STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967108	11/12/2015
NAME OF PROVIDER OR SUPPLIER **GENTLE CARE ASSISTED LIVING II**	STREET ADDRESS, CITY, STATE, ZIP CODE **77-A BRUNSWICK LANE** **PALM COAST, FL 32137**	

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

0000 Initial Comments

On , 2015 a biennial relicensure survey was conducted at Gentle Care Assisted Living II. Deficient practice was identified during the survey.

0008 Admissions - Health Assessment

Based on observation, resident record review, and interview with the Administrator, the facility failed to obtain complete information on the Resident Health Assessment (AHCA form 1823) for 1 of 2 sampled residents whose records were reviewed (Resident #5).

The findings included:

A record review conducted for Resident #5 found a health assessment dated / and signed by the examining practitioner. The examiner neglected to indicate whether Resident #5 required assistance with the self-administration of her medications, and/or what level of assistance she required. Section 3, which is to be completed by the Administrator to indicate services provided to the resident was left blank.

An interview was conducted with the Administrator at 12:20 pm on / . She acknowledged the missing information on Resident #5's health assessment.

Class III

0052 Medication - Assistance with Self-Admin

Based on observation, resident record review, and interviews with staff, the facility failed to provide assistance with self-administration of medications accordance with procedures described in Section 429.256, F.S. and this rule for 4 of 4 residents observed for medication review (Residents #2, #3, #4, and #5).

The findings included:

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1. An observation was conducted for Resident #5 at 8:09 am on / . Employee A, a Caregiver, was observed to wash her hands, retrieve the resident's medications and the medication observation record (MOR) , pour a glass of water, and go to the resident's . She dispensed the following medications from their bubble pack(s) into her hand, then placed them into Resident #5's hand, one at a time: , 20 milligrams (mg), , 500 mg, , ( ) 100 mg. Employee A did not read the labels, or inform Resident #5 what she was receiving.

2. An observation conducted for Resident #4 at 8:15 am on / . Employee A was observed to retrieve the resident's medications, dispense her medications into her hand, and hand the following to the resident: 100 mg, 325 mg, 800 mg, 100 mg, 1000 micrograms (mcg). Employee A was unable to read the medication labels, so she retrieved her glasses. She was still unable to read the label or tell the resident what she was receiving while assisting her with medication self-administration.

3. Resident #3 was observed at 8:25 am on / / receiving assistance with medications. Employee A repeated the process with handwashing, retrieving medications, and taking them to the table where the resident was seated. She told Resident #3 she had her medication, provided a glass of water, and dispensed the resident's medications into her hand. She handed the following to the resident one at a time: 10 mg, 25 mg, 30 mg, 30 mg, extended release 100 mg. Employee A did not read the labels, or state what she was dispensing.

4. Resident #2 was observed at 8:30 am on / . Employee A repeated the same process with the set-up of medications. She dispensed the following medications from their pharmacy-labeled bottles into a small plastic cup: , 2 mg, , 8 milliequivalents (meq), D 600 mg, 100 mg, Presdnisone 5 mg, / mg, 320 mg, , 50 micrograms (mcg), , 500 mg, , 81 mg, 5 mg, and Oxybutinin 5 mg. She was reminded by the Administrator early in the dispensing process to tell the residents what medications they would be receiving. Employee A still did not read the labels or tell the resident what was being dispensed. At 8:40 am Resident #2 stopped Employee A, stating the brown pill, which had been already been placed into the cup, was for night time only. Employee A double-checked the MOR and the label, picked the pill up from the plastic cup, and returned it to it's pharmacy issued bottle.

A review of the MOR and the resident record found that one medication, 0.5 mg, was also supposed to be taken daily at 8:00 am. This medication had been signed out as given all days during the month, including this same morning. However, Employee A was not observed to dispense this medication, and there were none located in Resident #2's medication storage bin. The dosage

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SUMMARY STATEMENT OF DEFICIENCIES
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was noted on the MOR as 80 mcg instead of 8 meq, per the pharmacy label. The MOR also noted ..... 500 mg daily at 8:00 am. The label for the ..... read 500 mg .... (twice daily); however, a hand-written sticker on the top of the bottle instructed "Direction change, take 1 at 8:00 am."

Review of Resident #2's record found no physician's order for the to change from twice daily, to only once per day. There was no discontinue order for the .

An interview was conducted with the Administrator at 9:15 am on / . When asked about the ....., she explained the resident had been out of this medication for several days. Resident #2's hospice nurse was aware of this. She was asked why the medication had been signed out as given, when in fact, it was not. The Administrator stated staff were supposed to circle the space on the MOR when the medication was not available, and note this on the back of the page. The Administrator confirmed the MOR did not match the label for the , and that it was a transcription error. She stated Resident #2's hospice nurse gave the verbal order to change the dose from twice to once daily, but she was unable to produce documented evidence of a physician-ordered direction change.

A telephone call was placed to the hospice provider's Team Manager at 9:30 am on / . She reviewed the physician's orders for Resident #2, and stated the was still ordered for twice daily. She did not know who gave the direction change order to the facility. The Team Manager insisted clarification was needed. The Administrator acknowledged the error in an interview at 9:40 am on / .

Class III

0054 Medication - Records

Based on observation, resident record review, and interviews with staff, the facility failed to maintain an accurate medication observation record (MOR) for 1 of 4 residents observed for assistance with self-administration of medications (Resident #2).

The findings included:

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Resident #2 was observed at 8:30 am on / receiving assistance with self-administration of medications. Per observation of the pharmacy labels, Employee A dispensed several medications, including the following, into a small plastic cup: 8 milliequivalents (meq) daily, and 500 mg twice daily. On the top of the bottle, there was a hand-written sticker on the top of the bottle instructing "Direction change, take 1 at 8:00 am."

A review of the MOR and the resident record found that one medication, 0.5 mg, was also supposed to be taken daily at 8:00 am. This medication had been signed out on the MOR as given all days in , including this same morning. However, Employee A was not observed to dispense this medication. Inspection of Resident #2's medication storage bin found there was no available for use. The dosage was noted on the MOR as 80 mcg , instead of 8 meq per the pharmacy label. The MOR also noted 500 mg daily at 8:00 am. The label for the read 500 mg (twice daily); however, a hand-written sticker on the top of the bottle instructed "Direction change, take 1 at 8:00 am."

Review of Resident #2's record found no physician's order for the to change from twice daily, to only once per day.

An interview was conducted with the Administrator at 9:15 am on /. When asked about the , she explained the resident had been out of this medication for several days. She was asked why the medication had been signed out as given, when in fact, it was not. The Administrator stated staff were supposed to circle the space on the MOR when the medication was not available, and note this on the back of the MOR. The Administrator confirmed the MOR did not match the label for the , and that it was a transcription error. She stated Resident #2's hospice nurse gave the verbal order to change the dose from twice to once daily. She was unable to locate documented evidence of a physician-ordered direction change.

A telephone call was placed to the hospice provider's Team Manager at 9:30 am on /. She reviewed the physician's orders for Resident #2, and stated the was still ordered for twice daily. She did not know who gave the direction change order to the facility. The Team Manager insisted clarification was needed. The Administrator acknowledged the error in an interview at 9:40 am on /.

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Class III

0078 Staffing Standards - Staff

Based on a review of employee records, and interview with the Administrator, the facility failed to obtain annual documentation of freedom from for 1 of 4 sampled employees (Employee D) whose files were reviewed.

The findings included:

A record review conducted for Employee D, the Administrator, found missing annual documentation of freedom from . Chest X-ray results in the record indicated the last screening was on .

An interview was conducted with the Administrator at 12:20 pm on / . She stated she thought the chest X-ray was good for two years. She acknowledged the regulatory requirement for annual examination and documentation from a health care provider.

Class III

0083 Training - First Aid and

Based on a review of employee records, and interview with staff, the facility failed to ensure that a staff member who had completed a course in First Aid and ( ) and held a currently valid card was in the facility at all times.

The findings included:

A personnel review conducted for Employee B found she was hired in 2012. The First Aid card issued to the employee expiring / was issued by an on-line provider, and was not on the approved list of agency trainers for First Aid and . There was no evidence indicating the employee

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was observed and signed off for skill proficiency in .

A telephone interview was conducted with the employee at 11:45 am on / / . She confirmed she worked in the facility on Sundays.

Per interview with the Administrator at 12:00 pm on / / , she confirmed this employee worked on weekends, alone. She did not realize the on-line First Aid/ provider was not on the agency's approved list of certifying trainers.

Class III

0085 Training - Nutrition & Food Service

Based on an review of personnel files and interview with the Administrator, the facility failed to ensure the individual designated as the food service supervisor received a minimum of 2 hours of continuing education annually in topics pertaining to nutrition and food service.

The findings included:

A review of Employee D's personnel file found she was the designated person responsible for the supervision of the facility's food service. Further review of the file found no documentation of the required two hours training in nutritional and food service pertaining to assisted living facilities. A certificate dated was located in the file, and noted it was good for three years.

An interview was conducted with the Administrator at 12:20 pm on / / . She acknowledged that although her food handling certificate was good for more than one year, that the regulatory requirement was for 2 hours of annual continuing education for the food service designee.

Class III

0093 Food Service - Dietary Standards

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Based on observation, facility record review, and interview with staff, the facility failed to note menu substitutions before or at the time the meal was served, or to maintain a 3-day supply of nonperishable food and water, based on the number of weekly meals the facility has contracted with residents to serve.

The findings included:

1. An observation of the breakfast meal conducted at 8:15 am on / found Resident #4 dining on biscuits, jelly and coffee. Interview with the resident at this time found that was her preferred breakfast. Observation of Residents #1 and #3 found they were served french toast, bacon, and hot cereal.

A review of the facility menu, signed and dated by the Registered Dietician on / found it called for french toast, bacon and hot cereal.

An interview was conducted with the Caregiver at 8:40 am on /. When asked to see a substitution log for Resident #4's meal, she was not able to produce one. In a subsequent interview with the Administrator at 12:05 pm on /, she confirmed no substitution log was being maintained to accommodate resident preferences.

2. An observation of the non-perishable emergency food supply found there was insufficient protein stores for the current census of 6 residents. A partially used container of peanut butter held only approximately 5 servings. There were 4 servings of canned tuna, 6 servings of chicken and dumplings and 10 servings of canned tuna. A 10 pound can of nacho style cheese was also located. For a current census of 6 residents, a minimum of 18 gallons of water was needed. There was only 14 on hand.

An interview was conducted with the Administrator at 12:05 pm on /. She inspected the non-perishable food and water supply, an confirmed insufficient amounts of protein and water in the event of an emergency. She confirmed there was no substitution log in place.

Class III

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0162 Records - Resident

Based on a review of resident records, and interview with staff, the facility failed to maintain complete resident records and demographic data including Medicaid and/or Medicaid, or other health insurance information, for 2 of 2 sampled residents (Residents #2 and #5) whose records were reviewed.

The findings included:

A record review for Resident #2 found he was admitted . Further review of the record found missing health insurance information on the resident's demographic information sheet.

A record review for Resident #5 found she was admitted to the facility on . Further review of the record found missing health insurance information on the resident's demographic information sheet.

An interview was conducted with the Administrator at 12:20 pm on / . She confirmed the missing information in both resident records.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Gentle Care Assisted Living II
77-A Brunswick Lane
Palm Coast, FL 32137

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by a representative 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 surveyor. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LL/JM/sm
Enclosure
XG90

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