STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964934	06/18/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Cabot Reserve On The Green	4450 8th Street Sarasota, FL 34232	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D

Specific Tag Findings:
An unannounced Biennial survey with Extended Congregate Care (ECC) was conducted on through at Cabot Reserve on the Green an Assisted Living Facility (ALF) in Sarasota, Florida.

The following is a description of non-compliance:

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation, interview, and record review, the facility failed to appropriately assist with the self-administration of medications for 2 (Residents #15 and #16) of 5 residents surveyed resulting Resident #15 being given a medication that had been discontinued by the physician and Resident #16 (an resident) being given an as needed medications without an assessment and being given the wrong dosage of the medication administered.

The findings include:

1. Resident #16 is a female who was admitted to the Facility on

Review of the 1823 dated revealed that it indicated that the resident has a history of and a Brainstem Accident.

Review of her status revealed that she has profound with speech and communication

On at 12:28 p.m., Staff A who is a Certified Nursing Assistant (CNA) was observed assisting Resident #16 with medications. Resident #16 was observed sleeping in her wheelchair in the living the memory care unit. Staff A was observed to pour 30 ml of Milk of Magnesia (MOM) in a plastic cup. Staff A then woke Resident #14 up from her sleep. She was observed to place the medication in the resident's right hand. Staff A was then observed to move Resident #16's right hand to her mouth and Resident #16 was observed to drink the medication from the cup. Review of the resident's electronic MOR (Medication Observation Record) at that time showed the order to read, "MOM two tablespoons (30 ml's) daily as needed for The MOR showed the medication had been signed off at 8:30 am on

In an interview with Staff A at 12:30 p.m. on , she verified she had given the medication to the resident at 8:30 a.m. and at 12:02 p.m. Staff A verified at that time that Resident #16 was not able to understand when she would need to take the as needed medication or why she would take the medication.

Review of Resident #16's printed MOR on showed Resident Aides administered MOM to the resident on at 12:01 p.m. and 4:49 p.m. Staff A administered MOM to the resident on at 8:30 a.m. and 12:28 p.m. The MOR also showed the resident had 500 mg ordered as an as needed medication for pain and There was no record on the MOR of ever being administered to the resident.

In an interview with the Director of Personal Care, CNA, at 1:30 p.m. on she verified Resident #16 had been given the wrong dosage of MOM. She verified Resident was not able to understand when to ask for an as needed medication and that staff assisting Resident #16 were not qualified to assess the residents need for taking

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an as needed medication. She was asked at that time how staff would document a change in the resident's condition. She stated Resident Aides do not document in the resident's record. Resident Aides document on a 24 report sheet that is discarded weekly.

Review of the 24 hour report sheets dated from . . . . to shows no staff reported any resident being constipated during that time.

In an interview with the Administrator at 2:30 p.m. on she verified Resident #16 was not competent. She also verified there was currently no staff working that was capable of administering an as needed medication to an resident.

2. Resident #15 is an female who was admitted to the Facility on

Review of the resident's 1823 (Health Assessment) dated revealed that Resident #15 suffer from and has memory loss.

Staff A was observed assisting Resident #15 with her medications at 12:10 p.m. on . . . . . Observation of the medication label showed the label read, Chew and swallow 2 tablets by mouth three times daily for 36 hours for and . . . . . ' Resident #15 was observed to ambulate to the medication cart. Staff A was observed explaining to the resident to chew the medication and Resident #15 was observed to chew and swallow the medication.

Review of the MOR on showed the medication was ordered for the resident on . . . . . Staff had continued to give the medication beyond the 36 hour it had been ordered for. The last dosage given was . . . .

In an interview with the Director of Personal Care, CNA, at 2:35 p.m. on she verified the medication had been given to the resident 17 times when it should not have been given. She was not able at that time to say if the resident was having any . . . . . or . . . . She stated staff would document this on the 24 hour report sheet.

Review of the 24 hour report sheets from . . . . . to . . . . . shows staff reported Resident #15 was having . . . . . on . . . . . There had been no reports of . . . . . or . . . . . for Resident #15 since that date.

An interview was conducted with Administrator at 3:00 p.m. on . . . . . She verified Staff had administered the medication to the resident 17 times when it was not ordered. She verified the resident had not had since . . . . . .

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation, interview, and record review, the facility failed to place an alert on the medication of 1 (Resident #16) of 5 residents surveyed and failed to contact the resident's health care provider to revise as needed medications resulting in the resident being given the wrong dosage of a medication.

The findings include:

Resident #16 is a female who was admitted to the Facility on

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Review of the 1823 (Health Assessment) dated revealed that the resident has a history of , and a Brainstem Accident.

Review of her status revealed she has profound with speech and communication

On at 12:28 p.m. Staff A who is a Certified Nursing Assistant (CNA) was observed assisting Resident #16 with medications. Resident #16 was observed sleeping in her wheelchair in the living the memory care unit. Staff A was observed to pour 30 ml of Milk of Magnesia (MOM) in a plastic cup. Staff A then woke Resident #14 up from her sleep. She was observed to place the medication in the resident's right hand. Staff A was then observed to move Resident #16's right hand to her mouth and Resident #16 was observed to drink the medication from the cup. The label of the medication was observed to read, "Milk of Magnesia take 30 at bedtime as needed for Review of the resident's electronic MOR (Medication Observation Record) at that time showed the order to read, "MOM two tablespoons (30 ml's) daily as needed for The MOR showed the medication had been signed off at 8:30 a.m. on

In an interview with Staff A at 12:30 p.m. on she verified she had given the medication to the resident at 8:30 a.m. and at 12:02 p.m., Staff A verified at that time that Resident #16 was not able to understand when she would need to take the as needed medication or why she would take the medication.

Review of Resident #16's printed MOR on showed Resident Aides administered MOM to the resident on at 12:01 p.m. and 4:49 p.m. Staff A administered MOM to the resident on at 8:30 a.m. and 12:28 p.m. The MOR also showed the resident had 500 mg ordered as an as needed medication for pain and There was no record on the MOR of ever being administered to the resident.

In an interview with the Director of Personal Care, CNA, at 1:30 p.m. on she verified Resident #16 had been given the wrong dosage of MOM. She verified Resident was not able to understand when to ask for an as needed medication and that staff assisting Resident #16 were not qualified to assess the residents need for taking an as needed medication. She was asked at that time how staff would document a change in the resident's condition. She stated Resident Aides do not document in the resident's record. Resident Aides document on a 24 report sheet that is discarded weekly.

Review of the 24 hour report sheets dated from /14 to shows no staff reported any resident being constipated during that time.

In an interview with the Administrator at 2:30 p.m. on she verified Resident #16 was not competent. She also verified there was currently no staff working that was capable of administering an as needed medication to an resident. She verified the Label on the bottle was not correct and there was no alert noted to the bottle.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation, record review, and interview, the facility failed to post the dated weekly menus and failed to serve dinner rolls with the meal according to the daily posted menus.

The findings include:

On at 12:12 p.m., an observation of the dining that at the beginning of the halls leading to the

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residents facility post a daily menu. The daily menu was identified as Tuesday. Lunch called for Peppered Pork Loin, Tricolor Spiral Pasta, Herbed Green Beans, Dinner Roll w/margarine, Red Velvet Cake, and Beverage of Choice. At 12:30 p.m., observation of the meal served to residents found they received Pork Loin with gravy, spiral pasta, green beans, and beverage of choice. As residents were observed eating it was observed that none of the resident had been served a dinner roll or bread with their meal. At 12:45 p.m., during the dining observation, Residents
#8, #12, #13, and #14 were observed seating at a table together eating their meal. They stated they would like to have a dinner roll but never get one. They stated they like bread with their meal but it's just never served.

On at 12:46 p.m., observation of the tray line found there were no dinner rolls on the tray line to be served to the residents. The Director of Dining Services (DDS) stated, "we do not serve bread with the meal. The residents don't eat bread. We have one or two resident who ask for bread and we have already given them bread."

On at 12:55 p.m., a staff person was observed bring a basket full of sliced bread into the dining area and asked resident if they would like a slice of bread. Most of the residents were observed requesting bread. One resident was observed taking a slice of bread even though she had finished her plate. She had eaten 100% of her meal.

On at 1:01 p.m., the DDS stated the facility has a 5 week menu cycle. She has them on a bulletin board in the kitchen. The menu were signed and dated when they were approved. The menus were not dated as to which week was being served. The DDS she just goes from one week to the next and then starts over at the end of the 5 week cycle. She stated she does not date the week menu to indicate which week is being currently used. She state these weekly menus are not posted in areas readily accessible to residents. She stated that each morning the menu to be served is placed in the display case in the resident's hall.

On at 10:10 a.m., the Administrator stated she was unaware that dated weekly menus must be posted in areas accessible to residents.

On at 12:20 p.m., the daily menu was observed posted. It was noted as Wednesday there was no date on the menu. The menu called for a dinner roll to be served with the noon meal. At 12:35 p.m., the noon meal was observed being served. It was observed that a dinner roll was on the plates as they were served. Observation of the noon meal found most of the residents ate at least a portion of their roll.

On at 12:40 p.m., Residents #12, #13, and #14 stated they really like getting a roll with their meal.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Cabot Reserve On The Green
4450 8th Street
Sarasota, FL 34232

Dear Administrator:

This letter reports the findings of a Biennial and Extended Congregate Care (ECC) survey that was completed on , 2014 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure: State Form

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