STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967108	R 01/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTLE CARE ASSISTED LIVING INC 2	**77-A BRUNSWICK LANE PALM COAST, FL 32137**

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

0000 - Initial Comments

On a revisit to the biennial relicensure survey was conducted at Gentle Care Assisted Living, Inc.2 (License #11197). Deficient practice was identified during the survey.

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

Based on observation, resident record review, and staff and pharmacist interview, the facility failed to provide medications as ordered by the physician for 3 of 6 residents whose records were reviewed (Residents #1, #3 and #4).

The findings included:

1. Observation of the contents of Resident #1's current medications bin revealed a pharmacy-issued bottle of - 5-3 (#2012388), take one tablet by mouth ever 4 hours for 7 days for moderate pain. The fill date for the medication was .

Record review for Resident #1 revealed a pharmacy-printed medication observation record (MOR) for the month of 2018. One section of the MOR noted " 325/. A hand-written entry after the forward slash mark (/) noted "). The pharmacy instructions stated "take one tablet by mouth every 6 hours as needed for pain." (# 2012320). The MOR did not match the bottle's label.

A telephone interview was conducted with the Pharmacist on at 11:41 am. He stated the MOR for Resident #1's was incorrectly printed. He said the pharmacy should have printed the word on the MOR instead of " /". He confirmed the corresponding # for this entry was for the , and not the . The Pharmacist confirmed his staff printed an incorrect MOR, and said he would have it corrected. The pharmasit stated the order for Resident #1's , should have been discontinued as of , since the ordering physician's instructions were to take it for only 7 days. He confirmed there was no current order for for Resident #1.

The Administrator, who was present during the telephone interview, stated she thought the " / section on Resident #1's pharmacy printed MOR was for , therefore she added that to the MOR. She did not realize the intended entry was for , and acknowledged

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she should have addressed the discrepancy with the pharmacy.

2. Review of the medication bin for Resident #4 found a bottle of , mg tablets. The pharmacy label instructed to take 1 tablet ever 6 hours for pain (or 4 times daily). The MOR for Resident #4 instructed , 1 tab three times a day.

During the telephone interview with the Pharmacist on at 11:41 am, he stated the most current order on file for Resident #4's , was on for ever 6 hours, or 4 times daily. (The hospice physician) authored this order.

The Administrator then produced a copy of a handwritten prescription dated by (Resident #4's primary care physician) for Norco ( ) 5-325 mg tablets, 1 three times daily. She said she had hand delivered this order to the pharmacy on . She did not realize that on the very next day, Resident #4's hospice physician electronically filed a new order for 4 times daily. She had not been notified of this change. She admitted she did not notice the discrepancy between the pharmacy's medication label and her MOR, which she said she wrote reflect the primary care doctor's prescription on . She stated she would need to clarify the orders with both physicians.

3. Review of the current MOR for Resident #3 revealed the following provider's order: , 325 mg, take 2 tablets by mouth every 4 hours as needed for pain. Review of Resident #3's bottle of , revealed a label with the following order: , 325 mg tablet, take 2 tablets by mouth every four hours as needed, pain.

Additional review of the MOR from to demonstrated that , was listed as a scheduled medication instead of an as needed (PRN) medication, and was indicated to be given at 8:00 am. The corresponding space for documentation was blocked-out, with the exception of the dates , , and , further indicating to give the medication on a schedule.

At 10:50 am, the Administrator reviewed the MOR and confirmed that the , for Resident #3 was marked as scheduled when the provider's order stated that it was as needed. The Administrator was unable to produce a previous MOR that accurately reflected the provider's order.

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Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on employee record reviews staff interview, the facility failed to obtain a written statement from a health care provider documenting that the individual did not have signs or symptoms of communicable for 1 of 4 employees whose files were reviewed (Employee E).

The findings included:

On at 11:15 am, a review of the employee file for Employee G revealed an expired skin test ( ) from . No communicable statement was found in the file.

An interview with the administrator on at 11:25 am, she confirmed that Employee G's was expired and that there also was no communicable statement present in the file.

An employee file review for Employee E found she was hired as a Caregiver on . She had a negative screen dated ; however, there was no statement from a heath care provider that she was free from communicable .

An interview was conducted with the Administrator on at 12:20 pm. She reviewed the record and confirmed the missing communicable statement for Employee E.

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Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on a review of resident records and interview with staff, the failed to include written notification of a 30-day notice of rate increase for 1 of 3 residents (Resident #6) whose contracts were reviewed.

The findings included:

Record review for Resident #6 revealed an admission agreement completed on . The contract contained no provision of a 30-day notice for any increase in the daily/monthly rate, as required.

An interview was conducted with the Administrator at 12:20 pm on . She reviewed the records and confirmed the missing provision in Resident #6's contract.

This was previously cited during the biennial licensure survey conducted by a representative of this agency's office on .

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on a review of the Agency for Healthcare Administration's Background Screening Unit's clearinghouse website, and interview with the Administrator, the facility failed to include 2 of 6 employees (Employees B and E) on the facility's employee roster.

The findings included:

A review of facility records revealed there were 6 employees employed by the facility at the time of survey (Employees A, B, C, E, F and the Administrator).

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A review of the AHCA Background Screening clearinghouse website at 11:26 am on revealed Employees B and E were not listed on the roster as being employed in the facility, despite being employed for more than 10 days at the time of the review.

An interview was conducted with the Administrator at 11:35 am on . She reviewed the roster and confirmed Employees B and E were still not listed as being employed in the facility.

This was previously cited during the biennial licensure survey conducted by a representative of this agency's office on .

Unclassified