STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11968253 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTLE CARE ASSISTED LIVING 3	27 ROLLING SANDS DR PALM COAST, FL 32164

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0008 Reg. # 429.26(4-6) FS; 58A-5.0181(2) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR [signature]	DATE 4/25/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/1/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

EVENT ID: F8OK12

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968253	R
NAME OF PROVIDER OR SUPPLIER **GENTLE CARE ASSISTED LIVING 3**	STREET ADDRESS, CITY, STATE, ZIP CODE **27 ROLLING SANDS DR** **PALM COAST, FL 32164**	

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

0000 Initial Comments

On , 2016 a follow-up to the biennial relicensure survey in was conducted at Gentle Care Assisted Living 3. Deficient practice was identified during the surveys.

0054 Medication - Records

Based on a review of resident records, and interview with staff, the facility failed to maintain a daily medication observation record (MOR) for residents who received assistance with self-administration of . The MOR did not list the health care provider ' s telephone number for 4 of 6 sampled residents (Residents #3, #4, #5 and #6), and did not include a chart for recording each time the medication is taken, any missed dosages, or refusals to take medication as prescribed for 4 of 6 sampled residents whose records were reviewed (Residents #1, #3, #4 and #5).

The findings included:

A review of the MOR for Resident #1 found she was scheduled to take Qietapine 50 milligrams (mg) 2 x a day (8:00 am and 8:00 pm) for . The corresponding signature box intended to be initialed by staff members when the medication was taken was not initialed for the 8:00 pm dose on or . She was scheduled to take D 1000 units 2 x daily (8:00 am and 8:00 pm) as a supplement. This was not signed out as given on at 8:00 pm. Resident #1's 5 mg tablet at bedtime for was not signed out at 8:00 pm on at 8 pm. There was no note on the back of the MOR explaining why, or if, the resident did not receive his medication.

A review of the MOR for Resident #3 found she was scheduled to 50 mg (sleep aid) each evening at bedtime. The medication was not signed as provided on at 8:00 pm. There was no note on the back of the MOR explaining why or if the resident did not receive her medication. In addition, there was no telephone number for the prescribing physician on Resident #2's MOR.

A review of the MOR for Resident #4 found she was scheduled to receive ( ) (an) twice daily (8:00 am and 8:00 pm). There was no signature on indicating the medication was dispensed at 8:00 pm. There was no documentation on the MOR to indicate whether Resident #4 received this medication or not. The prescribing physician ' s phone number was not listed on the MOR.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968253	R
NAME OF PROVIDER OR SUPPLIER **GENTLE CARE ASSISTED LIVING 3**	STREET ADDRESS, CITY, STATE, ZIP CODE **27 ROLLING SANDS DR PALM COAST, FL 32164**	

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

Resident #5's MOR was left blank on for his 8:00 pm scheduled dose of 10 mg (used for), which he was to receive twice daily, at 8:00 am and 8:00 pm. The MOR was not signed this day at 8:00 pm for 0.5 mg, 0.5 mg (an anti-), Amylopsin 0.4 mg (for retention), and 50 mg (used to aid sleep). All boxes were left blank. The signature box for D 3 5000 units once daily at 8:00 am was left blank on . There were no notes on the MOR explaining why the medications were not signed as received on these days. In addition, there was no phone number for the prescribing physician listed on Resident #5's MORs.

The MOR for Resident #6 failed to list the telephone number of the prescribing physician. He had a separate MOR for the home health nurse to document the resident's sugar and Lantus 100 mg/ml solution ( ), 8 units daily. The signature box on was blank. There was no documentation on the MOR whether or not the nurse checked the resident's sugar, or administered his . There was no telephone number for the prescribing physician on the MOR.

An interview was conducted with Employee A at 8:20 am on . He stated if a medication was not available for administration, he would call the pharmacy. He stated he had not been trained to circle the signature box on the MOR, or put a note anywhere, if a medication had not been given.

An interview and record review was conducted with the Administrator at 9:00 am. She confirmed the missing signatures, explanations, and physician's phone numbers on the MORs.

This was previously cited at the biennial licensure survey conducted on / .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Gentle Care Assisted Living 3
27 Rolling Sands Drive
Palm Coast, FL 32164

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016 by a representative of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

All deficiencies shall be corrected no later than , 2016.

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 (904) 798-4201.

Sincerely,

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

LL/JM/sm
Enclosure

BBT7

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