STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967955	01/20/2017
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)

0000 Initial Comments

An unannounced Monitoring Assisted Living Facility survey was conducted on , 2017.

The facility was not in compliance at the time of the visit.

0052 Medication - Assistance with Self-Admin

Based on observation, record review and staff interview the facility failed to verbally prompt a Resident to rinse her mouth after using an inhaler (Resident #7) during assistance with medication administration, 1 of 3 sampled residents.

The findings include:

A medical record review of the AHCA 1823 Resident health Assessment form dated reported Resident #7 needs assistance with self administration of medications.

An observation of assistance with self administration of medication for Resident #7 was conducted at 8:55 AM on / / . Employee A, a Care giver gathered all of the medications after checking the Medication Observation Record (MOR) and placed it in a basket to take to Residents the MOR.

An observation of the label for the medication inhalation label read 1 puff by mouth daily. Rinse mouth thoroughly after each use was noted at the top of the label (Photographic evidence is included).

Employee A gave the medication to Resident #7 and instructed to take one puff. After Resident #7 used the inhaler, Employee A took the med's out of the the medication cart after signing the MOR.

Employee A was asked about rinsing the mouth after use of the inhaler. Employee A confirmed she did not prompt Resident to rinse mouth after using inhaler.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

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

Dear Administrator:

This letter reports the findings of a state licensure monitoring survey that was conducted on , 2017 by a 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 , 2017.** 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 .

Sincerely,

Amanda Wisehart

Amanda Wisehart
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LW/AW/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