RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Gulf Breeze Courtyard
3428 GULF BREEZE PARKWAY
GULF BREEZE, FL 32561

Attention: Tamie Frazier, Administrator

Dear Frazier:

This letter reports the findings of a licensure and complaint survey (2016001247) conducted 6-8, 2016 by representatives of the Agency for Health Care Administration. Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's request as directives below:

The inspection resulted in findings of non-compliance in the following areas:

A 0025 – Resident Care – Supervision - The facility failed to provide necessary care and follow-up related to prescribed medication and health care for three of ten sampled residents.

You are directed to comply with the following:

1) The Administrator, Director of Nursing and all facility employees must complete the 4-hour training on Assistance with Self-Administration of Medication from a licensed pharmacist or Registered Nurse. The documentation of completion of this training should include the name of the trainer, credentials, location of training, and number of hours of training provided, and must be maintained in each employee's employee file, and be available for Agency staff to review upon request. This must be completed no later than **, 2016.**

2) The facility must establish a medication policy that will address the following:

A) Obtaining/ordering resident medications from the pharmacy,
B) Who has access to medication;
C) What to do in the event that medication is reported missing by residents or staff, to whom it should be reported, and where it should be documented;

D) Procedure for pain medications and "as needed" medications,

E) When to contact a resident's health care provider and responsible party if the resident does not receive prescribed medication.

All current and future staff must be trained on this policy and these steps and be able to demonstrate knowledge of this policy. Documentation of this training must be maintained at the facility and available for Agency staff to review upon request. This must be completed no later than , 2016.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact **Laura Manville**, ALF Enforcement Team Manager, Survey and Certification Support Branch, at (727) 552-1955 or **Donah Heiberg**, Tallahassee Field Office, 850-412-4540.

Sincerely,

Donah Heiberg
Field Office Manager

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965645	04/08/2016
NAME OF PROVIDER OR SUPPLIER **GULF BREEZE COURTYARD**	STREET ADDRESS, CITY, STATE, ZIP CODE **3428 GULF BREEZE PARKWAY** **GULF BREEZE, FL 32561**	

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

0000 Initial Comments

A re-licensure survey with LMH and LNS survey was conducted at Gulf Breeze Courtyard on 4/6- . At the time of survey the facility had deficient practice at a harm level.

0025 Resident Care - Supervision

Based on observation, resident and staff interview and record review the facility failed to provide appropriate care related to pain medication for residents #5, : medication for resident #10, and behavior medications for resident #14, impacting three of 10 sampled residents.

The findings are:

1. Resident #5:

Review of resident #5 health assessments (HA) found she was admitted / from local hospital with admitting diagnosis is , , and Joint Replacement.
During interview with resident #5 on / at approximately 2:00 PM indicated the Advanced Registered Nurse Practitioner (ARNP) met with her about 3 weeks ago. She told her that the pain medication she was taking was not helping with pain. The ARNP said she would try a patch for pain. She indicated she has not received any new pain medication and she indicated she asks nurses daily about it and no one knows anything. The resident said last year she her left femur which developed an then she her left hip and had to have surgery for this. She said she has in her left knee which is very painful. Observation of the knee noted it and painful when she touched it and upon movement. She indicated she is receiving 2 times a week her and that even makes the pain worse.
Interview with Medical Tech A on at 2:15 PM indicated the resident asks everyday about the pain patch and all I do is let the nurses know.
Interview with the Director of Nursing (DON) on at 2:20 PM indicated we do have a problem with this. I do remember the ANRP about 2 - 3 week ago saying she was going to request a pain patch for pain to MD. I have not heard anything about that.
Review of the chart lacked any notes from the ARNP since admission / / . Interview with the DON indicated the ARNP visits weekly and sees all residents once a month. She said the ARNP's company never sends us any documentation of the visits and we don't get any from the MD. We have had problems in the past about MD not responding to issues in a timely manner.
Record review indicated a fax the ARNP had sent the request to the MD on / . The request indicated the resident current pain medication regimen is ineffective, please provide recommendations. The MD faxed recommendation back to ANRP on (11 days later) with recommendation "sounds

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appropriate, watch SATs and sedation, Question-OSA ( ), start , 25 milligram patch and titrate up slowly and wean signed and dated / .
Interview with DON on at 2:50 PM indicated it will take a few more days to get the medication because this is a and the MD has to sign the script and send it to pharmacy in Bradenton, Florida. Then it will be sent. The DON stated they have a backup pharmacy in town but they use it for and for emergency medications. Review of the order found the MD ordered 25 mg (milligram) patch; apply one patch every 72 hours and remove old patch 3 days.
Review of ARNP evaluation dated indicates patient pain is , constant and activity worsens the signs and symptoms. She states that simply bending or attempting to straighten leg causes severe increased stabbing pain. She states she is no longer ambulating with rollator secondary to unsteadiness and level of pain. She states pain is constant and does not improve regardless of position, activity or rest. She says she is taking her pain meds as ordered however she reports it is ineffective. She states it lasts approximately 2 hours and then pain returns. She states pain disturbs her sleep and her functional ability. She says when pain is controlled she is fairly independent and can do things herself. She reports pain does decrease to at times and on a rare occasion as little as 3- / . She is currently on pain medication regimen of 5 mg every 4 hours and 50 mg three times a day and Voltaren gel four times a day. She states that if it wasn't for pain she feels she would be doing very well.
Interview with resident on at 3:30 PM found her in bed. When entering the was moaning in pain. She pointed to her right knee which she said she has . It is enlarged and when she moved it or touched it she grimaced and moaned with pain. She indicated on pain scale it was . She couldn't understand why it takes so long to get pain medications. During interview she was trying to reposition self and she kept moaning in pain.
Interview with the ANRP on at 10:30 am indicated she did an evaluation on concerning pain. She notified MD of the evaluation requesting stronger pain medication. She indicated she sent it to the MD on . On received back the ordered for patch. Now the MD has to sign the script and send it the pharmacy. She indicated she saw the resident this morning in the dining she was frustrated about the pain med.
Interview with resident on / at 10:00 am indicated she got the patch yesterday evening. It has helped so much. Pain level now is / . She indicated she couldn't believe it took this long to suffer in pain.
2. Resident #10:
Interview with resident on at 11:23 am indicated she has had missing medications. She stated, "I was without my for about a week. My physical kept telling me that my was up when I would show up for . I was feeling more short of breath when I didn't have it. I told the staff and they told me that they were just waiting for it to come in, that it was a mix up. I was really concerned about it. They are giving it to me now. I just got it back yesterday / ."
A record review a prescription written on for 40 mg by mouth daily, dispense 30, no refills. The MOR (Medication Observation Record) shows that starting on , the resident began receiving

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her . There are several dates circled on the 2016 MOR. The Director of Nursing (DON) was interviewed at this time and asked what the circles indicate. She stated that the circles meant that the medication wasn't given for some reason. On , , , , , , , and , the initials on the medication line for were circled, indicating they weren't given. A review of the legend indicates that on each date listed above, "meds not arrived" was documented. The MOR for 2016 indicates med's not given on 4/1 and . The reason was meds not arrived. There was no order within the chart reordering the .

Review from thinned record for and for indicates the resident was ordered to receive 40 mg daily shows medication given.

Interview with Medication Tech on / at 11:40 am indicated she couldn't give the medicine because it wasn't here.

An interview was conducted with ARNP on at 10:30 am about this resident. The ARNP states that during her meeting with the resident last week that the resident stated that she had been without her for approximately one week. The ARNP said, "The day she mentioned it, I wrote an E-script for the medicine and sent it to the facility." The surveyor notified the ARNP that the resident's record does not contain any notes or orders from her visit. She stated that she would fax them from her office. The fax arrived to the facility. Upon review, there was an E-script filed by the ARNP on / via pharmacy. The E-script showed that it was filed on / via pharmacy, resuming the 40 mg by mouth daily. Eleven refills are ordered. In addition, notes from the visit with the resident are faxed as well. The notes are dated / from the ARNP which states, "Patient reported elevated over the past 1-2 weeks. Patient reports she was told by that had been elevated. She is unaware of the actual reading. Per staff they are not aware of elevated and no available to discuss. Per staff patient is out of for the past few days. Patient reports she has noticed increased at rest and on exertion and just not feeling as well as usual." Within the notes, the plan indicates, "F/U (follow-up) on daily monitoring x 14 days, facility not performing. -refill ."

Upon record review of resident's chart, no order for is noted. There are no notes from the nurse practitioner regarding visit. Also, there are no documented. The are no notes from the resident's physical either.

A record review was conducted of the resident's Health Assessment (HA) dated / . The medical history is listed as: muscle , seborrhea , , pain, aphasia, , a-fib, , sequelae, , , , and , . It indicates no or behavioral issues, only and .

Record review of the physical notes indicated for the following dates: , ; on , ; on , ; on 4/1, . After reviewing the physical , the surveyor reviewed the facility's log for this resident. On , ; on , / ; on , ; on 4/1, . Of note, the MOR indicates that the resident is also taking 25 mg by mouth twice daily for . She was receiving the throughout the month of

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An interview was conducted with the DON on at 1:40 PM indicates she didn't know why mediations were not given.

3. Resident #14:
Record review of Health Assessment (HA) dated / indicated resident was admitted / with diagnosis of and Right sided .
Review of Nursing notes dated from / - / / indicated the resident alert and oriented and a times. On / the resident was found crying and states that she didn't expect it to be so hard. On / resident expressed she disliked the facility, it's not what she thought it would be. A note in the resident's record on / indicates resident having trouble adjusting to her surrounding, asking why she is here. On / / the resident indicated I feel like I want to commit . Staff notified the director of nursing and administrator. The resident indicated she wanted to cut her throat. 911 was called and the resident was sent to hospital for evaluation.
Upon admission the resident had orders to give resident 1 milligram (mg) ii (2) at bedtime for . Review of the medication observation record (MOR) for /, 23, 25 and 26 indicted the resident did not receive her medication The resident did not receive the ordered medication 500 mg ii in the AM. The MOR shows on /, 21 and 27 she didn't receive medication.
Another medication was not given (32.4 mg one half tabs, take 4 tabs at bedtime). On /, 22, 23 she did not receive medication and no reason documented. 25 mg I two times a day was ordered for . The resident did not receive medication /, 22 and 23. Reasons for medications not given on MOR are for meds not arrived and no reasons given.
Interview with the director of nursing on indicated this resident was sent to hospital on / for behaviors issues. She confirmed the findings and indicated staff are to order medications and make sure medications are available. They are to document when they give medications and if they don't they are to document why.
Class II

0052 Medication - Assistance with Self-Admin

Based on observation, record review and staff interview found unlicensed staff administering medications to 5 of 5 sampled residents observed during medication administration. (#4, 6, 10, 11, 12)

The findings are:

Review of all resident's Health Assessments incated they need assistance with self adminstration of medications.

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#10-
Observation of medication administration by Medication Tech A (MT) on starting at 10:00 am indicated MT standing in living many residents and staff. She pulled meds from the med cart out of view of resident #10. She poured the med's into a med cup out of view of the resident. She gave the med cup with medications to the resident and she took them.

#4-
Observed MT A on at 11:04 am pour resident #4 med's up at med cart away from resident and then take the meds in the cup to the resident.

#11
MT A poured medications into med cup for residnets #11 on / at 11:09 am away from the resident and out of view.

#6-
Observed MT A pour up resident #6 medications into med up in front of resident on at 11:11 am. She did not take the medications to the resident and discuss what medications she was pouring up.

#12-
Observed resident attempting to take medications from MT A on at 11:17 am. She poured up his medication while standing at the med cart away from him. She crushed the medication and put in applesauce. She handed the med to the resident and handed him the spoon. He didn't know what to do with the medication cup and the spoon. After several attempts by the MT explaining and showing him what to do it took the medications.

Interview with the administrator on / at approximately 2:10 PM indicated we have nurses around the clock 24 hours per day and seven days a week who are to administer medications. The MT is not to administer medications.
Class III

0093 Food Service - Dietary Standards

Based on staff interview and record review the facility failed to have menus reviewed annually by a licensed or registered dietitian.

The findings are:

Review of cycled menus for 2016 found them not reviewed and signed by a registered dietitian. The last

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menus reviewed and signed was cycle II dated for 2014-2015 and dated / .
Interview with dietary manager on at 3:30 PM indicated this cycle of menus have not been signed but will be sent out today to be approved and signed.
Interview with administrator confirmed the findings on at 10:45 am confirmed the findings.
Class III