| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11967623 | R<br>05/14/2019 |
| NAME OF PROVIDER OR SUPPLIER<br>**MAGNOLIA HOUSE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**103 YACHT HAVEN DRIVE**<br>**COCOA BEACH, FL 32931** | |

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

**0000 - Initial Comments**

A revisit to a re-licensure survey with Extended Congregate Care (ECC) was conducted at Magnolia House on . Deficiencies were identified at the time of the visit.

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

THIS DEFICIENCY REMAINED UNCORRECTED

Based on observation, medication review and interview, the facility failed to ensure the unlicensed caregiver (A) who assisted a resident (#5) with self-administered medications followed the correct procedures.

Findings:

Observations made on upon entry into the facility found resident #5 seated at the kitchen table eating his breakfast. Staff A was present and stated she would be assisting medications when resident #5 finished eating.

Observations during the medication pass for resident #5 on at 9:25 AM revealed staff A, unlicensed caregiver, unlocked the medication cabinet, removed a basket with the medications for resident #5 and brought the basket and the medication observation record (MOR) to the kitchen table. She sat next to resident #5 and told him it was time for his medications. She took the first pill vial out of the basket and read aloud, "Here is your 40milligrams, take 1 tablet daily before breakfast." Staff A placed one pill in a small cup and marked the MOR that the pill was given. She proceeded to read the labels for the other 9 medications that resident #5 was to take in the morning, placing each one in the cup after reading the label and marking the MOR. After she had all 10 pills in the cup, she handed it to the resident, who poured them out on the table and took each pill one at a time. Staff A remained with the resident until he was finished, then she put the basket in the locked cabinet.

On at 9:30 AM, staff A confirmed she had marked the MOR for each pill before the resident swallowed the medications, she also confirmed she read the , instructions as "give before breakfast" and the resident had already finished his meal.

Class III