STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969133	R 03/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRILLIANCE LIVING CORPORATION	**699 N DIXIE FREEWAY** **NEW SMYRNA BEACH, FL 32168**

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

0000 - Initial Comments

A follow up visit to CCR # 2017009851 was conducted on . . . . . at Brilliance Assisted Living Facility (License # 12974). Brilliance Assisted Living had deficient practice identified during the survey.

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

Based on observations, resident record reviews, and staff interviews, the facility failed to properly assist residents with medication assistance by trained unlicensed staff in accordance with procedures described in Section 429.256, F.S. for 3 of 4 sampled Residents (Resident #4, #5, #6).

The findings include:

1. An observation was conducted on . . . . . at 8:17 AM of Employee B, Medication Technician, assisting Resident #4 with her medications scheduled for 9:00 am.

An observation was conducted on at 8:36 of Employee B as she proceeded to give the medications to Resident #4. Employee B handed the resident her medications and said "Here are your pills". At no time was she observed informing the resident of the pills she received. The resident was seen refusing to take her . . . . . , stating " It make my eye brows . out and I don't want to take it." Employee B was then observed taking the . out of the souffle cup, which had been in the residents hands, and placing the pill it back into the medication bottle.

During an interview with Employee B on . . . . . at 8:40 AM, she confirmed when a resident refuses a pill she puts it back into the medication bottle and does not dispose of it.

An interview on at 8:40 AM with Employee A, an LPN who was present during the medication pass, she confirmed medications should be disposed of and not placed back into the medication bottle after it has been contaminated.

2. A record review for Resident #5 revealed she was ordered . 500 mg (2 tabs) and 10 meq (1 capsule), along with other medications.

An observation was conducted on . . . . . at 8:14 AM of Resident #5 being assisted with her medications by Employee B. Employee B obtained the resident's pills and handed them to the resident and stated "Here are your pills." Resident #5's . . . and . . . . . were not included in the pills she

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was handed.

During an interview with Employee B on at 8:45 AM, she confirmed she did not give the resident her and said " I don't have it on the cart". Employee B also stated that she didn't give the resident her as she thought she was not longer taking it. When the MOR was reviewed with Employee B, she confirmed both medications were listed on the resident's MOR to be given. (photographic evidence obtained)

At 8:50 AM on , Employee B was observed assisting Resident #5, offering her and . Upon further review, Resident #5 was given 650 mg instead of the 500 mg as the MOR directed.

In an interview with Employee A and Employee B on at 8:55 AM, they confirmed the MOR for Resident #5 listed she is to receive 500 mg (2 tablets) but was given 650 mg (2 tablets) instead.

3. An observation was conducted on at 8:20 AM of Resident #6 receiving medication assistance from Employee B, for his morning medications. Employee B handed Resident #6 his medication and did not inform him of the medications he was taking. The resident was observed asking Employee B, "What pills am I taking? and she replied, "You are taking some colorful pills."

An interview was conducted with Employee A & B on at 9:02 AM, and they confirmed Employee B did not inform residents what pills they were taking. Employee B also confirmed she was not aware she couldn't return medications back into the bottle if a resident refuses their medications.

CLASS III

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

Based on observation, record reviews, and staff interviews, the facility failed to maintain an accurate daily Medication Observation Record (MOR) for residents who received assistance with self-administration of medications for 2 residents (Residents #4 and #5) out of 4 residents sampled.

The findings include:

1. On , a review of the Medication Observation record (MOR) for Resident #4 revealed several

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medications listed, including the following: , ( ) 81 milligrams (mg) 1 pill daily; K+ ( ) 100 meq (milli-equivalents) 1 a day; , 12.5mg twice a day; and , 15mg 1 qd.

After reviewing the labels for the above stated medications, the orders for several medications did not match what was on the MOR. The differences were as follows: the , was listed as being a chewable tablet on the package, but the order on the MOR did not say it was the chewable form for the medicine. The 's package was labeled as being 10 meq's, not 100. The , was labeled as 25 mg twice a day, while the MOR indicated it was to be 12.5 mg twice a day. The , 's package indicated 1 tablet was to be given equaling 2.5 mg, but the MOR indicated 1 tablet was to be given equaling 5 mg.

In an interview on at 8:30 AM with Employee A, Licensed Practical Nurse (LPN), she stated she had placed a call to Resident #4's doctor on Friday ( ) to clarify the orders but forgot to update the MOR. She said "I called them on Friday because I was too. " Employee A stated the orders on the bottles were right and that's what should be on the MOR.

On at 8:34 AM Employee A reviewed the medication bottles against the MOR and confirmed they did not match. She also confirmed the dosage for the resident's was listed in error as 100 meq and should be listed as 10 meq. (photographic evidence obtained)

An interview with the Administrator on at 9:00am confirmed the MOR for Resident #4 was not accurate.

2. A record review was conducted on of the Medication Observation Record (MOR) for Resident #5. An order for 1 vial via every 8 hours scheduled for 7 am, 3 pm, and 11 pm on the MOR. The 3 pm medication was observed to be blank for the whole month of thus far (3/1 -) except for 3/3, and is not initialed by facility licensed staff to verify the medication had been given. In addition, on , the 7 am dose was also observed blank and not signed for.

During an interview with Employee A on at 8:50 AM, she confirmed she gave Resident #5 her treatment this morning but forgot to sign the MOR. She also confirmed the resident is to have the three times a day and is not signed as required for the 3 pm dose.

Photographic Evidence Obtained

CLASS III

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

Based on observations, resident record reviews, and staff interviews, the facility failed to ensure that medications were refilled in a timely manner for residents who received assistance with medications for 1 resident (Resident #5) out of 4 resident sampled.

The findings include:

1. A record review for Resident #5 revealed the resident was prescribed , 500mg, 2 tabs, 10meq, 1 capsule twice daily, and Co-Q 10, 1 daily.

An observation was conducted on at 8:07 AM of Resident #5 being assisted with her 9 AM medications by Employee B.

An interview with Employee B, on at 8:43AM confirmed she did not give the resident her as it is not available. A review of Resident #5 MOR reveals the staff has documented the resident's is "Out" starting through the time of the survey. She also confirmed she gave the resident , 650mg 2 tabs instead of the , 500mg that was ordered.

An interview with Employee A, LPN, on at 8:44 AM confirmed Resident #5 did not have any in the medication cart, and it has been signed as "Out" by the staff since .

An observation of medication storage was conducted for Resident #5, which revealed the resident only had a bottle of , 650 mg tablets instead of the , 500 mg that was ordered. Upon further observation, no CoQ10 could be found.

An interview with Employee A, LPN, on at 8:55 AM confirmed Resident #5's family brings her the , in, and they must have brought in with the wrong dosage of , . Employee A stated that she doesn't have the CoQ10 because she thinks it was discontinued on Friday ( ) at her physician's appointment.

A record review for Resident #5 revealed a physician order for the Co-Q10 daily. Nothing in the file at the time of the survey indicated the Co-Q 10 had been discontinued.

An interview with Employee A, on at 10:08 AM confirmed she had spoken with Resident #5 physician and he wanted her to continue on the medication. The employee confirmed she has been out of the medication and would get the medication filled.

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2. An observation was conducted on at 8:50 AM of Employee B assisting Resident #5 with medications. The resident asked Employee B where her new cream is that she just had ordered that "started with a K?". Employee B informed Resident #5 that she would look for the cream.

A record review for Resident #5 revealed a physician order for Ketoconizole cream to be applied twice a day, dated .

An observation of the facility's medication cart was conducted on and no Ketoconizole cream could be found for Resident #5.

An interview was conducted with Employee A, LPN on at 9:50 AM, and she confirmed there was a new order for Ketoconizole for Resident #5 and was not yet ordered, and it would need to sent to the pharmacy.

Photographic evidence obtained.

CLASS III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on observation, record review and staff interview, the facility failed to correct previously deficient practice related to assistance with medication self-administration in accordance with Florida statute 429.256(4), F.S. for 3 of 4 sampled residents (Resident #4, #5, and #6), and to ensure medications were filled timely according to 58A-5.0185 for 1 of 4 sampled residents (Resident #5).

The findings include:

1. An observation was conducted on at 8:17 AM of Employee B, Medication Technician, assisting Resident #4 with her medications scheduled for 9:00 am.

An observation was conducted on at 8:36 of Employee B as she proceeded to give the medications to Resident #4. Employee B handed the resident her medications and said "Here are your pills". At no time was she observed informing the resident of the pills she received. The resident was seen refusing to take her , stating " It make my eye brows out and I don't want to take it." Employee B was then observed taking the out of the souffle cup, which had been in

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the residents hands, and placing the pill it back into the medication bottle.

During an interview with Employee B on at 8:40 AM, she confirmed when a resident refuses a pill she puts it back into the medication bottle and does not dispose of it.

An interview on at 8:40 AM with Employee A, an LPN who was present during the medication pass, she confirmed medications should be disposed of and not placed back into the medication bottle after it has been contaminated.

2. A record review for Resident #5 revealed she was ordered 500 mg (2 tabs) and 10 meq (1 capsule), along with other medications.

An observation was conducted on at 8:14 AM of Resident #5 being assisted with her medications by Employee B. Employee B obtained the resident's pills and handed them to the resident and stated "Here are your pills." Resident #5's and were not included in the pills she was handed.

During an interview with Employee B on at 8:45 AM, she confirmed she did not give the resident her and said " I don't have it on the cart". Employee B also stated that she didn't give the resident her as she thought she was not longer taking it. When the MOR was reviewed with Employee B, she confirmed both medications were listed on the resident's MOR to be given. (photographic evidence obtained)

At 8:50 AM on , Employee B was observed assisting Resident #5, offering her and . Upon further review, Resident #5 was given 650 mg instead of the 500 mg as the MOR directed.

In an interview with Employee A and Employee B on at 8:55 AM, they confirmed the MOR for Resident #5 listed she is to receive 500 mg (2 tablets) but was given 650 mg (2 tablets) instead.

3. An observation was conducted on at 8:20 AM of Resident #6 receiving medication assistance from Employee B, for his morning medications. Employee B handed Resident #6 his medication and did not inform him of the medications he was taking. The resident was observed asking Employee B, "What pills am I taking? and she replied, "You are taking some colorful pills."

An interview was conducted with Employee A & B on at 9:02 AM, and they confirmed

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Employee B did not inform residents what pills they were taking. Employee B also confirmed she was not aware she couldn't return medications back into the bottle if a resident refuses their medications.

4. A record review for Resident #5 revealed the resident was prescribed , . . 500mg, 2 tabs, 10meq, 1 capsule twice daily, and Co-Q 10, 1 daily.

An observation was conducted on at 8:07 AM of Resident #5 being assisted with her 9 AM medications by Employee B.

An interview with Employee B, on . . . . . at 8:43AM confirmed she did not give the resident her . . as it is not available. A review of Resident #5 MOR reveals the staff has documented the resident's . . . . . is "Out" starting . . . . . through the time of the survey. She also confirmed she gave the resident , . . 650mg 2 tabs instead of the , 500mg that was ordered.

An interview with Employee A, LPN, on at 8:44 AM confirmed Resident #5 did not have any . . . . . in the medication cart, and it has been signed as "Out" by the staff since . . . . . .

An observation of medication storage was conducted for Resident #5, which revealed the resident only had a bottle of , 650 mg tablets instead of the , 500 mg that was ordered. Upon further observation, no CoQ10 could be found.

An interview with Employee A, LPN, on . . . . . at 8:55 AM confirmed Resident #5's family brings her the , in, and they must have brought in with the wrong dosage of , . Employee A stated that she doesn't have the CoQ10 because she thinks it was discontinued on Friday (. . . . .) at her physician's appointment.

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An interview with Employee A, on . . . . . at 10:08 AM confirmed she had spoken with Resident #5 physician and he wanted her to continue on the medication. The employee confirmed she has been out of the medication and would get the medication filled.

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An interview was conducted with Employee A, LPN on at 9:50 AM, and she confirmed there was a new order for Ketoconizole for Resident #5 and was not yet ordered, and it would need to sent to the pharmacy.

Photographic evidence obtained

In accordance with 429.42 F.S. & 58A-5.033 F.A.C., the facility must now employ or contract with a licensed registered nurse. Consultation services must begin within 14 days of the notice of uncorrected deficiencies. The facility must have available for review by the agency, a copy of the consultant ' s license and a signed and dated review of the corrective action plan within 10 days subsequent to initial on-site consultation visit. The facility must provide the agency with, at minimum, quarterly on-site corrective action plan updated until the agency determines after written notification by the consultant and the facility administrator that deficiencies are corrected and that staff have been trained to ensure that proper medication standards are followed and that consultation services are no longer required. The agency must provide the facility with written notification of such determination.

Class III