STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964654	02/10/2017
NAME OF PROVIDER OR SUPPLIER **ST . . . . . PLANTATION**	STREET ADDRESS, CITY, STATE, ZIP CODE **2507 OLD ST. . ROAD** **TALLAHASSEE, FL 32301**	

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

0000 - Initial Comments

An unannounced Change of Ownership (CHOW) including an Extended Congregate Care survey was conducted at St. . . . Plantation Assisted Living Facility, license number 9149 on . . . - . . . .
At the time of survey there were deficiencies identified.

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

Based on observation, staff interview and record review, the facility failed to ensure prescription drugs for assistance were properly labeled and dispensed and that the correct dosage was provided for 1 out of 3 residents sampled for a medication pass observation. (Resident # 11).

The findings include:

Missing Label:

On at approximately 10:57 am, employee C was observed taking a box with a manufacturing label with ProAir HFA; however, the required label with the client, healthcare provider information and the label by a licensed pharmacist was noted to be pulled off.

On at 12:41 PM interviewed employee E and reviewed the box with manufacture label and asked her what was the procedure for giving medications with proper labels. Staff E confirmed that the proper procedure for giving medications was to have proper labels with healthcare provider, resident and a licensed pharmacy with directions must be present. Staff E confirmed that all medication should be labeled properly when dispensing.

On at 12:49pm interviewed the Director of Health and Wellness (DHW) relating to orders, Medication Observation Reviews and labels. Explained to DHW that employee C was observed administering medications with only the manufacture label. DHW explained that all medications should have the proper labels when administering or assisting. DHW reviewed the medication and confirmed that the medication did not have the proper label in place.

Wrong Dosage:

On at 10:57am, Employee C was observed assisting resident #11 with the medication . . . . . 10mg. The medicaton label stated . . . . . 10mg tablets, take 1 tablet by mouth. Employee C checked the MOR after assisting with the medication and it indicated a lesser dose of 5mg ordered on . . . .

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SUMMARY STATEMENT OF DEFICIENCIES
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On . . . at 11:15am, a record review of resident #11 file was conducted and orders for Amlodopine , was changed to 5 mg on .

On at 12:41am, staff E was interviewed and reviewed the physician orders for resident #1 and it was documented that the order was decreased to 5mg on . . Staff E looked in the medication cart and found that the new medication had arrived, but had not been used as ordered. Staff E counted and verified that the resident had received 16 doses of the wrong strength Amlodopine.

On . . . 12:49pm an interview with the Director of Health and Wellness to review resident #1 file and explain the process of administering medication by unlicensed staff. DHW reviewed the file and confirmed that the medication was decreased to 5mg on and the medication that was given that morning was the wrong dosage of 10mg. DHW stated that staff while administering medication should look also at the label to verify dosages to be given with the MORs.

Class III