STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967442	08/09/2018
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

An unannounced complaint survey, CCR #2018007258 and an Emergency Power Plan monitoring was conducted on at Gold Choice of Ormond Beach (License #11475). Deficient practice was identified during the survey.

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on record reviews and interviews the facility failed to provide assistance with self-administration of medications in accordance with a health care provider's order for 1 of 3 residents (Resident #1), and according to package instructions for 1 of 3 residents reviewed (Resident #3).

The findings include:

1. A record review was conducted for Resident #1, and revealed a she had diagnoses including, but not limited to, and . A review of her Medication Observation Record (MOR) for 2018, revealed an order for (/Anti- medication) 0.2 mg (milligrams), give one (1) tablet by mouth three times a day. The medication was docuented on the MOR to be given at 6 AM, 12 PM, and 4 PM.

Further review of the MOR revealed that the boxes indicating the medication was recieved had several blanks, indicating Resident #1 did not recieve it, for the entire month of 2018. A review was then conducted of her 2018 MOR, and revealed the had blanks for the entire month of up to the date of the survey.

On at 2:05 PM an interview was conducted with the Director of Nursing regarding the medication order for Resident #1. She explained the facility uses a color coding system, with each shift's medications highlighted in a specific color, to direct the med techs to which pills residents were to recieve on the specific shifts. She confirmed that Resident #1's had not been being given as ordered, since nobody had highlighted the MOR as was their procedure. She continued to say that after observing Resident #1's MOR lacking the color coding, they color coded it during the survey. When asked if the facility had any auditing system in place to ensure accuracy of the MORs and she said they did not have a system in place.

2. A record review was conducted for Resident #3 and revealed a female admitted with diagnoses including, but not limited to, pain in unspecified joint.

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SUMMARY STATEMENT OF DEFICIENCIES
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A review was conducted of Resident #3's physician's orders, which revealed an order for Norco mg (pain medication) with instructions to give one tablet by mouth three times daily as needed for pain. A review of the medication label for the Norco indicated it was to be discarded aftr ,2018.

A review was conducted for her medication sign-out sheet, and it revealed that she had taken the medication on , 2018 at 8:30 PM, and on , 2018 at 8:00 PM, after the medication had expired.

On at 2:31 PM, during an interview conducted with Employee B, Medication Tech, she verified that the medication was expired and acknowledged her responsibility to go through the cart to get rid of expired medication.

Photographic Evidence Obtained

Class III