted on 05/21/19, the Medication Administration P&P stated that the Facility's Mission was, " to be unfailing in serving our resident's needs [and] it is imperative that we reduce the risk of resident's taking medications inappropriately while ensuring medications ordered are consumed as prescribed and intended". The Medication Administration P&P stated, "The assigned nurse will conduct their medication assistance in the order in which the Electronic Charting System displays as these times are directed from the Health

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Care Provider's order". The Medication Administration P&P stated, "the assigned nurse will conduct Medication Administration by following the sequence for each resident when they provide service to the resident needing medication administration" and that the nurse was to "administer the med to the resident in the safest manner as prescribed and in compliance with their individual licensure".

A review of the Facility's Controlled Substance P&P, conducted on 05/21/19, the Controlled Substance P&P stated that, "in the event the controlled med [was] not taken, dropped, or contaminated, the assigned staff [were] to obtain the med and dispose of it with a licensed witness [and] both the assigned staff and witness must note the disposal of the med in the controlled med log".

A review of the Facility's Controlled Substance Discrepancy P&P, conducted on 05/21/19, the Controlled Substance Discrepancy P&P stated that, "to avoid occurrences of discrepancies, the Health and Wellness Director (H&WD) [would] conduct med inventory audits in its entirety minimally monthly". Controlled Substance Discrepancy P&P stated that, "the H&WD [would] be notified immediately upon discovery including any missing or unaccounted for controlled meds [and] the med pass [would] be stopped immediately and all med carts [would] be secured until the H&WD acquired all accessing keys". Controlled Substance Discrepancy P&P stated that, "the H&WD and the Executive Director [would] initiate further investigation including staff statements, med administration records review, and any pertaining information in writing (this is a DEA recommendation)" and request an Pharmacy audit.

During an interview with Staff A, conducted on 05/21/19 at 12:30pm, Staff A stated that the expectation regarding the timeframe to give meds was "up to an hour before and an hour after the time it is scheduled for". Staff A stated the "nurse better be there present with the resident" while receiving an [redacted] treatment. Staff A stated that, Staff E was retrained before and "will give [the staff] more training". Staff A agreed that Staff E did not follow the Facility med P&P. Staff A stated that there had been approximately five or six issues with the [redacted] count was off in approximately two months and that on one incident "staff disposed of [redacted] without witnesses to sign for the disposal". Staff A stated that there was another incident in which the "nurse popped the pill and put it [redacted] taping it in place [and] three or so shifts later it was discovered by another nurse that it was not the [redacted] but a [redacted]". Staff A stated that the staff did not come into the Facility to investigate but "fixed the [redacted] count remotely and corrected the count" on the computer.

During an interview with the Interim Administrator (IA), conducted on 05/21/19 at 12:45pm, the IA stated "I came in last week related to issues with [redacted] and potential of diversion of [redacted]". The IA stated that the Facility only performed random drug testing of staff "only if there are red flags and suspicion of drug diversion". The IA stated "no" when questioned if any staff had been drug tested with the frequency of missing [redacted] within the past two months.

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Class III

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

Based on observation, record reviews, and interviews, the Facility to follow Health Care Providers orders; failed to follow their medication policy and procedures; and, failed to have all medications with proper labeling for ten Residents (#1, #4, #8, #15, #16, #18, #19, #20, #21, and #22) of ten sampled residents that required either assistance with medications or medication administration.

Findings Included:

During an interview with Staff D, conducted on 05/21/19 at 06:46am, Staff D stated that residents were "not receiving their meds on time or not receiving them at all". Staff D stated "09:00pm meds [were] signed off at 05:00pm [and] if there [were] meds due at 07:00am, they are signed off at 11:00am". Staff D stated that there were "a lot of refusal of meds when I am off" [and Staff E was] slow [and Staff N had] a lot of discrepancies in [the staff's] med pass".

During an observation of the med pass with Staff E for Resident #21, conducted on . . . . . at 08:00am, Staff E took twenty-one minutes to give Resident #21 meds which included and treatment of the meds . . . . . 0.083% 3ml and . . . . . 0.25mg/2ml . . . . . Solutions. Staff E emptied the with approximately one quarter of the meds still in the not taken by Resident #21 at 08:21am. Staff E did not provide Resident #21 with the resident's prescribed med . . . . . 325mg as the bottle contained 65mg tablets. The bottle was opened with meds taken from it. There was no med label on the bottle. Resident #21's prescribed . . . . . meds had no med labels on the bottle. Resident #21 counted the number of pills in the med cup and stated there were "seven pills". Resident #21 should have received eight pills. Staff E left the Unit without giving the other two residents residing on the Unit their meds that were due and proceeded to the Assisted Living area dining room. At 08:24am, Staff E provided Resident #22 with meds. At 08:31am, Staff E provided Resident #16 with meds. In total, Staff E provided meds to three resident's in thirty-one minutes and needed to pass meds to thirty-two more residents for the 08:00am med pass.

During an interview with Resident #1, conducted on 05/21/19 at 08:35am, Resident #1 stated that the resident did not receive the resident's prescribed meds "this morning [or] yesterday".

During an interview with Resident #4 and #8, conducted on 05/21/19 at 12:42pm, Resident #4 and #8

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stated that neither resident got their meds today.

During an interview with Resident #18, conducted on 05/21/19 at 01:00pm, Resident #18 stated that the Facility "sometimes give them (referring to meds) late".

A review of Medication Observations Records (MORs) with the Interim Administrator and Staff F (Assistant Director of Nursing), conducted on 05/21/19, revealed that:
- Resident #1 and #19 had not received their 08:00am meds at 11:34am. Resident #1 did not receive the resident's prescribed med 20mg on ; , 50mg on through ; and, 10milliequivalent on due to the unavailability of the meds. Resident #1's 05:00pm med , was signed as given at 06:19pm on . Resident #1's 08:00am med was signed as given at 09:53am on and 10:49am on . Resident #1's 08:00am med was signed as given at 10:49am on . Resident #1's record did have documented insurance issues with the resident's prescribed med but there was no indication found that the resident had issues with other prescribed meds.
- Resident #4's 09:00am med , 2.5mg was signed as given at 07:25am on . Resident #4's 04:00pm med , was not administered on "because the one previous was administered late and signed as given at 07:00pm on . Resident #4's med was not given on and due to the med was not available to given.
- On Resident #15's 08:00pm med , 300mg was signed as given at 09:30pm. On , Resident #15 did not receive meds due to "too late to give meds due to nurse being called late". On and , Resident #15 did not received meds due to "out of building".
- Resident #20's 08:00am meds were signed as given at 11:21am.

A review of the Facility's Medication Administration Policy and Procedure (P&P), conducted on 05/21/19, revealed that the P&P stated that the Facility's Mission was to, "be unfailing in serving our resident's needs [and] it is imperative that we reduce the risk of resident's taking medications inappropriately while ensuring medications ordered are consumed as prescribed and intended". The P&P stated, "the assigned nurse will conduct their medication assistance in the order in which the Electronic Charting System displays as these times are directed from the Health Care Provider's order". The P&P stated, "the assigned nurse will conduct Medication Administration by following the sequence for each resident when they provide service to the resident needing medication administration" and that the nurse was to "administer the med to the resident in the safest manner as prescribed and in compliance with their individual licensure". The P&P stated, "if the resident who received this assistance is away from the facility the resident will be able to take the medication they are receiving with them by signing the med out with the Licensed Nurse via a "Pill Organizer" based on the orders which are current from the Health Care Provider".

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During an interview with the Interim Administrator and Staff F, conducted on 05/21/19 at 11:42am, the Interim Administrator and Staff F agreed that the med pass continued as incomplete and that there were issues in providing residents prescribed medications on time or not at all. Staff F stated that Resident #1 had no prescription insurance coverage and that the Facility assisted the resident in obtaining the coverage and "got all meds about a month ago". There was no evidence that the resident's Health Care Providers or Responsible Parties were notified that the aforementioned resident did not receive their meds as prescribed.

During an interview with Staff A (Director of Nursing) conducted on 05/21/19 at 12:30pm, Staff A stated that the timeframe to pass meds was "up to an hour before and an hour after the time it is scheduled". Staff A stated that, "the nurse better be there present with the resident" during the course of a treatment administration. Staff A stated that Staff E had previous re-education and training for previous med pass issues and that "we will give [the staff] more training.

Class III

0083 - Training - First Aid and CPR - 58A-5.0191(5) FAC

Based on record review and interview, the Facility failed to provide staff on each shift with training in Cardiopulmonary Resuscitation (CPR) as required.

Findings Included:

A record review for Staff A, B, and C, conducted on 05/21/19, revealed that Staff A, B, and C did not have CPR training as required in their employee records. Staff A was hired on 03/06/19. Staff B was hired on 04/10/19. Staff C was hired on 02/08/19. A further review of employee records found that the evening shift (03:00pm to 11:00pm) had one staff, Staff J with CPR training and that there were no staff on the overnight shift (11:00pm to 07:00am) that had CPR training.

During an interview with Staff L conducted on 05/21/19, Staff L stated that there were "no other employees with CPR training [and] we went through every file".

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the Facility failed to maintain an up-to-date Admission and

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Discharge with all required admission and discharge data for seven Residents (#1, #5, #10, # 11, #12, #13, and #14) of seven sampled current and former residents.

Findings Included:

A review and comparison of the Admission and Discharge Log to the Resident Roster, conducted on 05/21/19, revealed that the Admission and Discharge was not kept up-to-date (See Photographic Evidence1). There was no admission dates for Residents #1, #5, and #10. Resident # 11 and #12 had a place of discharge listed as home with no corresponding address. There was no place of discharge for Residents #13 and #14.

During an interview with the Interim Administrator, conducted on 05/21/19 at 12:45pm, the Interim Administrator agreed that the Admission and Discharge Log was not kept up-to-date with all required data for residents admitted into the Facility and discharged from the Facility.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the Facility failed to complete Health Assessments documented on the Agency for Health Care Administration Form 1823 (AHCA 1823) as described in Rule 58A-5.0181, Florida Administrative Code for three Residents (#1, #4, and #15) of three sampled residents.

Findings Included:

A record review for Resident #4, conducted on 05/21/19, revealed that Resident #4 had an AHCA 1823 dated , which was incomplete and did include the required nursing services of or the type of assistance that the resident required for medication administration as required.

A record review for Resident #15, conducted on 05/21/19, revealed that Resident #15 had an AHCA 1823 dated , which was incomplete and did not include the resident's name and date of birth on pages 2, 3, and 4. Resident #15's AHCA 1823 did not include the examining physician's name, address, telephone number, and title as required.

A record review for Resident #1, conducted on 05/21/19, revealed that Resident #1 had an AHCA 1823 dated , which was incomplete and did not include the address of the resident's physician as

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required.

During an interview with the Interim Administrator, conducted on 05/21/19 at 11:42am, the Interim Administrator agreed that Resident #1, #4, and #15's AHCA 1823s did not include all required data.

Class III