STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967442	08/04/2017
NAME OF PROVIDER OR SUPPLIER **GOLD CHOICE ORMOND BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **1410 HAND AVENUE** **ORMOND BEACH, FL 32174**	

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

0000 - Initial Comments

Two unannounced complaint Surveys (CCR # 2017005008 & 2017005914) were conducted from to at Gold Choice Ormond Beach. The facility had deficiencies at the time of the visit.

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

Based on observation and record review, the facility failed to have unlicensed staff properly assist with medication administration for 1 of 4 sampled residents, Residents #2.

The findings include:

1. On at 10:10 a.m. , a medication pass was observed with Employee A, a Medication Technician, assisting Resident #2 with medications. Employee A gathered the oral medications and inhaler and brought them to his . Employee A was observed to shake the , and gave it to the Resident for use. The resident took one puff and handed it back to Employee A. Employee A returned the inhaler to the box and returned it to the medication cart. She did not instruct the resident to rinse mouth out and spit it out afterwards.

The instructions on the Inhaler was administer 1 puff by mouth twice a day. Review of the Manufacturer's Specification for revealed after using the inhaler, one should rinse the mouth with water, and spit out the water, but not to swallow it, to prevent the chance of fungal .

On at 10:13 a.m. Employee A was interviewed. She confirmed she did not know about the rinsing/spitting following inhaler use. She stated she did receive medication training, but does not remember learning that.

The Interim Director of Nursing presented the Assistance with Self-Administered Medications study guide by the Department of Elder Affairs on at 2:00 p.m. She stated this was the training that staff received. Skill #9 was listed as "Providing Assistance with Inhalers" and listed the resident may wish to rinse his/her mouth with water.

The Record review for Resident #2 revealed a Health Assessment dated . It revealed he needed assistance with medication administration, and the Aerosol inhaler was listed as being ordered twice a day.

Class III

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

Based on record review, observation, and staff interview, the facility failed to re-order medications in a timely manner for 2 of 6 sampled residents, Resident #4 & #6.

The findings include:

1. An interview was conducted with employee G, a Medication Technician on at 3:30 pm. She stated she has worked here since , 2017. She stated that they do run out of medications. She believes it is because the nurse was not reordering them from the pharmacy in time. If a medication is not available on their shift, they are to document it and pull the slip and the nurses were to fax it to the pharmacy.

Resident #4's, medications on hand were compared with the 2017 Medication Observation Record on at 3:30 pm. by Employee G. She stated the resident did not have , , , , , , , , , , , or . She produced the pharmacy sheet and the 7.5 mg was on the list to be re-ordered but it was not dated and she was not sure how long this request has been here.

Employee E, A Licensed Practical Nurse was interviewed on at 4:30 p.m. She stated she was aware of Resident #4 running out of medications. She was trying to reorder them since but she did not know who the Resident's physician was to get the medications refilled.

Employee H, an employee in the Marketing Department was interviewed on at 5:00 p.m. She stated that Employee E was calling the wrong physician for refills. Employee H confirmed the physician's name in the computer was the wrong doctor for Resident #4 and it would need to be fixed.

An Interview with, Employee I, also a Med Tech, was conducted on at 11:00 a.m. She said she has been working here about a month. She stated that she has been passing medications to Resident #4, and he has many missing medications, especially his . It has not been available for the past week and a half. She has been documenting it each time "9" not available in progress note.

Review of the & 2017 Medication Observation Record (MOR) for Resident #4 revealed the order for , 5 mg , to be given by mouth two times a day related to unspecified combined (and Diastolic). There were 22 days when this medication was not given and a "9" was documented, meaning "see Progress Notes" according to the legend. Progress notes revealed the facility was out of the medication, with "waiting on pharmacy" as the reason. There were also instances where it was not documented why it was not given. Other medications were also

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not given : , , Rosuvastatin, , , , , , and , .

2. During a comparison of the medications at the facility for Resident #6 with the physician ordered medications, the following was discovered: Resident #6 was ordered Immodium and Milk of Magnesia. The Immodium A-D directions were to give 2 tablets by mouth as needed for . It was ordered on . The Milk of Magnesia Suspension 400 mg/5 ml directions were give 30 ml by mouth as needed for , . It was ordered on . These medications were not on hand for Resident #6.

The Acting Director of Nursing on at 11:52 a.m. confirmed the medications were not reordered.

Photographic evidence obtained.

Class III

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

Based on observation, record review and interviews, the facility failed to keep a record of substitution items on hand for at least 6 months prior to the survey date, and failed to have provide a therapeutic diet for 1 of 12 sampled residents (Resident #12).

The findings include:

1. An observation of the lunch dining experience was made on at 12:10 pm. There was a weekly menu in small print located on a back hallway. The menu posted on the small menu was served to the residents except for the dessert. Raspberry Whips was on menu. A piece of cake was substituted instead.

On at 12:13 p.m., Employee L, a Dietary Aide stated they normally have the big menus to post for the next day but do not have them. The previous person left with them Saturday. She usually writes substitutions on them. She does not know where they are kept. She did not record the substitution for the lunch meal. She asked the Kitchen Manager for the substitution book.

On at 12:16 p.m., the Kitchen Manager stated she was not aware that a substitution log had to be kept for 6 months.

2. On at 2:20 p.m., Resident #12 complained that she can't eat any of the food served here. She is on a ر free diet. She has asked for ر free items but they do not give it to her. She does

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not eat that much because of it.

The Health Assessment dated for Resident #12 revealed she was on a healthy, no lactose, no , no wheat, no tomatoes, no honey diet. This was signed off by her physician.

An Interview was conducted with the Kitchen Manager on at 2:40 p.m. She was asked if anyone needed a free diet, and she stated no. She stated she would know this by the medication record. If it was not on the medication record she would not know.

Review of the Physician's Order Summary showed that under , Wheat Products was listed.

Photographic evidence obtained.

Class III