STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967108	R 03/06/2018
NAME OF PROVIDER OR SUPPLIER **GENTLE CARE ASSISTED LIVING INC 2**	STREET ADDRESS, CITY, STATE, ZIP CODE **77-A BRUNSWICK LANE PALM COAST, FL 32137**	

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

0000 - Initial Comments

A second follow up survey was conducted on at Gentle Care Assisted Living, Inc. (License #11197). There was one uncorrected deficiency at the time of the visit.

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

Based on record review and staff and resident interview, the facility failed to properly assist with medication administration for 1 of 5 sampled residents, Resident #7. This was previously cited on and .

The findings include:

Record review revealed Resident # 7 was admitted to the facility on . Resident # 7 had a Health Assessment (1823) dated revealing diagnoses of , accident, , and Parkinson's . He was also receiving hospice services. The 1823 also revealed he needed help with taking his medications.

His medications were packaged in "bubble" backs and separated into morning and bedtime doses. In his morning medications , the resident was receiving a half tablet of a 25 mg of daily per bubble pack label. The facility also had a medication list to include this medication and hand written in was instructions to "take every other day". The Medication Observation Record (MOR) for , 24-, 2018 revealed he was receiving this dose of medication daily.

Record review for Resident #7 revealed the hospice physician ordered a decrease in this on from daily to every other day. This change was not transcribed to the facility MORs.

The Pharmacist was called on at 9:30 a.m. He stated that he did not get the new order to decrease the to every other day.

The facility Administrator on at 9:31 a.m. stated she did not who hand wrote the change in frequency for the medication on the medication list. She did confirm that the new order on had not been transcribed to the MOR and the resident was still receiving it daily instead of every other day.

The Hospice Patient Care Administrator was interviewed on at 10:25 a.m. She confirmed that

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the hospice nurse should be reviewing medications on each visit. The nurse made a visit on and she did not note the discrepancy in the frequency of the Sprinolactone. She should have corrected it right away and ensured that the pharmacy received the new medication order.

Resident #7 was interviewed on at 10:35 a.m. He stated that he does get , when he gets up. He states he is thirsty a lot and he should drink more. (possible side effects of ,).

Class III