STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965343	03/17/2016
NAME OF PROVIDER OR SUPPLIER **CHRISTIAN MANOR OF CLEARWATER, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1845 N. KEENE ROAD CLEARWATER, FL 33755**	

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

0000 Initial Comments

Assisted Living Facility

An unannounced Complaint survey (CCR#2015013388 & 2016002433 & 2016002453 & 2016002513) was conducted at Christian Manor of Clearwater on .

The Christian Manor of Clearwater, Assisted Living Facility, had deficiencies at the time of this visit. Complaints CCR#2015013388 & 2016002433 & 2016002453 & 2016002513 were all substantiated with deficiencies cited.

0007 Admissions - Criteria

Based on record review and interview the facility failed to follow the admission criteria regarding medication administration, special diets, not requiring 24 hour nursing or care and by having a medical examination from a health care provider stating the residents's needs could be met in an assisted living facility by allowing 3 (#1, #2 & # 9) of 8 residents sampled for admissions to be admitted to the facility.

Findings included:

A Record review on of Resident #1's health assessment dated (no date on the health assessment) revealed the health care provider stated on the first page that the resident needed medication administration but on page 4 of the same health assessment there was a check mark by assistance with self-administration of medication. His diet was regular, blenderized texture and he needed 24 hour nursing or care and in the health care provider's professional opinion, the resident's needs could not be met in an assisted living facility.

A Record review of the medical record on / for Resident #1 revealed the facility never got a clarification from the health care provider on what kind of medication assistance the resident actually needed. The diet of regular, blenderized textured was not a diet the facility could offer the resident. The facility's therapeutic diets were no concentrated sweets, no added salt and low fat/low . The facility could not provide 24 hour nursing or care for the resident because the facility did not employee nurses or psychiatrists. The health care provider stated his needs could not be met at an assisted living facility. The facility administrator could have determined if the resident was appropriate for admission to the facility if she had based her decision on an assessment of the strengths, needs and preference of the resident. There was no documentation in the medical record showing this was ever done.

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A Record review on of Resident #2's health assessment dated / / revealed the health care provider stated on the first page that the resident needed medication administration but on page 4 of the same health assessment there as a check mark by assistance with self-administration of medication. Her diet was low concentrated sweets, no added salt and mechanical soft. and she needed 24 hour nursing or care and in the health care provider's professional opinion, the resident's needs could not be met in an assisted living facility.

A Record review of the medical record on for Resident #2 revealed the facility never got a clarification from the health care provider on what kind of medication assistance the resident actually needed. The diet of low concentrated sweet was not a diet the facility could offer the resident. The facility's therapeutic diets were no concentrated sweets, no added salt and low fat/low . The facility could not provide 24 hour nursing or care for the resident because the facility did not employee nurses or psychiatrists. The health care provider stated her needs could not be met at an assisted living facility. The facility administrator could have determined if the resident was appropriate for admission to the facility if she had based her decision on an assessment of the strengths, needs and preference of the resident. There was no documentation in the medical record showing this was ever done.

A Record review on of Resident #9's health assessment dated revealed the health care provider did not state whether the resident needed medication assistance with self-administration of medication or needed medication administration. Her diet was calorie controlled .

A Record review of the medical record on for Resident #9 revealed the facility never got a clarification from the health care provider on what kind of medication assistance the resident actually needed. The diet of calorie controlled was not a diet the facility could offer the resident. The facility's therapeutic diets were no concentrated sweets, no added salt and low fat/low .

The facility administrator could have determined if the resident was appropriate for admission to the facility if she had based her decision on an assessment of the strengths, needs and preference of the resident. There was no documentation in the medical record showing this was ever done.

Staff #B when interviewed on at 12:15 pm stated she cooked the meals and she did not know what mechanical soft or belnderized texture meant. She stated everyone gets what she serves.

The administrator stated on at 2:30 pm that she doesn't pay attention to the health assessments because the doctors don't know her residents. Only she knows them so she does what is best for them.

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Class III

0008 Admissions - Health Assessment

Based on record review and interview, the facility failed to provide a completed health assessment within 30 days of admission for 8 (#1, #2, #3, #4, #6, #9, #12 & #13) of 8 residents sampled for completed health assessments.

Findings included:

A Record review on of Resident #1's health assessment dated (no date) revealed the resident's health assessment did not have the following information completed: whether the individual will require any assistance with the administration of medication and the date of the examination, and the name, address, telephone number of the examiner, the title of the examiner and license number of the examining health care provider.
The resident was admitted to the facility on / and the facility had 30 days to have the health assessment completed.

A Record review on of Resident #2's health assessment dated revealed the resident's health assessment did not have the following information completed: the resident's date of birth on the front page, the facility name, facility address, facility phone number and facility contact person,whether the individual will require any assistance with the administration of medication and the address and telephone number of the examiner and the title of the examiner.
The resident was admitted to the facility on / / and the facility had 30 days to have the health assessment completed.

A Record review on of Resident #3's health assessment dated (no date on health assessment)) revealed page 4 of the health assessment was missing. The information contained on this page was: a list of all current medications, whether the individual will require any assistance with the administration of medication and the date of the examination, and the name,signature, address, telephone number of the examiner, the title of the examiner and license number of the examining health care provider.
The resident was admitted to the facility on and the facility had 30 days to have the health assessment completed.

A Record review on of Resident#4's health assessment dated revealed the resident's health assessment did not have the following information: the facility name, facility address, facility

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phone number and facility contact person, special diet instructions was not completed the address and telephone number of the examiner.
The resident was admitted to the facility on and the facility had 30 days to have the health assessment completed.

A Record review on of Resident#6's health assessment dated / revealed the resident's health assessment did not have the following information: the facility name, facility address, facility phone number and facility contact person, no list of prescribed medications, whether the individual will require any assistance with the administration of medication and completed the address and telephone number of the examiner and license number of the examining health care provider.
The resident was admitted to the facility on / and the facility had 30 days to have the health assessment completed.

A Record review on of Resident #9's health assessment dated / revealed the resident's health assessment did not have the following information: the resident's name and date of birth was not filled in on all four pages, the facility name, facility address, facility phone number and facility contact person, no height and weight filled in, no medication list, there was no mark placed in the appropriate box which indicated if the resident needs assistance with self-administration of medications or if the resident needs medication administration and there was no phone number for the health care provider.
The resident was admitted to the facility on / and the facility had 30 days to have the health assessment completed.

A Record review on of Resident #12's health assessment dated / revealed the facility information on the first page of the health assessment was the name, address and phone number of another facility, not the facility where she was to be admitted.
The resident was admitted to the facility on / and the facility had 30 days to have the health assessment completed.

A Record review on of Resident #13's health assessment dated revealed the resident's name and date of birth were no identified at the top of page 2, 3 and 4 of the health assessment.
The resident was admitted to the facility on and the facility had 30 days to have the health assessment completed.

The administrator was interviewed on at 2:30 pm and she stated she must have missed those sections. She stated it was her responsibility to look them over when the physician gives them to her and

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somehow she missed those sections.

Class III

0025 Resident Care - Supervision

Based on observation, record review, and interview, the facility did not provide the care and services deemed needed per Resident Health Assessments (AHCA Form 1823) for 5 (#1, #2, #9, #12 & #13) out 8 residents sampled for care and services.

Findings included:
A Record review on of Resident #12's health assessment dated / revealed resident needs assistance with bathing, dressing, and toileting, needs to be monitored for well-being, and needs to be assisted with self-administration of medication or medication administration. The health care provider did not state which one was appropriate.
When asked on at 9:35am where Resident #12's located in the facility, the Administrator stated Resident #12 and Resident #13 are living in the independent house in the back of the facility. The Administrator stated the residents do not receive any services from the facility.
When Resident #12 was interviewed on at 9:42 am, she was observed sitting on her bed crying with a bag of medications in her hand. She stated she could not do her own medications and she needed to have help with bathing and dressing. She stated the Administrator put me over here without asking and told me I was independent and I was not going to get my medications from the girls anymore and I would have to do everything myself. Resident #12 stated: " I cannot do that and I want to be moved back into the house. This is the second time she has done this to me and I cannot take it anymore. What am I going to do? "
Surveyor observed there were Medication Observation Records in the MOR notebook for 9 current residents (#3-#11) as of at 9:00am. There were no MORs in the book for additional current residents #12 & #13. On at 9:30am, Surveyor had observed in the medication cart a drawer section with Resident #12 ' s name and one pack containing medications (, , , &) for bedtime on . On at 2:15pm, Surveyor observed 2 packs filled with daily medications (Aspir-Low, , , , , , & ,) and a bottle of medications (50mg), all labeled for Resident #12, sitting unattended on the table in the area with medication cart & unlocked refrigerator. Staff B stated she didn ' t know where the medications came from, that they belong to Resident #12, and that the Owner/Administrator must have put them there. Surveyor observed the medications still left unattended on the table at 3:00 pm. The facility is not

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providing the services required for Resident #12.
A Record review on of Resident #13's health assessment dated revealed resident is independent in all activities of daily living (ADLs), but needs assistance with self- administration of medications. Resident #13 was observed in the independent house on at 9:50 am and she agreed to be interviewed on at 9:51 am. Resident #13 stated she had been living there for about one year. She stated she used to live in the facility but the Administrator told her she was moving to the independent house and she would do her own medication. Resident #13 stated she was told by her daughter that she had to live in an assisted living facility so she could have her medications given to her. The resident expressed over having to remember to give herself medication. She was afraid she might forget and then something bad would happen to her. She had finally told her daughter she didn't want to do her medications anymore. She said her daughter was surprised to hear she was not getting help with her medications because no one had told her daughter the mother was no longer going to get assistance with her medications. The facility is not providing the services deemed required for Resident #13.
When interviewed on , at 2:45 pm, the Administrator stated that Resident #12 and Resident #13 are capable of doing everything by themselves. The Administrator further stated: " The Resident Health Assessments are wrong. I know what is best for them. They can be independent. "
Per interview with Resident #13 ' s daughter on at 5:00 pm, she stated she is taking her mother out of the facility because the only reason she was in there was to have assistance with her medications. She stated the Administrator "at some point and without notice to me decided to no longer assist my mother with her medications. My mother did not say anything to me because she feels she should try to do it by herself but this only puts more stress on her." Resident #13's daughter further stated: " When I found out, I decided to move her to another facility where she will have assistance with her medications. "
A Record review on of Resident #1's health assessment dated (no date on the health assessment) revealed the health care provider stated on the first page that the resident needed medication administration but on page 4 of the same health assessment there was a check mark by assistance with self-administration of medication. Resident #1's health assessment indicated need for a regular diet with blenderized texture, need for 24-hour nursing or care, and, in the health care provider's professional opinion, the resident's needs could not be met in an assisted living facility.
A Record review of the medical record on for Resident #1 revealed the facility never got a clarification from the health care provider on what kind of medication assistance the resident actually needed. The diet of regular, blenderized textured was not a diet the facility could offer the resident. The facility's therapeutic diets are no concentrated sweets, no added salt and low fat/low . The facility could not provide 24-hour nursing or care for the resident because the facility did not employee nurses or psychiatrists. The health care provider stated Resident #1 ' s needs could not be met in an assisted living facility. The facility Administrator could have determined if the resident was appropriate for admission to the facility if she had based her decision on an assessment of the

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strengths, needs and preferences of the resident. There was no documentation in the medical record showing this was ever done. The facility could not provide the dietary, medication, and nursing or services needed by Resident #1. The health care provider had stated the resident's needs could not be met in an assisted living facility.
A Record review on of Resident #2's health assessment dated revealed the health care provider stated on the first page that the resident needed medication administration but on page 4 of the same health assessment there as a check mark by assistance with self-administration of medication. Her diet was low concentrated sweets, no added salt and mechanical soft. and she needed 24 hour nursing or care and in the health care provider's professional opinion, the resident's needs could not be met in an assisted living facility.
A Record review of the medical record on for Resident #2 revealed the facility never got clarification from the health care provider on what kind of medication assistance the resident actually needed. The diet of low concentrated sweet was not a diet the facility could offer the resident. The facility's therapeutic diets were no concentrated sweets, no added salt and low fat/low . The facility could not provide 24 hour nursing or care for the resident because the facility did not employee nurses or psychiatrists. The health care provider stated her needs could not be met at an assisted living facility. The facility administrator could have determined if the resident was appropriate for admission to the facility if she had based her decision on an assessment of the strengths, needs and preference of the resident. There was no documentation in the medical record showing this was ever done.
The facility could not provide the dietary, medication, and nursing or services needed by Resident #2. The health care provider had stated the resident's needs could not be met in an assisted living facility.
A Record review on of Resident #9's health assessment dated revealed the health care provider did not state whether the resident needed assistance with self-administration of medication or needed medication administration. Her diet was calorie controlled . Record review of the medical record on for Resident #9 revealed the facility never got a clarification from the health care provider on what kind of medication assistance the resident actually needed. The diet of calorie controlled was not a diet the facility could offer the resident. The facility's therapeutic diets were no concentrated sweets, no added salt and low fat/low .
The facility administrator could have determined if the resident was appropriate for admission to the facility if she had based her decision on an assessment of the strengths, needs and preference of the resident. There was no documentation in the medical record showing this was ever done.
The facility cannot provide the dietary and medication services needed by Resident #9. The health care provider had stated the resident's needs could not be met in an assisted living facility.
When interviewed on at 12:15 pm, Staff B stated she cooks the meals and does not know what mechanical soft or blenderized texture means. She stated everyone gets what she serves.
The Administrator stated on / at 2:30 pm that she doesn't pay attention to the health assessments

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because the doctors don't know her residents. Only she knows them so she does what is best for them.

Class III

0052 Medication - Assistance with Self-Admin

Based on observation, record review, and interview, the facility failed to ensure that residents are assisted with self-administered medications in accordance with physician orders and in accordance with procedures described in Section 429.256, F.S., including prompting residents to take medications as prescribed. The facility also failed to ensure that when a resident who receives assistance with self-administration of medication is away from the facility and from facility staff, an option is provided for the resident to take medications as prescribed. Medications were not being provided as ordered for 6 of 6 residents reviewed.

Findings included:
Per Surveyor review of Medication Observation Records (MORs) in use by the facility on beginning at 9:30am, Resident #6 was prescribed 1000mg with orders to take one tablet by mouth twice a day with meals. The medication was listed on the MOR to be provided at 8am & 8pm and initialed as provided daily at 8am & 8pm on 3/1 through and at 8am on day of visit , not provided with meals as prescribed.
On at 12:30pm, Surveyor observed Staff C provide Resident #6 a soufflé cup with generic . Staff C stated Resident #6 gets 30mg of for an upset stomach. After providing the medication and returning the to the cart, Surveyor asked Staff C if she was going to write it down (that she gave the medication)- Staff C said yes, checked the MOR, could not find the medication listed, was looking at back of MOR when Staff B showed her where the medication was listed; Staff C initialed as provided. Surveyor observed handwritten on Resident #6 ' s MOR, listed after medications typed by the pharmacy, with no physician order found per record review: - Take 2 tbsp as needed for upset stomach. PRN was listed in the MOR time slot. The medication was initialed as provided daily 3/1- , with no times specified, and not listed on reverse (page blank) with times provided, reason/results, etc.
Resident #6 was prescribed Sucralfate 1gm with orders to take one tab by mouth 3 times a day before meals on an empty stomach. This medication was not provided to the resident on . When Surveyor asked Staff B at 12:40pm on why the medication had not been given before lunch as prescribed, Staff B stated that the Owner/Administrator gives Resident #6 her meds. Per review of Resident #6 ' s MOR, this medication was listed to be provided at 8am, 12pm & 8pm, not before meals as prescribed, initialed as provided at 8am, 12pm, & 8pm 3/1 through and at 8am on day of visit - not provided at noon, or before lunch meal, on day of visit .
Resident #6 was prescribed 0.5% 3 times a day inhalation 30 days - no start or end

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date specified; initialed as provided at 8am, 12pm , & 8pm 3/1 through and at 8am on day of visit - not provided at noon on day of visit .

Resident #6 was prescribed 20mg with orders to take one tablet by mouth with meal daily (typed on MOR by pharmacy). A hand-printed note was added: " at bedtime. " This medication was listed to be provided at 8pm and initialed as provided daily at 8pm, not with meals as prescribed.

Staff C stated at 10:30am Resident #5 has lunch meds, a pain pill. Surveyor observed no noon medications provided on day of visit. Staff B stated at 1:05pm that Resident #5 doesn ' t get 12pm med ( ) because she is not here. Staff B stated Resident #5 left at 8:30am, went out for the day with her daughter, will return at 3:30pm, and will get 8pm med. When Surveyor asked why Resident #5 wasn ' t given her 12pm med to take while out, Staff B then stated Resident #5 got one before breakfast, then another after breakfast. Per MOR review, Resident #5 was prescribed 600mg with orders to take " 1 PO 3x daily " at 8am, 12pm, & 8pm - initialed as provided at 8pm on , at 8am, 12pm, & 8pm through and at 8am on day of visit . There was no notation on the MOR of Resident #5 having been given her 12pm medication on as prescribed.

Resident #7 was prescribed 25mg tablets with orders to take one tab PO if Syst>150. 8pm is listed on the MOR next to this medication & initialed as provided 3/1 through at 8pm. Surveyor observed no readings listed & no list on reverse of MOR (page blank) with times provided, reason/results, etc. Listed below is 5mg tab with orders to take one tab PO at bedtime. It appears that initials signifying provision of medication belong to this med - not correctly documented & confusing - no indication of provision of , as ordered.

Resident #9 was prescribed HFA 0.09mg with orders to take 1-2 puffs every 6 hours as needed for . Per review of Resident #9 ' s MOR, 8, 12, & 8 are handwritten in the hours column, and the medication is initialed as provided every day 3/1 through at noon, not every 6 hours as needed. The medication was not listed on reverse (page blank) with times provided, reason/results, etc.

Resident #4 was prescribed 10MEQ with orders to take 4 capsules by mouth every 8 hours. Per review of Resident #4 ' s MOR, 8A & 8P are handwritten in the hours column, and the medication is initialed as provided every day 3/1 through at 8am & 8pm and at 8am on , day of facility visit. This medication is not being provided every 8 hours as prescribed.

Resident #4 was prescribed 2.5mg with orders to take one tablet every other day 30 minutes before last dose. Per review of Resident #4 ' s MOR, this medication is initialed as provided every other day 3/2 through . There is no time of provision indicated; there is no way to determine or ensure provision of this medication 30 minutes before the last dose, as ordered.

Record review on of Resident #1's Resident Health Assessment revealed the doctor prescribed NORCO to be given 3 times a day. NORC is the same thing as , as it was written on the Medication Observation Record (MOR). Resident #1 was admitted on ; his MOR for , 2015, indicated he received this pain medication three times a day starting on . On

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, the resident ran out of the pain medication and it was reordered from the pharmacy. The resident did not get the pain medication until .
The Administrator stated on at 10:30am that while she was waiting for the pharmacy to send her the pain medication, she used Staff A's medication, which was , to give to Resident #1. She stated she could not stand to see the resident in pain so she used the Staff A's medication to keep the resident pain free. The Administrator stated she feels she did nothing wrong by giving the resident the employee's medication until his prescription order arrived from the pharmacy. Per interview conducted with the Administrator on at 2:00pm, the Administrator stated residents are being provided the medications they need.

Class III

0054 Medication - Records

Based on record review and interview, the facility failed to ensure proper maintenance of a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications that includes the name of the resident and any known the resident may have, the name of the resident's health care provider, and the health care provider's telephone number.

Findings include:
Per Surveyor review of Medication Observation Records (MORs) on beginning at 9:30am, the facility uses a mixture of typed and handwritten MORs that do not include required information. Seven of 7 Medication Observation Records (MORs) randomly selected do not contain required information as follows:
Resident #4 ' s typed MOR contains resident ' s name, , date of birth, facility name, & date: 2016. The MOR does not include any known the resident may have, the name of the resident's health care provider, and the health care provider's telephone number.
Resident #5 ' s handwritten MOR contains resident ' s name & date: 2016. The MOR does not include any known the resident may have, the name of the resident's health care provider, and the health care provider's telephone number.
Resident #6 ' s typed MOR contains resident ' s name, , date of birth, facility name, & date: 2016. The MOR does not include any known the resident may have, the name of the resident's health care provider, and the health care provider's telephone number.
Resident #7 ' s handwritten MOR contains resident ' s name & date: 2016. The MOR does not include any known the resident may have, the name of the resident's health care provider, and the health care provider's telephone number.
Resident #9 ' s typed MOR contains resident ' s name, , date of birth, facility name, & date: 2016. The MOR does not include any known the resident may have, the name of the resident's

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health care provider, and the health care provider's telephone number.
Resident #10 ' s typed MOR contains resident ' s name, , date of birth, facility name, & date: 2016. The MOR does not include any known the resident may have, the name of the resident's health care provider, and the health care provider's telephone number.
Resident #11 ' s handwritten MOR contains resident ' s name & date: 2016. The MOR does not include any known the resident may have, the name of the resident's health care provider, and the health care provider's telephone number.
The Owner/Administrator acknowledged the missing information and was observed on at 2:40pm calling Resident #6 ' s daughter at her place of employment. With telephone on speaker, the Owner/Administrator was asking the person on the other end of the phone to get Resident #6 ' s daughter on the phone because she needed the name of the resident ' s doctor. The daughter was unavailable at the time, so the owner left that message. Per record review, Resident #6 had been admitted to the facility on / .

Class III

0055 Medication - Storage and Disposal

Based on observation and interview, the facility failed to ensure that centrally stored medications are kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times, failed to ensure that medications requiring refrigeration are secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked, and failed to ensure that medications are kept separately from the medications of other residents.

Findings included:
On at 8:30am, AHCA Surveyors observed an unlocked refrigerator in an area with a medication cart & small table with 2 chairs adjacent to open living the left and kitchen/counter to the right. Two signs were observed posted on the unlocked refrigerator, one stating: " Residents are not allowed in the refrigerator; " the second stating: " Do not draw and put in fridge. Only draw up when it is going to be given. "
Surveyor opened the unlocked refrigerator on at 9:15am and observed on the top shelf 4 boxed medications in front of 2 bags of hotdog rolls and one medication container leaning to the side of the rolls. Surveyor observed on the second shelf 5 bottles of Boost nutritional drinks, not labeled for any specific resident, next to loaves of bread. Surveyor observed bags of hamburger rolls on the bottom shelf. Surveyor observed on the door of the unlocked refrigerator medications belonging to Resident #12, labeled as follows: Sol 0.5% filled / / - Instill one drop in each eye every 12 hours; Sol 2% - Instill one drop in each eye every 12 hours; and 2

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Sol.005% - 1opened filled // // & 1 unopened filled - Instill one drop in each eye at bedtime.
Surveyor also observed on the door of the unlocked refrigerator medication belonging to Resident #10, labeled as follows: Gel Dro 0.4-0 3% - Instill one drop in each eye 4 times a day as needed for dry eyes.
When Staff B opened the refrigerator on at 10:15am to retrieve food items, she stated the medicines belong to different residents.
Surveyor observed there were Medication Observation Records in the MOR notebook for 9 current residents (#3-#11) as of at 9:00am. There were no MORs in the book for additional current residents #12 & #13. The Owner/Administrator stated @9:30am that both residents #12 & #13 are independent residents. Per Surveyor interview conducted with Resident #12 on at 9:42am, the resident was very upset that the Owner/Administrator had brought her medications to her in the morning of AHCA visit ( ) and told Resident #12 she is independent and will have to do her own medications. On at 9:30am, Surveyor had observed in the medication cart a drawer section with Resident #12 ' s name and one pack containing medications (, , &) for bedtime on . On at 2:15pm, Surveyor observed 2 packs filled with daily medications (Aspir-Low, , , , , &) and a bottle of medications (50mg), all labeled for Resident #12, sitting unattended on the table in the area with medication cart & unlocked refrigerator. Staff B stated she didn ' t know where the medications came from, that they belong to Resident #12, and that the Owner/Administrator must have put them there. Surveyor observed the medications still left unattended on the table at 3:00pm.
All of the medications referenced above were freely accessible to all residents, staff, and visitors, not stored and secured as required.

Class III

0056 Medication - Labeling and Orders

Based on observation, record review and interview, the facility failed to ensure that medications prescribed to be provided as needed include specific directions, including the circumstances under which it would be appropriate for the resident to request the medication and any limitations, for 4 of 4 residents reviewed with as needed (PRN) medication orders.

Findings include:
Per Surveyor review of Medication Observation Records (MORs) in use by the facility on beginning at 9:30am, several medications are prescribed to be given as needed, without any directions specifying when it would be appropriate for the resident to request the medication, no records of reason for provision of PRN medications, and no record of results of the PRN medication provision. Examples

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include:
Resident #6 was prescribed SOD 100mg with orders to take 1 capsule by mouth twice a day as needed for . PRN is listed twice in the MOR times slot - the 1st PRN line is initialed as provided daily 3/1- /, no times specified, and not listed on reverse (page blank) with times provided, reason/results, etc.
Handwritten on Resident #6 ' s MOR, not typed by pharmacy, and no physician order found per record review: - Take 2 tbsp as needed for upset stomach - PRN listed in time slot; initialed as provided daily 3/1- /, no times specified, and not listed on reverse (page blank) with times provided, reason/results, etc. The facility is providing this medication on a scheduled, not PRN, basis.
Resident #5 was prescribed 5.325mg - " 1 PO every 6 hrs as needed. " The medication is listed on the MOR to be provided at 8am, 12pm, 8pm, & 12am, every 4 hours, not 6, and not as needed-scheduled times listed and initialed as provided at 8am, 12pm, & 8pm on , 8am & 8pm on /, 8am, 12pm, & 8pm on through , and at 8am on ; not listed on reverse (page blank) with times provided, reason/results, etc. The facility is providing this medication at incorrect times on a scheduled, not PRN, basis.
Resident #5 was prescribed 15mg - " 1 PO every 4 hrs as needed for pain. " The medication is listed on the MOR to be provided at 8am, 12pm, 8pm, & 12am - initialed as provided at 8pm on , at 8am, 12pm, & 8pm through and at 8am on day of visit ; not listed on reverse (page blank) with times provided, reason/results, etc. The facility is providing this medication at incorrect times on a scheduled, not PRN, basis.
Resident #5 was prescribed Inhaler - 2 puffs 2x daily as needed - listed as PRN to be provided at 8am & 8pm, not as needed -scheduled times listed and initialed as provided at 8am on through and at 8pm on ; not listed on reverse (page blank) with times provided, reason/results, etc.
Resident #7 was prescribed 25mg - Take 1 tab PO if Syst>150. 8pm is listed on MOR next to medication & initialed as provided 3/1 through / at 8pm - no readings listed & not listed on reverse (page blank) with times provided, reason/results, etc. Listed below is 5mg tab - Take 1 tab PO at bedtime - Appears that initials signifying provision of med belong to this med - not correctly documented & confusing - no indication of provision of as ordered.
Resident #9 was prescribed HFA 0.09mg - Take 1-2 puffs every 6 hours as needed for . 8, 12, & 8 handwritten in hours column; initialed as provided every day 3/1 through / at noon, not provided during facility visit. The facility is providing this medication once a day on a scheduled, not PRN, basis.
Per interview conducted with the Administrator on at 2:00pm, the Administrator stated residents are being provided the medications they need.

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0057 Medication - Over The Counter (OTC) Products

Based on observation and interview, the facility failed to ensure that over the counter medications, , nutritional supplements and nutraceuticals, referred to as OTC products, are labeled with the resident's name for whom the product is prescribed. The facility failed to abide by regulations specifically stating that a stock supply of OTC products for multiple resident use is not permitted in any facility.

Findings included:
On at 9:30am, AHCA Surveyor observed a sign stating " PRN " on one drawer of the locked medication cart. Per observation, the drawer contained CVS cream with Resident #12 ' s name handwritten on the box; CVS Nasal not labeled for any specific resident; Maximum Strength Suppressant & not labeled for any specific resident; Walgreens Milk of Magnesia not labeled for any specific resident; Good Neighbor Pharmacy Chest not labeled for any specific resident; Plus Day & Night capsules with first name " Bob " handwritten on the box (not a current resident, per observation and record review); Liqui-Gels not labeled for any specific resident. Surveyor had also observed (at 9:15am) 5 bottles of Boost nutritional drinks, not labeled for any specific resident, next to loaves of bread on the second shelf of an unlocked refrigerator adjacent to the medication cart . Per interviews (9:30-10:00am) with Staff B & Staff C, the Owner/Administrator gets those products for the residents, or sometimes families will bring them in, and Staff give residents those medications when residents need them, when they have a or a or a . Staff B stated the Owner/Administrator tells them which product to give the residents unless she is not in the facility. Per interview conducted with the Administrator on at 2:00pm, the Administrator stated residents are being provided the medications they need.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on observation, record reviews, and interviews, the facility failed to ensure that all unlicensed staff providing residents assistance with self-administration of medications complete an initial 4-hour training in providing assistance with self-administered medications and safe medication practices in an assisted living facility and a minimum of 2 hours of continuing education training annually.

Findings included:
Per record reviews conducted at the facility on , 1 of 4 unlicensed staff (Staff A) providing residents assistance with self-administration of medications has not completed the required initial

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minimum 4-hour training in providing assistance with self-administered medications and safe medication practices in an assisted living facility; 1 of 1 unlicensed staff (Staff D) providing residents assistance with self-administration of medications, due for annual updated training, has not completed the required annual minimum of 2 hours of continuing education.
Per record review, Staff A, hired on , is an unlicensed staff person who provides residents assistance with self-administration of medications. Staff A ' s employee file contains a certificate entitled " RN.org Certificate of Completion " dated for 2 online hours in Assistance with Self Administration of Medications. The Certificate states the training is approved in 5 states by Boards of Nursing for 2 contact hours " For an employee who is a licensed healthcare practitioner as defined in Florida Statutes. " Per record review and interview with the facility Administrator on , Staff A is not a licensed healthcare practitioner. The Administrator further stated: " Staff A is the Manager, and it ' s the Manager ' s responsibility to make sure meds are written on the MOR (Medication Observation Record). " There was no evidence of Staff A having completed the required initial 4 hour training in providing assistance with self-administered medications and safe medication practices in an assisted living facility.
Per record review, Staff D, with employment/hire dates listed as / / - / & & / , is an unlicensed staff person who provides residents assistance with self-administration of medications. Staff D ' s employee file contains a training certificate for 4 hours of medication training on / . As of review, there was no evidence of Staff D having completed the required minimum of 2 hours of continuing education training annually on providing assistance with self-administered medications and safe medication practices in an assisted living facility. Staff D was due for the 2-hour update by .
Per observation, review of the facility ' s , 2016, Medication Observation Records (MORs), and interviews with the Administrator and Staff B and Staff C, residents are provided medications by the Administrator and Staff A, Staff B, Staff C, and Staff D.

Class III

0092 Food Service - General Responsibilities

Based on record review and interview, the facility failed to have the administrator provide therapeutic diets as ordered by the residents' health care provider for 3 of 7 residents who were sampled for therapeutic diets.

Findings included:

Record review on of the facility's menu revealed the facility's only therapeutic diets which were offered to the residents were: no concentrated sweets, no added salt and low fat/low .
Record review on of Resident #1's health assessment dated revealed he needed a

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regular, blenderized textured diet. The facility does not offer this diet.
Record review on of Resident #2's health assessment dated / / revealed she needed a low concentrated sweet, no added salt and mechanical soft diet. The facility does not offer mechanical soft diets.
Record review on of Resident #4's health assessment revealed she did not have a diet marked on her health assessment. The facility did not verify what diet the health care provider would like the resident to have for her diet.
Record review on of Resident #9's health assessment dated / revealed she needed a calorie controlled diet. The facility does not offer this diet.
Staff #B stated on at 12:00 pm that she did not know what mechanical soft or blenderized texture was and she said everyone gets what she serves.

Class III

0093 Food Service - Dietary Standards

Based on observation and record review, the facility failed to provide a nutritious noon meal for 11(#3, #4, #5, #6, #7, #8, #9, #10, #11, #12 and #13) of 11 residents observed during the noon meal.
The facility did not keep a substitution log of foods substituted from the posted menus and substitutions was not noted before the meal was served so the residents were made aware of the change in the menu.
The facility failed to have the menu conspicuously posted and easily available for the residents to read.

Findings included:

The menu was observed on to be on the far side of the refrigerator next to the counter. The residents would have to come into the kitchen and look around the refrigerator to see it. It was not readily accessible to the residents.
There was no substitution log to be reviewed and observations in the kitchen and dining area on before the lunch meal revealed no one posted a revised menu so the residents were aware of the changes in the menu for the lunch meal.
The menu was observed to be reviewed by a licensed dietician and it was signed as reviewed on / and met the required nutritional standards. The lunch menu for was roasted turkey, stuffing, string beans, mixed salad with salad dressing, ice cream. coffee, tea or water. The meal was observed at 12:15 pm and the staff served baked chicken and pasta, green beans, no mixed salad and fresh fruit for dessert. The dessert was suppose to be ice cream.
The facility was not providing a nutritious meal because the mixed salad was part of the nutritional value of the meal and without it the meal did not meet the nutritional standards for the meal.

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When staff#B on at 12:15 pm was asked where was the mixed salad, she stated the residents can not eat it so they don't serve mixed salad. Nothing was observed to be substituted for the mixed salad. She also stated she does not have a substitution log so she doesn't write down the substitutions and keep them. She also stated she does not tell the residents ahead of time if there is a substitution on the menu.
Class III

0160 Records - Facility

Based on record review and interview, the facility failed to ensure maintenance of an up-to-date admission and discharge log including resident discharge dates, reason for discharge, and identification of the facility or home address to which the resident was discharged (or date of if occurred while in the care of the facility), for 8 former facility residents.

Findings included:
AHCA Surveyor reviewed the facility ' s Admission/Discharge Log on beginning at 8:20am. The Log revealed two residents (#1 & #2) who had been discharged from the facility that did not have discharge dates, reasons for discharge, and identification of the facility or home address to which the residents were discharged. Per interview on at 8:30 am, the Administrator stated that she had not had time to fill out the discharge dates. She stated they both were gone and she would do it later.
AHCA Surveyor ' s further review of the facility ' s Admission/Discharge Log on revealed a pattern of not completing the Admission/Discharge Log as required:
Resident #14 had been admitted to the facility on . Per observation and confirmation by Staff B and the Administrator on , Resident #14 was discharged from the facility - The Admission/Discharge Log did not indicate Resident #14 ' s date of discharge, reason for discharge, or information regarding facility or home address to which the resident was discharged.
Resident #15 had been admitted to the facility on . Per observation and confirmation by Staff B and the Administrator on , Resident #15 was discharged from the facility - The Admission/Discharge Log did not indicate Resident #15 ' s date of discharge, reason for discharge, or information regarding facility or home address to which the resident was discharged.
Resident #16 had been admitted to the facility on . Per observation and confirmation by Staff B and the Administrator on , Resident #16 was discharged from the facility - The Admission/Discharge Log did not indicate Resident #16 ' s date of discharge, reason for discharge, or information regarding facility or home address to which the resident was discharged.
Resident #17 had been admitted to the facility on . Per observation and confirmation by Staff B and the Administrator on , Resident #17 was discharged from the facility - The Admission/Discharge Log did not indicate Resident #17 ' s date of discharge, reason for discharge, or information regarding facility or home address to which the resident was discharged.

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Resident #18 had been admitted to the facility on . Per observation and confirmation by Staff B and the Administrator on , Resident #18 was discharged from the facility - The Admission/Discharge Log did not indicate Resident #18 ' s date of discharge, reason for discharge, or information regarding facility or home address to which the resident was discharged.
Resident #19 had been admitted to the facility on . Per observation and confirmation by Staff B and the Administrator on , Resident #19 was discharged from the facility - The Admission/Discharge Log did not indicate Resident #19 ' s date of discharge, reason for discharge, or information regarding facility or home address to which the resident was discharged.
Resident #1 had been admitted to the facility on . Per observation and confirmation by Staff B and the Administrator on , Resident #1 was discharged from the facility - The Admission/Discharge Log did not indicate Resident #1 ' s date of discharge, reason for discharge, or information regarding facility or home address to which the resident was discharged.
Resident #2 had been admitted to the facility on . Per observation and confirmation by Staff B and the Administrator on , Resident #19 was discharged from the facility - The Admission/Discharge Log did not indicate Resident #19 ' s date of discharge, reason for discharge, or information regarding facility or home address to which the resident was discharged.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Christian Manor Of Clearwater, Inc
1845 N. Keene Road
Clearwater, FL 33755

RE: CCR #2016002433, 2015013388, 2016002453 & 201602513

Dear Administrator:

This letter reports the findings of four complaint surveys that was conducted on , 2016 by representative(s) 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 , 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(s). Should you have any questions please call **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

fcl

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
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PRC/clt
Enclosure: State (5000-3547) Form
XG90