STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969069	R 11/05/2018
NAME OF PROVIDER OR SUPPLIER **NATIONAL CHURCH RESIDENCES OF BRADENTON**	STREET ADDRESS, CITY, STATE, ZIP CODE **3229 19TH ST W** **BRADENTON, FL 34205**	

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

0000 - Initial Comments

Assisted Living Facility

A revisit survey was conducted on 11/5/18 for National Church Residences of Bradenton. At the time of the survey, the facility had deficient practice.
License #12926.

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

Based on observation, interview and record review, the facility failed to make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration were labeled correctly for 2 of 3 residents observed (#4 and #5).

Findings included:

During a medication observation at 11:15am on , Staff A, a licensed practical nurse (LPN) was preparing to assist Resident #4 with medications. The medication observation record (MOR) indicated that Resident #4 was due for 2 medications: (a , supplement) and (a). When Staff A read the MOR, it said M20 ER 20 milliequivilent (mEq)1 tablet 3 times per day. The label on the medication package said M20 ER 20 mEq 1 tablet 1 time per day. Staff A then checked the medication orders in the resident's record and it said M20 ER 20 mEq 1 tablet per day. Staff A then looked at Resident #4's MOR for the second medication. The MOR said 40 milligrams (mg) 1 tablet by 1 time per day. The label on the medication package said 40mg 1 tablet by 2 times per day. Staff A then checked the medication orders in the resident's record and it said 80mg by per day.

Staff A was then asked how one could tell if they were giving the resident the correct dose, as ordered, when there were discrepancies between the MORs, the medication labels and the health care provider's orders? Staff A was not able to provide an answer to the question.

At 11:25am on , Staff A was preparing to assist Resident #5 with medications. The MOR indicated that Resident #5 had 1 medication due: , (a , reliever). The MOR said , MAPAP 10-325mg, 1 tablet by every 6 hours. The medication label said , MAPAP 10-325mg, 1 tablet by every 6 hours and there was also a sticker adhered to the label that said "directions changed, refer to chart". The resident's record (or "chart") said , MAPAP 10-325mg, 1 tablet by every 6 hours. Staff A could not explain why there

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was a sticker on the medication label that directed the staff that the medication directions had changed , when the resident's chart had the same directions as the MOR and the medication label.

In an interview with the Administrator at 1:45pm on . . . . , the Administrator stated that the facility needed to do a better job of insuring that the medications were entered in the MORs more accurately and following up on discrepancies on MORs, medication labels and medication orders.

Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42( ) FS; 58A-5.033(3)(a) FAC

Based observation, records review and interviews, the facility failed to correct a medication related deficiency related to Medication Labeling and Orders.

Findings included:

On . . . . , during a biennial re-licensure survey, the facility was found to have deficient practice with regards to failing to make every reasonable effort to ensure that prescriptions for residents , who receive assistance with self-administration of medication, are filled in a timely manner and labeled correctly. On . . . . at 11:15am, during a revisit to the previous survey, Staff A was observed assisting 3 residents who required assistance with medication self-administration. During the observation, the facility failed to make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration are labeled correctly for 2 of 3 residents observed (#4 and #5).

In an interview with the Administrator at 1:45pm on . . . . , the Administrator stated that the facility needed to do a better job of insuring that the medications were entered in the MORs more accurately and following up on discrepancies on MORs, medication labels and medication orders.

Class III