STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965343	09/18/2017
NAME OF PROVIDER OR SUPPLIER **CHRISTIAN MANOR OF CLEARWATER, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1845 N. KEENE ROAD CLEARWATER, FL 33755**	

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

0000 - Initial Comments

Assisted Living Facility

A Complaint investigation (CCR#2017007558, 2017008421 and 2017008775) was conducted at Christian Manor of Clearwater, Inc. on . Christian Manor of Clearwater, Inc. had deficiencies at the time of the investigation.

License (#9718)

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review, observation and interview, the facility failed to maintain accurate daily medication observation records for 2 of 6 residents reviewed (Resident #1 and Resident #6).

Findings included:

A review of Resident #1's record indicated that the resident had been in the facility since . Resident #1's medication observation records (MOR) were reviewed at 11:00am and the records revealed that the facility did not sign the medication observation record (MOR) correctly with the initials of the Med Tech issuing the medications, but instead inserted a check mark in the MOR for 2 of the medications given to Resident #1; one a pain killer in the form of a , patch and the other a cream that the resident self-administered.

The pain killer patch ordered stated 1 , patch,100mcg, to be applied to the skin every 72 hours. It was scheduled for 8:00am in the morning. Resident #1's , 2017, MOR showed 4 check marks for the patch on dates , , and , (photographic evidence obtained - Photo 1). Twice the medication was checked off within a 48 hour/2 day period, not 72 hour/3 day period as prescribed. In an interview with Staff B at 12:20pm on , Staff B stated that Resident #1 was scheduled for the patch and was going to give it to the resident during the medication pass that she was currently performing. Staff B admitted charting in the MOR on the previous days and used a check mark instead of initials because "that's the way they did it at another facility". According to the MOR, the medication was due at 8:00am, however Staff B was preparing to give the medication at 12:20pm. Staff B could not explain why there was no mark or initial on the MOR from to for the patch or why the patch was being given at 12:20pm instead of 8:00am as directed.

The cream that Resident #1 self-administers was also ordered every 72 hours. Resident #1's , 2017, MOR showed 4 check marks for the cream on dates , , , and

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, photographic evidence obtained. Twice the medication was checked off within a 48 hour/2 day period, not 72 hour/3 day period as prescribed.

Resident #6's MOR for the month of , 2017 was reviewed at 2:00pm. The MOR revealed that the facility signed off that the resident received all ordered medications from up to , even though the facility's admission and discharge log revealed that the resident was discharged from the facility on . (Photographic evidence obtained - Photo 9 and Photo 11).

Class III

0163 - Records - Resident, Penalties for Alteration - 429.49 FS

Based on records review and interview, the facility falsified medical records for 2 of 6 residents records reviewed (Resident #3 and Resident #6).

Findings included:

A review of Resident #2's record at 10:00am on revealed that the resident was admitted to the facility on . The weight record in Resident #2's record had weight entries for the following dates: 1/1, 2/1, 3/1, and 4/1. The facility had recorded weights for 4 months prior to the resident arriving to the facility. The resident observation log in the resident's chart revealed that the facility had recorded observations of Resident #2 on the following dates: , , , and . The facility had recorded observations notes on the resident 4 months prior to the resident arriving to the facility. (Photographic evidence obtained - Photo 3).

A review of Resident #3's records at 10:30am on revealed that the resident's medication observation record (MOR) for the month of , 2017 was signed as if all medications given for every shift and every day were given by one staff member, based on the initials all being the same. (Photographic evidence obtained - Photo 2). Staff B admitted in an interview, at 12:20pm on during a medication observation, that those were Staff B's initials written on Resident #3's MORs. Staff B stated that Staff B works long hours, from 7:00am to 7:00pm every day, except not all weekend. Staff also stated that Staff B stayed home from facility on , 10 and 11, 2017 to be with family during hurricane. Resident #3 is scheduled for medications every day, 4 time per day - at 8:00am, 12:00pm, 5:00pm and 8:00pm. The initials that Staff B stated were Staff B's were written on every day and every medication pass from , 1 until , 18 at noon when interview was conducted.

Resident #6's medication observation record (MOR) for the month of , 2017 was reviewed at 2:00pm on . The MOR revealed that the facility signed off that the resident received all ordered

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medications from up to . The facility's admission and discharge log, reviewed at 9:30am on , revealed that Resident #6 was discharged from the facility on . (Photographic evidence obtained - Photo 9 and Photo 11).

Class III