STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967671	**07/13/2017**
NAME OF PROVIDER OR SUPPLIER **EMERALD GARDENS PROPERTIES, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1012 N 72 AVENUE PENSACOLA, FL 32506**	

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

0000 - Initial Comments

An unannounced abbreviated biennial survey with limited nursing services was conducted in conjunction with a complaint survey for allegations contained within CCR#2017007157 on , 2017 through , 13, 2017 at Emerald Gardens Assisted Living Facility (license # 11667). Deficiencies were found at the time of the survey.

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation, interview, and record review, the facility failed to ensure an over the counter (OTC) medication was given in accordance with the manufacturer's directions for use, for 1 of 1 residents sampled with OTC medications. (#12)

Findings include:

An observation of staff C, an unlicensed medication technician, was conducted on at 09:49 AM. Staff C was observed to remove a bottle of Extra Strength 500 milligrams (mg) and 200 mg. Staff C told resident #12 what medications she was giving and handed her a cup with one 500 mg tablet and one 200 mg tablet. The resident then swallowed the medication.

Resident #12's Medication Observation Record (MOR) was reviewed. A handwritten order read "Resident request rotation of pain relief. Extra Strength 500 mg. Take two gelcaps every 4 hours by mouth while awake. Split with rotation." The times assigned to give the medication included 6 AM, 2 PM, and 10 PM. The section directly below read, "Resident request rotation of pain relief. 200 mg. Take one tablet every 4 hours by mouth while awake. Split rotation." The times assigned to give the medication included 10 AM and 6 PM.

An interview was conducted with staff C on at 09:55 AM. She stated she was supposed to give the resident 2 during med pass in addition to the . When asked what the directions for use were, she stated the medications were to be rotated. She was unable to state what rotation of the medications meant. She then stated it was her procedure to always give 2 and 1 each time the medication was given.

The resident's medical record was reviewed and did not reveal a physician's order for the medication. The bottle used was obtained and the manufacturer's directions for use were reviewed. "Directions: do not take more than directed. Adults and children and over: take 2 gelcaps every 6 hours while symptoms last. Do not take more than 6 gelcaps in 24 hours unless directed by a doctor. Do not use for more than 10 days unless directed by a doctor."

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Resident #12's MORs were reviewed for 2017. The order for rotation of and was handwritten on the MOR and began on . The back of the MOR however revealed handwritten notes by staff. at 4 PM, 1 and 2 were given per resident request. Again on at 8 PM, 1 and 2 were given per family request. On , , and , 1 and 2 were given again per either resident or family request.

These events and records were brought to the attention of the facility Administrator on at approximately 12:00 PM. She stated she was not aware the staff were giving the medications together, they were meant be given alternatingly. She then stated she would contact the resident's physician to let them know the medications were not being given according to the directions provided.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview with the facility administrator the facility failed to ensure each employee had a statement of freedom from communicable for 1 of 4 employee files reviewed (staff D).

The findings were:
Review of personnel files showed that staff member D, hired , did not have a current freedom from communicable form. This was brought to the attention of the administrator. She stated that there was a form for in the file. After explaining that there are other communicable , she agreed that the form was missing from documentation. No additional information was provided prior to exit.

Class III