STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968875	R-C 04/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWOOD LODGE ASSISTED LIVING	**6873 SW US HWY 27 FORT WHITE, FL 32038**

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

0000 - Initial Comments

A revisit to a biennial and complaint investigation (complaint #2018017733) survey was conducted at Riverwood Lodge Assisted Living on , , . Deficiencies were found to be uncorrected at the time of the survey.

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

Based on observation and interview, the facility failed to ensure assistance with self- administration of medication was provided as ordered by the physician for 4 of 4 sampled residents (Resident #1, #4, #5, and #6).

Findings:

On at 10:45 AM, Staff A, Medication Technician (MT), was observed assisting Resident #4 with self administration of medication. Resident #4 came to the medication cart and the MT prepared one , 150 mcg tablet and one / 750-600 mg tablet. After stating the medications to the resident, the resident took the medications.

Record review of the physician's order for Resident #4 revealed , 150 mcg, one time a day at 7:00 AM, and / 750-600 mg tablet, two tablets by every morning.

Record review of the Medication Observation Record (MOR) for Resident #4 revealed , 150 mcg, one tablet by every morning at 7 AM and / 750-600 mg tablet, take two tablets daily at 8 AM.

During an interview on at 10:50 AM with Resident #4, she stated: "Today my medications are later than usual."

An observation was conducted on at 10:00 AM of Resident #1 and it showed he was up walking around in his room.

On at 11:30 AM, Staff A, MT, was observed assisting Resident #1 with self- administration of medication. The MT took , / , 25 mg-250 mg tablet and put it in a medication cup and took the cup to the resident's room. The MT did not remove the medication from the pack in front of the resident, she stated the medication, gave Resident #1 the medication cup and the resident took his medication.

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On at 12:40 PM, Staff A, MT, was observed assisting Resident #1 with self- administration of one , / , 25 mg-250 mg tablet. Resident #1 was at the medication cart as the MT removed the medication from the pack and stated it to the resident. The MT gave the medication cup to the resident and the resident took his medication one hour and ten minutes after his previous dose.

Record review of the physician's order for Resident #1 revealed , / , 25mg-250 mg, take one tablet by every two hours while awake at 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM and 8:00 PM.

On at 12:00 PM, Staff A, MT, was observed assisting Resident #5 with self- administration of medication. Resident #5 came to the medication cart. The MT removed , 125 mcg from the pack and stated the medication to the resident. The MT handed Resident #5 the medication cup and the resident took the medication.

Record review of the physician's order for Resident #5 revealed , 0.125 mg tablet, take one tablet by daily on an empty .

Record review of the Medication Observation Record (MOR) for Resident #5 revealed , 125 mcg tablet, take one tablet by every day for , on an empty at 8 AM.

During an interview on at 12:10 PM with Resident #5, she stated: "I thought she had forgotten about me. I guess it's a good thing I only take medications once a day."

During an interview on at 9:50 AM, Resident #6 stated: "I haven't had any of my morning pills yet and it's getting late."

On at 12:30 PM, Staff A, MT, was observed assisting Resident #6 with self-administration of medication. The MT called Resident #6 over to the medication cart. The MT removed the medications from the packs as she stated them to the resident. The medications observed were 99 mg, 50 mcg, , 81 mg, D 400 IU, and 1 mg.

Record review of the Medication Observation Record (MOR) for Resident #6 revealed 99 mg tablet, take one tablet by every morning at 8 AM; 50 mcg tablet, take one tablet by every morning at 8 AM; , 81 mg tablet, take one tablet by every morning at 8 AM; D 400 IU capsule, take one capsule by every morning at 8 AM; 1 mg tablet,

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take one tablet by every morning at 8 AM.

Record review of the physician's order for Resident #6 revealed 99 mg by daily, 50 mcg one table by daily, , 81 mg by daily, D 400 IU by daily, and 1 mg one tablet by daily.

During an interview on at 1:00 PM, Staff A, MT, stated: "I know all of those medications were late."

During an interview on at 4:00 PM with the Assistant Administrator (AA), she stated: "Staff A knows medications can only be given one hour before and one hour after they are due for them to be on time. She also knows she is supposed to check the MOR as she goes and make sure she is giving the right number of pills. There is no excuse."

During an interview on at 4:10 PM with the Administrator, she stated: "I agree with the AA, there is no excuse for the medications not being given on time."

Class III

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

Based on record review and interview, the facility failed to ensure complete and accurate documentation for reconciliation for 2 of 5 sampled residents (Resident #3, and #7).

Findings:

Record review of the count sheet reconciliation for Resident #3 revealed , 0.5 mg tablet with a total count of 90. Dated at 8:00 PM, there was no staff member signature for the removal of the medication for pill count number 88. On or around , or 4, 2019, no time, date or staff documented the removal of medication from the container for pill count number 87.

Record review of the count sheet reconciliation for Resident #7 revealed 14 count. The container contained 12. Dated at 2:00 PM, there was no staff member signature for the removal of the medication for pill count number 23.

During an interview on at 4:00 PM with the Assistant Administrator, she verified the documentation for the count sheet for Resident #7 was not accurate and the medication count

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sheets were missing signatures/date/time for the removal of medications for Residents #3 and #7.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and interview, the facility failed to store a 3-day supply of water sufficient for drinking and food preparation or to have a plan for obtaining water in an emergency, coordinated with and reviewed by the local disaster preparedness authority

On [redacted] at 2:35 PM, an inventory of the facility's emergency water supply was observed, accompanied by the Assistant Administrator. On the day of the survey, the facility had 8 gallons of stored water for 21 residents.

On [redacted] at 2:40 PM, an interview was conducted with the Assistant Administrator. She confirmed the facility did not have an adequate emergency water supply or have a plan for obtaining water in an emergency."

Class III