STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967442	12/14/2017
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

A complaint investigation (CCR #2017011607, CCR #2017010976, and CCR #2017014594) was conducted at Gold Choice Ormond Beach on . Gold Choice Ormond Beach had deficiencies at the time of the investigation.

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

Based on interview and record review, the facility failed to ensure that medications were filled or refilled in a timely manner for 2 of 3 sampled residents (Residents #5 and #8).

The findings included:

In an interview with Resident #5 on at 12:30 pm, she reported her sleep and pain medication not being available as ordered during the current month, 2017.

Review of page four of the 2017 Medication Observation Record (MOR) for Resident #5 revealed a provider's order for , tablet 5 milligram (mg) tablet, Give 1 tablet by mouth at bedtime related to , unspecified. Based on the MOR, four (4) consecutive doses of , were not provided on through . Page four of the MOR also revealed a provider's order for tablet 50 mg, Give 1 tablet by mouth two times a day for pain, supervised self-administration. Based on the MOR, four (4) consecutive doses of were not provided on through at 1700 (5:00 pm). Photo evidence obtained.

Review of page three of the 2017 MOR for Resident #5 revealed a provider's order for Capsule 3 mg, Give 1 capsule by mouth at bedtime for sleep. Based on the MOR, four (4) consecutive doses of were not provided on through . Page three of the MOR also revealed a provider's order for Multivital Tablet (Multiple -), Give 1 tablet by mouth in the evening related to age-related , . Based on the MOR, ten (10) consecutive doses of Multivital tablet were not provided on through at 1700 (5:00 pm). Photo evidence

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obtained.

Review of page five of the 2017 MOR for Resident #5 revealed a provider's order for Tablet 150 mg ( ), Give 1 tablet by mouth two times a day related to . Based on the MOR, four (4) doses of were not provided on through at 1600 (4:00 pm). Photo evidence obtained.

Review of page one of the 2017 MOR for Resident #8 revealed a provider's order for tablet 5 mg tablet, Give 1 tablet by mouth one time a day for high . Based on the MOR, fourteen (14) consecutive doses of were not provided on through . Page one of the MOR also revealed a provider's order for capsule 60 mg, Give 1 capsule by mouth one time a day for supplement. Based on the MOR, thirteen (13) consecutive doses of were not given. Photo evidence obtained.

An interview was conducted with the Executive Director (ED) on at 11:15. The ED reported that the facility had changed from e-MORs (electronic MORs) to paper MORs because medications were not being re-ordered correctly.

In an interview with Medication Technician A on at 2:00 pm, she reviewed page one of the 2017 MOR for Resident #8, and confirmed that the code "9" represented that and were not available to be given to the resident on through .

In an interview with Medication Technician B on at 3:40 pm, she stated that she was told by another staff to stop marking "9s" on the MOR when there was no medication available to give to a resident, so she started leaving the corresponding boxes blank. She confirmed that there was no supply of , , , and on 5-8 for Resident #5, as she worked on those dates. When asked to check the available medication supply for Resident #8, she unlocked the

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cart and showed the surveyor that there was only Centruvite available, although there were three (3) medications ordered on the MOR. She verbally confirmed this.

In an interview with LPN B on at 3:10 pm she confirmed that the facility did have an issue with reordering resident medications. She acknowledged that there was no formal reordering system, stating "anyone can reorder medications." She reported that she has not formally communicated to the medication technicians that they are required to reorder medication from the pharmacy when it is needed.

Class III