STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963835	**11/20/2017**
NAME OF PROVIDER OR SUPPLIER **CHATEAU BLANC**	STREET ADDRESS, CITY, STATE, ZIP CODE **711 CASLER AVENUE** **CLEARWATER, FL 33755**	

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

0000 - Initial Comments

Assisted Living Facility

Two unannounced complaint surveys, (CCR# 2017010085 & CCR# 2017010453) were conducted on , at Chateau Blanc II , (License # 8775), an assisted living facility in Clearwater, Florida. There were deficiencies identified at the time of visit.

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

Based on observation and interview, the facility failed to provide assistance with self-administered medications in accordance with procedures described in Section 429.256, F.S. Specifically, Staff A failed to remove medications from the original packaging in the presence of residents and inform residents of medications provided for three (#1, #2 and #3) of three resident who resided at the facility; and Staff A failed to observe resident take medications provided for two (#2 and #3) of three residents who resided at the facility.

Findings included:

While conducting a tour of the facility, on at 07:46 a.m., a tray was observed on top of filing cabinet with medications. Some medication tablets/capsuled were removed from the primary packaging and placed in clear disposable cups. Image taken.

Staff A, who was present during the facility tour, stated that she made preparation at 06:30 a.m. on , for assisting with medication by removing medication from packaging and placing the medication into cups. Staff A confirmed that the prescribed medication time was at 08:00a.m. Staff A stated that she initialed the Medication Observation Records (MORs) when she took the medications out of the cabinet this morning at 06:30a.m.
Review of MORs revealed that staff documented medications as given (image taken).

On at approximately 08:00 a.m. Staff A placed the tray of medications belonging to Residents #1, #2 and #3 on table while the residents were eating and Staff A continued to work in the kitchen, washing dishes. Staff told the residents that they could take their medications after they had their meal.

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On at 08:07 a.m., Resident #3 was observed self-administrating medications tablets orally. Staff A was unaware as she was cleaning in the kitchen.
On at 08:10 a.m., Staff A asked Resident #3, "did you take your meds already?" Staff called Resident #1 and placed medications in front of him, and observed Resident #3 take his medication without informing the resident of what medication was provided.
On at 08:13 a.m., Resident #2 was observed self-administering oral dosages of tablets, injection of pen, and a prescribed mouthwash syrup while Staff A was in the kitchen.

During interview with Staff A, on at08:15 a.m., she shat she only watched residents as they take the two , and confirmed that she did not watch Resident #2 and # 3 take their medications.

Class III

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

Based on observation and interview, the facility failed to ensure that medications were centrally stored and locked for three (#1, #2, and #3) of three residents who received assistance with self-administration of medication.

Findings included:

While conducting a tour of the facility, on at 07:46 a.m., a tray was observed on top of filing cabinet with medications (Image taken).

Staff A, who was present during the facility tour, stated that she prepared for assisting with medication by removing medication from packaging and into cups at 06:30 a.m. of . She confirmed the medications were not stored in the locked medication cabinet after the preparations.

Class III

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

Based on observation and interview, the facility failed to ensure that the meal served was consistent with the nutritional standard and portion size established by the facility's menu; and failed to ensure that facility's menus were reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a

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registered dietetic technician supervised by a licensed or registered dietitian.

Findings included:

Review of the facility scheduled for meals, on revealed that facility menu on display for the residents and original menu, maintained by the facility, was reviewed and validated from through .

Review of the posted menu (Week 4, regular diet) revealed that scheduled breakfast for residents on consisted of:
Cup of orange juice (3/4c)
Cereal of choice (3/4 c)
Sausage gravy (1/2c) on 1 biscuit
Low fat milk (1cup)
Coffee/tea

During meal observation on at approximately 08:00 a.m., Resident #1, #2, and #3 were provided with two waffles, lemonade and yogurt. The meal provided was inconsistent with the posted menu.

When Staff A was asked about the meal menu on 11/ at 9:15 AM, she indicated that she was not aware of any menu for meals. She was not sure about any guidance for meals to be provided to residents

During interview with the Administrator, with owner present, conducted on at 009:36 a.m., she confirmed that the facility menu, reviewed by the registered dietitian, was dated through . She stated that the facility should be on week 3 menu, and confirmed that posted menu was week 4. She confirmed that the residents should not have been served two waffles for breakfast.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on interview and record review, the facility failed to maintain an up to date admission and deischarge log with the admission and the discharge date, the reason for discharge, and where the

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resident was discharged for one (Resident #6) of four residents selected for record review.

Findings included:

Review of Facility's admission discharge log revealed that Resident #6 was not listed. Review of Resident #6's record revealed she resided at the facility for 71 days.
During interview with the Administrator, on at 01:02 p.m., she confirmed that Resident #6 was not included on the Admission discharge log.

Class III

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

Based on record review and interview, the facility failed to retain a discharged resident's record for two years following departure for one (#1) of two discharged resident selected for record review.

Findings included:

Review of Resident #6's record revealed the absence of a Medication Observation Record (MOR).

During interview with the Administrator, on at 01:48 p.m., she stated that that the facility did not have the MORs for Resident #6 and that some of Resident #6's records were stored at another facility, where she was for, a temporary, emergency/hurricane stay. Resident #6 was not a resident of that facility.

Class III