STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964654	08/23/2018
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 biennial licensure survey with Extended Congregate Care and a Generator Assessment were conducted in conjunction with a complaint survey for allegations contained within CCR#2018009967 and CCR#2018010939 at St. . . . . Plantation, state license #9149, on . . . . . & . . . At the time of the surveys, deficiencies were identified.

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on observation, staff interview and resident record review, the facility failed to appropriately assist with the self-administration of medication by failing to read the medication label, open the container, and remove the prescribed medication from the container in the presence of 1 of 6 residents sampled for medication observation (resident #11).

The findings included:

On at approximately 09:28am, Staff Member A, an unlicensed Medication Technician, was observed assisting resident #11 with self-administration of medication. Staff member A was observed standing in front of a medication cart, outside the resident's . . . , popping medications from several different medication cards into a medicine cup. Staff Member A was also observed to pick up a Handi-inhaler, and then carried the medication cup with numerous pills and the handi-inhaler into the resident's . She gave the medicine cup to resident #11, who was seated in a wheelchair facing the television and away from the door. The resident placed the medicine cup on the table in front of her while staff member A retrieved a bottle of water from the resident's refrigerator. Resident #11 proceeded to take her medication, one or two pills at a time. Resident #11 was then asked if she knew what medication she was taking, and stated, "no, but I would recognize if something new had been added, or if a pill looked different."

Review of the medical record for resident #11 revealed a total of 14 different medications to be administered daily between 8:00am -9:00am. The resident's health assessment, form 1823, showed resident #11 required assistance with self-administration of medication.

The Director of Health and Wellness was asked on . . . . for a policy regarding the procedure for assisting a resident with self-administration of medication. She stated they didn't have a policy, but staff were expected to follow state regulations.

Class III

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0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and facility record review, the facility failed to ensure that medications and nutritional supplements were stored in a safe and sanitary manner for 1 of 2 units observed (Memory Care Unit)

The findings included:

On at approximately 9:58am, the two medication refrigerators located in the nursing station of the Memory Care Unit were inspected. The refrigerator on the right contained liquid nutritional supplements.The refrigerator felt cool, but did not have a thermometer. There was an opened container of yogurt on the top shelf, and the bottom of the refrigerator was not clean [photographic evidence obtained]. The temperature log maintained on the front of the refrigerator was dated 2018 and there was no other documentation to demonstrate monitoring of the refrigerator temperatures for and .

The refrigerator on the left, the smaller refrigerator, was unlocked. The refrigerator contained medications, which included , suppositories and Acidophyllis. Inside the refrigerator was an unopened can of Red Bull and Coke, and a specimen container, that looked like , in a plastic bag [photo evidence obtained].

Class III

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

Based on observation and interview, the facility failed to ensure that medications were properly stored and labeled for 2 of 3 medication carts inspected (2nd floor and Memory Care Unit).

The findings include:

On beginning at approximately 9:45am, an inspection of the medication cart in the Memory Care Unit was conducted with the assistance of Staff Member C. The top drawer of the medication cart contained eye drops for several residents that failed to be dated when opened and/or discarded after 42 days or per manufacturer's recommendations. Included in the drawer was an opened bottle of Lumigan eye drops for Resident #16, date filled - . The bottle of eye drops failed to be labeled when opened, or discarded after 42 days. There was also an open bottle of , and Timolo , both labeled with an open date of that failed to be discarded after 42 days or

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SUMMARY STATEMENT OF DEFICIENCIES
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per manufacturer's recommendations for the same resident. There was also a plastic bag with 1 opened bottle of care 1% eye drops and 2 sealed bottle of care 1% eye drops for Resident #17. The open bottle of eye drops had an open date of . All three bottles of eye drops had an expiration date of . The medicatin failed to be discarded. Staff Member C stated that Resident #17 received the medication on an "as needed" basis. [photo documentation obtained]

On beginning at approximately 3:55pm, the medication cart on the second floor, main building of the ALF, was inspected in the presence of Staff Member B. The top drawer of the medication cart contained resident eyedrops. Included in the drawer was an medication bottle labeled "Lantanoprost 0.005%" for Resident #18. Inside the bottle were 2 different eye drop bottles. One of the bottles was the 0.005% (as noted on the medication container label) and the second bottle was for solution. The medication container indicated that the medication should be discarded after 42 days from opening. The medication bottles were not dated when opened and one bottle failed to be stored in the original pharmacy container. Staff Member B stated the medication was filled on . [photo documentation obtained]. There was also an open bottle of Tropicamide solution which failed to be dated when opened, for Resident #19. There was a bottle of 2% eye drops for Resident #20, with a label "good for 30 days." The bottle had an opened date of but failed to be discarded (.) The drawer also contained two boxes of - Novolg and Levimir for Resident #21. The outside boxes were labeled with the Resident's name and prescribing information, but the bottles inside the box failed to be labeled with a resident name, in the event separated from the box.

The medication cart included over-the-counter medications for each resident. There was an open bottle of 81mg for Resident #22 with an expiration date of . The expired medication failed to be discarded.

Class III

0075 - Use of Personnel; Emergency Care ( ) - 429.255(3-5) FS

Based on observation and interviews, the facility failed to ensure the immediate availability of an Automated External Debribrillator ( ) for 24 of 24 residents living in the free-standing Memory Care Unit.

The findings included:

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On at approximately 10:00am, with the assistance of Staff Member C, the location of the facility's was requested. The Staff Member pointed to a corner cabinet in the nurse's station with a sign on the front, " Machine and AMBU bag." The cupboard was opened and was empty. The cupboard failed to include an and an AMBU bag. Staff Member C stated that someone must have taken it, and that she was not aware that it was missing.

On at approximately 10:00am, an interview was conducted with the Director of Health and Wellness (DHW), she stated that the for the Memory Care Unit needed a battery and that one had been put on order. She stated she thought Staff Member C was aware there was no , but must have forgot.

The facility, with a capacity of greater than 17 residents, failed to ensure the ongoing provision of Emergency Care equipment was on the premises and readily available for all residents. The facility does maintain an in the main building of the ALF, located on the second floor. The is not immediately accessible to residents in the free standing Memory Care unit, located away from the main building.

Class III