RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Watermark Of Gulf Breeze, Inc
101 McAbee Court
Gulf Breeze, FL 32561

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 through , 2016 by representatives 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 surveyors. Should you have any questions please call me at (850) 412-4540.

Sincerely,

Donah Heiberg, M.S.W.
Field Office Manager

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone:850-412-4540; Fax:(850) 922-9162
AHCA.MyFlorida.com

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965162	09/22/2016
NAME OF PROVIDER OR SUPPLIER **WATERMARK OF GULF BREEZE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **101 MCABEE COURT** **GULF BREEZE, FL 32561**	

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

0000 Initial Comments

An unannounced Biennial survey (with specialty license Limited Nursing Services) was conducted at Watermark of Gulf Breeze (Aka Villas of Gulf Breeze) license number 9664 on / - . At the time of survey there were deficiencies identified.

0030 Resident Care - Rights & Facility Procedures

Based on observation and staff interview the facility failed to ensure privacy was protected by covering the medication observation record during medication pass for 4 of 4 sampled residents, #11, 12, 13, and 14.

Findings include:

An observation of the medication pass was conducted with Staff C, a medication technician (med tech) on at 12:04 PM. The med tech moved the cart to the hallway and opened the Medication Observation Record (MOR) to resident #11. After obtaining the medication, the med tech left the MOR open and walked into the resident's , leaving the MOR open and in view of any resident walking down the hallway. The med tech was in the resident's 2 minutes with the MOR exposed. The med tech then moved the cart to the 3rd floor dining opened the MOR to resident #12. The med tech walked into the dining get the resident, leaving the MOR open and in view of any resident walking by. After handing resident #12 their medication, the med tech opened to resident #13's MOR. The med tech then walked to the table the resident was sitting at to get the resident, leaving their MOR open and exposed to any resident walking by. After the resident took their medication, the med tech turned to resident #14's MOR. The med tech again left the cart to get the resident and left the MOR open and exposed to any resident walking by. The dining that time had approximately 20 residents and at least one resident walked by the cart and could have seen another resident's information. The MOR for each resident listed their name, each medication they were taking, their , their date of birth, and their diagnoses.

An interview was conducted with the Director of Nursing (DON) on / at 12:30 PM. She confirmed that the MORs should be covered when staff are not at the carts. A second interview was conducted on at 09:12 AM. The DON stated that she had shown the med tech ways to keep the MORs covered when stepping away from the cart and that she would continue to re-educate the staff for the proper procedure for protecting privacy of the residents.

Class III

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

0052 Medication - Assistance with Self-Admin

Based on observation, interview, and record review, the facility failed to observe residents take their medication for 2 of 4 sampled residents (#11 and #12), and found unlicensed staff administering medications to 1 of 4 (#11) sampled residents observed during medication pass.

Findings include:

A medication observation was conducted with Staff C, a medication technician (med tech) on / / at 12:04 PM. The med tech moved the medication cart to outside of the resident #11's . Resident 11 was inside the . The med tech looked at the Medication Observation Record (MOR) then pulled the drug card. Then the med tech put one pill inside of a pill cup out of view of resident #11. She then entered resident #11's , who was in the process of eating lunch, and handed resident #11 a pill cup. The resident put the pill cup on the tray table and the med tech exited the observing the resident swallow the medication. The med tech then initialed the MOR indicating the medication was taken. The med tech failed to read the medication label, open the medication container and remove the prescribed amount of medication while in the presence of the resident.

An interview was conducted with the med tech on / / at 12:06 PM. She stated, "The resident likes to take her medication after she eats her meal."

The med tech was observed on / at 12:09 PM getting a medication from the cart for resident #12. Resident #12 was handed a pill cup containing one medication then turned from the cart and walked to a table in the dining . The med tech didn't observe the resident swallow the medication but did initial on the MOR that the medication was taken.

An interview was conducted with the Director of Nursing (DON) on / at 12:30 PM. She confirmed that the staff member should have watched the resident's swallow their medication. A second interview with the DON was conducted on at 09:12 AM. She stated that she understood what was done incorrectly during the medication observation and had already began retraining the med tech.

An interview was conducted with the med tech on / at 1:30 PM. The med tech confirmed that she should have watched the resident's swallow their medication.

A review of the facility's policy and procedure for "Assistance with Self-Administration of Medications" was conducted. The policy stated, "Observe the resident self administering the medication or provide assistance if needed. You must never remove the medication from the original container until you are in the presence of that resident."

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SUMMARY STATEMENT OF DEFICIENCIES
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Class III

0055 Medication - Storage and Disposal

Based on observation, interview, and record review, the facility failed to ensure that medications were kept in a locked cart at all times.

Findings include:

A medication observation was conducted on / at 12:04 PM of Staff C, a medication technician (med tech). The med tech moved the medication cart to in front of resident #11's door in the hallway of the 3rd floor. The med tech then removed the medication and entered resident #11's left the cart unlocked. The unlocked cart was unattended out of view of the staff member for approximately 2 minutes.

An interview was conducted with the Director of Nursing (DON) on / at 12:30 PM. She confirmed that the med tech should have locked the cart upon walking away.

The facility's policy and procedure for "Assistance with Self-Administration of Medication" was reviewed. It stated, "Once you have moved the medication cart to a public area never leave it unattended or unlocked."

Class III