| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11966430** | **06/27/2017** |
| NAME OF PROVIDER OR SUPPLIER<br>**GENTLE CARE ASSISTED LIVING, I** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**66 BLARE CASTLE DRIVE**<br>**PALM COAST, FL 32137** | |

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

**0000 - Initial Comments**

An unannounced biennial relicensure survey in conjunction with a revisit to the biennial survey dated was conducted at Gentle Care Assisted Living (Lic. #10635) on . The facility had deficiencies at the time of the visit.

**0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)**

Based on observation and staff interview, the facility failed to assist with medication Administration in accordance with procedures described in Section 429.256 for 1 of 2 residents, Resident #1.

The findings include:

On at 8:30 a.m., Employee A, a Medication Technician was observed to assist Resident #1 with medication administration.

She was observed removing 7 medications from the resident's bin, and she crushed them, and placed them in applesauce. Resident #1 consumed the medication in applesauce with a spoon. Employee A did not read the label of the medications to the resident during the time she was assisting.

On at 8:35 a.m., Employee A confirmed she did not read the medication label in front of the resident, despite having knowledge of the rules required of her to assist with medication self administration.

Class III

**0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC**

Based on observation and staff interview, the facility failed to store medications in a secure manner for Resident #1, and failed to dispose of expired medications for Resident # 7.

The findings include:

On at 12:30 P.M., the kitchen refrigerator was observed to have unsecured medications in it belonging to Resident #1, which were suppositories and , eye drops. Employee #1 on at 12:30 p.m. confirmed that there was no lock for these medications in the refrigerator and residents/ family members could have access to refrigerator.

On at 3:50 p.m. the refrigerator in the garage was observed to have a box of

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11966430 | 06/27/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GENTLE CARE ASSISTED LIVING, I | 66 BLARE CASTLE DRIVE PALM COAST, FL 32137 |

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

belonging to Resident #7. Review of the medication showed had an expiration date of . Resident #7 was discharged from the facility on . The Facility Manager on at 3:55 p.m. stated that she was responsible for disposing of medications and confirmed the medication had expired.

Class III

**0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC**

Based on record review and interview, the facility failed to refill a prescription in a timely fashion and failed to notify the physician of missed doses for 1 of 2 residents reviewed for medications, Resident #5.

The findings include:

Review of the Medicine Observation Record (MOR), used to document the medications taken by residents, was reviewed for Resident #5. The MOR from , 2017 to , 2017 had a medication listed as cream 0.1 %, with instructions to apply to upper arms twice daily. The staff was circling their initials for this medication twice a day (meaning not being given). There was documentation on the back of the MOR revealing they requested the doctor to change the medication because it was not covered under the resident's insurance, and they were waiting for the doctor to visit.

The MORs for Resident #5 was reviewed from , 2017 to , 2017. It revealed the medication 0.1% cream was still not being given. There was no documentation why the medication was not given.

Record review revealed the cream was ordered on to apply twice a day. The Medication tube was observed to be empty and was last filled on . The most recent MOR from , 2017 to , 2017 revealed this medication was not listed on it. The resident's record did not have documentation that the physician was notified and there was no order seen to discontinue the medication. The resident's Health Assessment dated 11/ revealed he needed assistance with medication administration.

The Facility Manager on at 3:36 p.m. stated that the medication was originally ordered as "as needed". She confirmed that the MOR's for Resident #5 from , 2017 - , 2017 did not have any documentation that an attempt was made to notify the physician of missed medication doses and possibly changing the medication to something in his insurance plan. She confirmed she did not see a physician order to discontinue the cream either. She does not know why it was not on the current

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11966430** | **06/27/2017** |
| NAME OF PROVIDER OR SUPPLIER **GENTLE CARE ASSISTED LIVING, I** | STREET ADDRESS, CITY, STATE, ZIP CODE **66 BLARE CASTLE DRIVE PALM COAST, FL 32137** | |

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

MORs.

Resident #5 was interviewed on at 3:49 p.m. He stated he still has issues with his arms having scabs and being red. He said he just puts over the counter lotion on his arms. He stated he used to get a prescription from the staff to apply to his arms, but they stopped bringing it to him and he does not know why.

Class III

**0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC**

Based on observation, record review,and interview, the facility failed to provide a therapeutic diet for Resident #5, 1 of 6 sampled residents.

The findings include:

On at 12 p.m. Resident #5 was observed sitting at the kitchen table with his meal in front of him consisting of Swedish meatballs and noodles. He stated he did not want that. Employee A, a caregiver, prepared barbecue chicken and potato salad for him instead.

On at 12:06 p.m. the Facility Manager was interviewed. She stated they only have a regular menu signed by the dietician. They do not offer any therapeutic diets.

Record review for Resident #5 revealed a Health Assessment dated 11/ . Under Special Precautions it listed a controlled diet. Under Special Diet Instructions, Calorie Controlled was checked and low was written in under Other. The health assessment also revealed a diagnosis of and hyerlipidemia.

On at 2:43 p.m. Resident #5 stated he was not on any special diet. He eats what they serve. If he does not like what they are serving, he will ask for something else.

On at 3:41 p.m., the Facility Manager stated that the resident refuses a low diet but she could not produce any documentation that this was true or that the doctor was notified of his refusal.

Class III

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11966430 | 06/27/2017 |
| NAME OF PROVIDER OR SUPPLIER<br>**GENTLE CARE ASSISTED LIVING, I** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**66 BLARE CASTLE DRIVE**<br>**PALM COAST, FL 32137** | |

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

**0162 - Records - Resident - 58A-5.024(3) FAC**

Based on record review and staff interview, the facility failed to have medical records available on , for 2 of 4 records reviewed, for Residents # 8 and #9.

The findings include:

On at 2:52 p.m., Resident #6 stated that there was a resident, Resident # 8 who was and would spit at you and he tried to run her over with his wheelchair. She called the police on him but the police did nothing.

On at 4 p.m., Employee A, a caregiver was interviewed. She stated that there were two previous residents that became violent and the police were called. They were Residents # 8 and #9.

Per Facility Owner on at 4:05 p.m., Resident #9 was cursing and trying to elope out of the facility. The Health Assessment dated revealed an altered mental state. The resident's record revealed Medication Records for , and 2016 only. The Admission/Discharge Log revealed he was admitted and was discharged . There was no documentation of how or why the resident was discharged or when the police was called. The Facility Owner stated that he was transferred to another assisted living facility (owned by the Facility Manager of this facility) and the records were sent with him.

The Admission/Discharge Log revealed Resident #8 was admitted to the facility on and discharged on . The only medical record from this resident was his last medication record from , 19- , , 2017. There was no demographic sheet, no health assessment, no progress notes of when the police was called, no resident contract, no informed consent, medication records or any other information. The Facility Manager on at 4:28 p.m. stated Resident #8 was transferred to another assisted living facility owned by the same owner. She confirmed the entire record was probably sent over to the other facility.

Class III

**Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS**

Based on review of the Agency for Health Care (AHCA) Background Screening Unit Website, record review, and staff interview, the facility failed to update the employee roster for 2 of 4 sampled employees, Employees B and C.

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11966430** | **06/27/2017** |
| NAME OF PROVIDER OR SUPPLIER<br>**GENTLE CARE ASSISTED LIVING, I** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**66 BLARE CASTLE DRIVE**<br>**PALM COAST, FL 32137** | |

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

The findings include:

The AHCA Background Screening Unit Website (BGS) was accessed on . . . . . at 8:52 p.m. for this facility and the employees on the roster were recorded.

The Employee Roster was reviewed with the Facility Manager on at 4:20 p.m. She stated she has only been the Manager here a month and Employee C has not worked here during that time. She confirmed Employee C was not removed from the facility employee roster within 10 days of termination of employment. The AHCA BGS website revealed Employee C was hired on 11/ as a nursing aide and was still listed as a current employee.

Employee Record Review for Employee B revealed she was hired on as a Caregiver. She was not listed as an employee roster on the AHCA BGS website for the facility. The Facility Manager confirmed on . . . . . at 4:25 p.m. that Employee B should have been added to the employee roster within 10 days of hire and was not.

Unclassified