STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965162	**09/07/2017**
NAME OF PROVIDER OR SUPPLIER **WATERMARK OF GULF BREEZE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **101 MCABEE COURT** **GULF BREEZE, FL 32561**	

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

0000 - Initial Comments

An unannounced complaint survey for allegations within CCR 2017006889 and 2017007914 in conjunction with a limited nursing services monitoring visit was conducted at Watermark of Gulf Breeze (license #9664) on to . Deficient practice was found at the time of the survey.

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on staff interview and clinical record review, the facility failed to provide medication administration according to medical provider direction to 1 of 6 (#8) residents observed for medication pass.

The findings were:

Resident #8 was observed being assisted with her medications by unlicensed staff, Medication Tech Employee D, on at approximately 8:00 am. The following medications were given to resident #8: 20 mg (milligrams), , 5 mg , 2.5 mg, caltrate +D , , 81 mg and 100 mg. Once medication pass was completed the resident's record was reviewed. The Resident Health Assessment for Assisted Living Facilities (1823) was observed. The 1823 indicates the resident has OBS (organic ,) with no short term memory. Page 4 of the 1823 Section B is marked yes to the question "does the individual need help with taking her medication" and there was a checkmark in front of the box that read "needs medication administration." The 1823 was signed by the resident's medical doctor and completed on .

An interview was conducted with the Administrator/Director of Nursing on at 8:34 am. She confirmed that Employee D was not a licensed nurse. She confirmed that the box for medication administration is checked. She then said that "the 1823 is checked by licensed staff to make sure it is appropriate. The medication administration should have been caught at that time and clarified with the doctor."

Class III

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

Based on staff interview and clinical record review, the facility failed to maintain an up to date medication observation record (MOR) for 1 of 6 (#8) residents observed during medication pass.

The findings were:

The MOR for Resident #8 was observed on . The record indicated that the resident had received

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medication ˬ cream 0.19% and triamcinolon cream 1 % daily since . The medication had already been given for .

A medication observation was made for Resident #8 on about 8:00 am. The above two medications were not given. A second observation of the MOR shows the two medications have been yellowed out and says no longer needed since radiation was finished.

An interview was conducted with the Administrator/Director of Nursing (DON) on at 8:34 am. She confirmed she had yellowed out the two above , medications. She said that radiation treatments had been completed on Resident #8 in ˬ of 2016. She confirmed the medication had remained on the MORs for more than a year. She also confirmed that staff were initialing they had been providing the medication as being given from to . She said the problem occurred when the medical doctor had not indicated a specific stop date. She also confirmed it should have been caught by her staff and clarified with the doctor.

The Medication Tech Employee D was interviewed at 10:00 am on . She said she worked with Resident #8 on Saturday . She confirmed she initialed the ˬ and triamcinolon as being given on the same date. She then said she had put "Vaseline" on the resident's chest. She was asked if the medications she put on the resident was the same as the ones on the MOR and she said , "No".

Class III