AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) DATE SURVEY COMPLETED
	AL11967955	11/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE MANOR ASSISTED LIVING AND MEMORY CARE	**1321 HERBERT ST PORT ORANGE, FL 32129**

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

0000 Initial Comments

A complaint investigation (CCR #2015008615) was conducted at Grace Manor on [redacted]. Grace Manor had deficiencies at the time of the investigation.

0052 Medication - Assistance with Self-Admin

Based on observation, record review and staff interview, the facility failed to properly assist residents with self administration of medications in accordance with procedures described in Section 429.256, F.S. and this rule for 4 Residents (Resident #1, Resident #2, Resident #3 and Resident #4) out of 5 sampled resident observed for medication assistance.

The findings include:

1) A record review was conducted for Resident #1 and it revealed a physician order dated [redacted] for [redacted] (anti-[redacted]) 0.5 mg 1 tablet twice a day ([redacted]). (photographic evidence obtained)

A review of the [redacted] Medication Observation Record (MOR) for Resident #1 revealed the order for [redacted] 0.5 milligrams (mg) 1 tablet twice a day ([redacted]) was not seen on the MOR. (photographic evidence obtained)

An interview with the Executive Director on [redacted] at 11:55 AM confirmed the order for Ativan 0.5 mg 1 [redacted] for Resident #1 was received from the physician on [redacted] and was not seen on the [redacted] MOR.

An interview with Employee A on [redacted] at 12:20 PM confirmed the facility did not have the medication [redacted] 0.5 mg for Resident #1 stored in the medication cart and the resident did not receive the medication. (photographic evidence obtained)

2)An observation was conducted on [redacted] at 9:36 AM of Resident #2 being assisted with her 9 AM

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) DATE SURVEY COMPLETED
	AL11967955	11/09/2015
NAME OF PROVIDER OR SUPPLIER **GRACE MANOR ASSISTED LIVING AND MEMORY CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1321 HERBERT ST** **PORT ORANGE, FL 32129**	

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

medication by Employee B. The Employee entered the residents handed the resident a clear medicine cup with the medications Hydroclorathiazide 12.5 mg 1 tablet and 100 mg 1 tablet in the cup. The resident proceeded to take the medications without difficulty and Employee B left the resident's .

A review was conducted of the Medication Observation Record (MOR) for Resident #2 and it revealed an order for the medication Balsalazide ( ) 750 mg 1 capsule three times a day on the MOR. Upon further review the initials of the staff were observed circled (signifies medication was not given) on the dates / to / . The reason the medication was not given was observed written on the back of the MOR and read "On order" (photographic evidence obtained). The Medication (for) 50 microkilograms (mcg) 1 tablet by mouth every morning was also circled as not given on / - / and no initials are seen for the date / .

An interview with the Administrator on / at 10:10 AM confirmed that Resident #2 had not received her Balsalazide from / - / . She stated " The pharmacy is waiting on a check from the family".

An interview with the Administrator on / at 11:38 AM confirmed Resident #2 did not receive her ordered by the physician. She stated "On 11/3 & 11/4 the resident probably didn't get her . And the day of the 11/5 I think she got it that day and the staff forgot to sign it".

3) A record review was conducted for Resident #3 and it revealed a signed order by Advanced Registered Nurse Practitioner (ARNP) dated / for treatment every 6 hours scheduled while awake as tolerated x 1 week then as needed (PRN) (photographic evidence obtained).

A review was conducted of the MOR for Resident #3 and no order for treatments was found.

An interview with the Executive Director on / at 11:15 AM confirmed the order for the 's is not entered on the MOR for Resident #3. The Executive Director was asked if the resident w... receiving the breathing treatments and she stated " I doubt she is getting them, if there not on the MOR".

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) DATE SURVEY COMPLETED
	AL11967955	11/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE MANOR ASSISTED LIVING AND MEMORY CARE	**1321 HERBERT ST PORT ORANGE, FL 32129**

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

An observation was made of the medication cart in the locked memory unit on / at 11:40 AM and it revealed a unopened box of breathing treatments stored in the top drawer.

4) An observation was conducted of Resident #3 being assisted by Employee B, Med tech, with her 9 AM medications. The resident received , , , , , and . (photographic evidence obtained)

A record review was conducted for Resident #4 and it revealed a laboratory result dated for Resident #4 of level 5.5 (range 3.5-5.1). On the bottom on the lab slip an orde written V.O. (verbal order) by ARNP discontinue (.) and recheck on /. (photographic evidence obtained)

A review was conducted of the MOR for Resident #4 and it revealed the resident continued to receive the twice a day until date of survey on / (photographic evidence obtained)

w with the Executive Director on / at 1:00 PM confirmed the ARNP had ordered the for Resident #4 to be discontinued and the resident was still receiving the medication from the facility staff and no work had been drawn for the resident due to her refusal as of today's date /.

A review was conducted of Resident #4's record and no documentation was found to notify the ARNP or the resident family member the resident refused her lab work on /, and the resident was still receiving her after it was ordered to be discontinued.

Class III

0054 Medication - Records

Based on record review and staff interviews, the facility failed to maintain an accurate daily medication observation record for 4 Residents (Resident #1, Resident #2, Resident #4 & Resident #5) out of 5

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967955	11/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE MANOR ASSISTED LIVING AND MEMORY CARE	1321 HERBERT ST PORT ORANGE, FL 32129

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

sampled resident.

The findings Include:

1) A record review was conducted for Resident #1 and it revealed a physician order dated for (anti-) 0.5 mg 1 tablet twice a day ( ).

A review of the Medication Observation Record for Resident #1 revealed no documentation for 0.5 mg 1 tablet and was not given.

An interview with the Executive Director on / at 11:55 AM confirmed the order for 0.5 mg 1 for Resident #1, and confirmed it was not on the MOR for the resident.

In an interview with Employee A on / at 12:20 PM, she confirmed the facility did not have the medication 0.5 mg for Resident #1. (photographic evidence obtained)

2) A review was conducted of the Medication Observation Record (MOR) for Resident #2 and it revealed the Resident's Health Care providers name, telephone number, and resident allergies medications was not seen on the MOR for Resident #2. In addition an order for Balsalazide ( ) 750 milligrams (mg) 1 capsule three times was seen on the MOR with the init s of the staff circled (signifies medication was not given) on the dates 11/ to 11/9/20915. The re ion medication was not given was written on the back of the MOR "On order". (photographic evidenc obtained). The Medication (for) 50 microkilograms (mcg) 1 tablet b mouth every morning was circled as not given on 11/3/2015 - / and not initials are seen the date / .

An interview with the Administrator on / at 10:10 AM confirmed that Resident #2 had nc received her Balsalazide from / - / .

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) DATE SURVEY COMPLETED
	AL11967955	11/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE MANOR ASSISTED LIVING AND MEMORY CARE	1321 HERBERT ST PORT ORANGE, FL 32129

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

An interview with the Administrator on / at 11:38 AM stated "On 11/3 & 11/4 the resident probably didn't get her . And the day of the 11/5 I think she got it that day and the staff forgot to sign it". The Executive Director confirmed no documentation can be found in the residents chart that the physician for Resident #2 was made aware she did not receive her medication as ordered.

3) A record review was conducted for Resident #3 and it revealed a signed order by Advanced Registered Nurse Practitioner (ARNP) dated / treatment every 6 hours scheduled while awake as tolerated x 1 week then as needed (PRN)(photog phic evidence obtained).

A review was conducted of the MOR for Resident #3 and it no order for treatments could be found.

An interview with the Executive Director on / at 11:15 AM confirmed the order for the 's is not entered on the MOR for Resident #3.

4) A review was conducted of the Medication Observation Record (MOR) for Resident #4 and it revealed the Resident's Health Care providers name, telephone number, and resident allergies to e ns was not seen on the MOR. In addition the initials of the staff where missing on the date / for her 9 am medications. The medications listed are , and (photographic evidence obtain

An interview with the Executive Director on / at 12:25 PM confirmed the facility staff did not sign the MOR for Resident #4 on / and could not verify if the resident received her medications that day.

5) A review was conducted of the MOR for Resident #5 and it revealed the Resident's Health Care providers name and telephone number, was not listed. Upon further investigation initials of the staff was missing on the dates / & 11/6/2015 for the Medication for 8 PM and Levothyroxine at 6 am on / . (photographic evidence obtained)

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) DATE SURVEY COMPLETED
	AL11967955	11/09/2015
NAME OF PROVIDER OR SUPPLIER GRACE MANOR ASSISTED LIVING AND MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1321 HERBERT ST PORT ORANGE, FL 32129	

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

An interview with the Administrator on / at 12:30 PM confirmed the initials from the staff are missing to verify the residents received their medications.

Class III

0056 Medication - Labeling and Orders

Based on observation and staff interviews, the facility failed to have medications filled timely for 3 of 5 (Resident #1, #2, & #3) sampled residents and failed to have medications properly labeled for 1 Resident (Resident #1) out of 5 sampled residents.

The findings include:

1) A record review was conducted for Resident #1 and it revealed a physician order dated for . (anti-) 0.5 mg 1 tablet twice a day ( ). (photographic evidence obtained)

A review of the Medication Observation Record (MOR) for Resident #1 revealed the order for 1 tablet twice a day ( ) was not seen on the MOR. (photographic evidence

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967955	11/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE MANOR ASSISTED LIVING AND MEMORY CARE	**1321 HERBERT ST PORT ORANGE, FL 32129**

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

#2 and it revealed an order for the medication Balsalazide ( ) 750 mg 1 capsule three times a day on the MOR. Upon further review the initials of the staff were observed circled (signifies medication was not given) on the dates / to / . The reason the medication was not given was observed written on the back of the MOR and read "On order". (photographic evidence obtained). The Medication (for) 50 rokilograms (mcg) 1 tablet by mouth every morning was also circled as not given o / :015 and no initials are seen for the date / .

An interview with the Administrator on / at 10:10 nfirm that Resid #2 had not received her Balsalazide from / / . She) " Th pharmacy is waiting on a check from the family".

3) A record review was conducted for Resident #3 and it ed a s ned order by Advanced Registered Nurse Practitioner (ARNP) dated /15 f tr tment every 6 hours scheduled while awake as tolerated x 1 week then as needed (PRN ograp c evidence obtained).

A review was conducted of the MOR for Resi and order for treatments was found.

An interview with the Executive Director on / at AM c firmed the order for the Duoneb's is not entered on the MOR for Resident #3. The Executi ector s asked if the resident was receiving the breathing treatments and she stated " I do e is g ng them, if there not on the MOR".

An observation was made of the medication cart in the mem / unit on 11/9/2015 at 11:40 AM and it revealed a unopened box of breathing tr nts st d in the top drawer.

3) An observation was conducted on / at 9:10 Emp ee A assisting Resident #1 with eye drops. The employee was observed taking a bottle drop rom the top drawer of the medication cart and walking over to the resident and pl drop each eye and Employee A returned the bottle back to the cart.

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967955	11/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE MANOR ASSISTED LIVING AND MEMORY CARE	**1321 HERBERT ST PORT ORANGE, FL 32129**

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

A review of the bottle of eye drops revealed Opti-Fresh eye drops with no Resident name or instructions were seen on the bottle.

An interview with Employee A on / at 9:15 AM and she confirmed there was no label on Resident #1 Opti-Fresh eyed drops. The employee was asked how she knew the drops were for Resident #1 and she stated, "I know their his. I was here when he got them and I know his bottle."

Class III

0057 Medication - Over The Counter (OTC) Products

Based on observation and staff interviews, the facility failed to have properly label Over the Counter eye drops for 1 Resident (Resident #1) out of 5 sampled residents.

The findings include:

An observation was conducted on / at 9:10 AM of Employee A assisting Resident #1 with eye drops. The employee was observed taking a bottle of eye drops (Opti- Fresh) from the top drawer of the medication cart, walked over to the resident and placed 1 drop in each eye of the resident. Employee A then returned the bottle of eye drops back to the cart.

A review of the bottle of Opti-Fresh eye drops revealed was no label on the bottle which identified the resident's name, or the health care provider's directions for use.

An interview with Employee A on / at 9:15 AM and she confirmed there was no label on Resident #1 Opti-Fresh eyed drops. The employee was asked how she knew the drops were for Resident #1 and she stated, "I know their his. I was here when he got them and I know his bottle."

Class III

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) DATE SURVEY COMPLETED
	AL11967955	11/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE MANOR ASSISTED LIVING AND MEMORY CARE	1321 HERBERT ST PORT ORANGE, FL 32129

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

Z816 Background Screening-Compliance Attestation

Based on employee record review and staff interview, the facility failed to have a current Level II background screening for 1 out of 3 employee records that were reviewed. (Employee A)

The findings include:

An employee record review was conducted for Employee A and it revealed a date of hire as / . Employee A was the Memory Care Coordinator at the facility. A Level II background screening found with the eligible date of / .

An interview with the Administrator on / at 10:55 AM confirmed the facility did not have a new Level II background screening completed for Employee A.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Grace Manor Assisted Living And Memory Care
1321 Herbert Street
Port Orange, FL 32129

RE: CCR #2015008615

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by 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 10, 2016.** 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, RP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

AF/JM/sm
Enclosure
XG90

Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone:(904) 798-4201; Fax:(904) 359-6054
AHCA.MyFlorida.com