Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965162	A. BUILDING: _____ B. WING _____	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERMARK OF GULF BREEZE, INC	101 MCABEE COURT GULF BREEZE, FL 32561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint numbers 2021003292 and 2021000625) was conducted at The Watermark of Gulf Breeze on -31, 2021. The facility had deficiencies at the time of the survey.	A 000		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the	A 054		

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A 054	Continued From page 1 medication. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medication technicians documented each time a medication was taken, missed, refused, or was unavailable for 3 of 3 residents reviewed for assistance with self-administration of medications (#6, #7, #9). The findings include: On . . . . . a review was conducted of the Medication Observation Record (MOR) for Resident #6 for . . . . . which revealed the resident was ordered , 15 milligrams (mg) Extended Release (ER), one tablet by every 12 hours dated . , ... ER is used for the management of severe , . Doses were scheduled for 9 AM and 9 PM daily. For the 9 AM and the 9 PM doses on there was no documentation that either dose was given and there was no documentation on the of the MOR to indicate why the doses were not administered. On . . . . & . . . the AM doses were not documented as given, on . . . . the AM or PM doses were not documented as given. On the PM dose was not documented as given and on . . . . and the PM doses were not documented as given. Observation of Cart 2 on the second floor was conducted on at 1:20PM, for Resident 7, revealed the resident was ordered , . . / (, and . . . . . , . . used to treat severe , . .) 5-325 mg. One tablet by three times daily dated . . . . Doses were set for 9 AM, 1 PM and 9 PM daily. On there was no 1 PM dose	A 054		

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A 054	Continued From page 2	A 054		

administered. On ..... no 9 AM or 1 PM doses were documented as given. On and ..... no 9 PM doses were documented as given. There was a handwritten note that states "I pop it but put it ... ", signed by Staff D, but it does not indicate what date this was done. There is no documentation on the ... of the MOR to indicate why doses were not given throughout the month of ...

Observation of Cart 3: third floor was conducted on at 10:55AM, for Resident 9. Review of MOR for ..... revealed the resident was ordered , / 7.5-325 mg. One tablet by ..... three times daily, dated . Times set for 7 AM, 1 PM and 7 PM daily. On ..... there was no 1 PM dose administered. On no 7 AM or 1 PM dose was administered. On ..... no 7 AM dose was administered. On and no 7 PM dose was administered. On ..... no doses were documented as given for the whole day. There was a note on the ... of the MOR that stated , 10:30 AM, "hydroco 7.5-325 OUT". No other explanation on the form is provided for the missing doses.

On at 12:15 PM, an interview was conducted with the owner of the facility regarding the missing doses on the residents MORs. The owner confirmed the ..... sign on/off sheet, for medication for residents 6, 7 and 9 were missing and stated he was unsure why this was not being done. The owner stated he was bringing in a nurse that teaches the med techs and they are going to start training today on how to properly handle and document ..... medications.

On /202 at 2:44 PM, an interview was

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A 054	Continued From page 3 conducted with the Registered Nurse (RN) for the facility. She stated she is the nurse who teaches "assistance with self-administration of medication" to the facility Medication Technicians (MT). Review of training material for administration of , reads: " must be signed out each time one is removed from cart and given. The remaining number is to be counted and recorded on the sign out sheet. All as needed medications are to be noted on the resident's MOR". She confirmed all should be counted after each shift by the staff person handling and distributing medications. Both off going and incoming person should count and verify the count. ANY discrepancies should be documented reported immediately. She also confirmed should ONLY be destroyed by the facility designated person." The RN confirmed medication sign on/off sheet Residents 6, 7 and 9 were inaccurate and stated, "I always train them on this but I was unaware that it was not being done. I am going to start training them today, because it looks like they do not know how to do it because even the employees that try to do it, are not doing it right". The RN was present at the nurse's station on third floor where waste box is located. She was unable to locate waste sheet. The RN stated "' I was not aware that there was not a waste sheet. I am going to train them on how to waste too." On at 09:35 AM, an interview was conducted with Staff E, medication technician (MT). When asked about the sign off she and waste documentation Staff E stated, " I have been working here for 2 years and nobody does the sign on/off sheet.'	A 054		

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A 054	Continued From page 4 On at 10:35 AM, an interview was conducted with Staff F MT. When asked about training and how to document the administration or waste of , Staff E stated, "I became a medication tech last Saturday; we had a 6 hour class. I did not know that we have to sign the sign in and off sheet. I did not know how to waste a medication. Review of Facility's "Medications" policy dated reads : " Medication will be administered according to physician's orders and recorded on the Medication Administration Form." Class III	A 054		