| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11966829** | **12/06/2018** |
| NAME OF PROVIDER OR SUPPLIER<br>**FORT CAROLINE GARDENS, INC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**9150 FT CAROLINE RD**<br>**JACKSONVILLE, FL 32225** | |

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

**0000 - Initial Comments**

On , 2018 a biennial relicensure survey was conducted at Fort Caroline Gardens Assisted Living. Deficient practice was identified during the surveys.

**0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(I)**

Based on record review, staff interview and facility policy and procedure reveiw, the facility failed to conduct two elopement drills per year for all direct care employees.

The findings include:

During the biennial licensure survey on a review of facility elopement drills for 2018 was conducted. Review of the Elopement Drill Record sign in sheets dated , and revealed the facility had conducted elopement drills on those dates. The drills were conducted at 4:15 PM, 2:43 PM and 2:40 PM, respectively (photographic evidence obtained).

Review of the elopement drill sign in sheets, staff schedules for the dates of the drills and employee list revealed nine night shift employees (11P-7A) had not attended any of the three trainings. Two night shift employees had only attended one training (photographic evidence obtained).

During an interview with the Assistant Administrator and the Executive Director on at 5:15 PM, they stated that they were not aware that all the staff had not been drilled two times during the year on elopement. They stated they would have to conduct drills at night to make sure they got everyone trained.

Review of the facility elopement drill policy and procedure effective date revealed: This elopement policy provides a plan to attempt to prevent resident elopements while ensuring every employee follows a standard protocol and adheres to all governing statutes and laws.

Class III

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

Based on observation and interview, the facility failed to read the label on the medication card aloud in the presence for 1 of 2 residents sampled for medication review, Resident #8.

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SUMMARY STATEMENT OF DEFICIENCIES
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The findings include:

During an observation of a medication pass on at 11:46am, Employee C, a Medication Assistant (MA) assisted Resident #8 with the self administration of medication. The MA led the resident to a chair located at the facility's designated medication station. When she returned to the medication station after cleaning her , she put on gloves as she greeted the resident. The MA pulled up the electronic medication observation record (MOR) and reviewed the medications listed on the screen. She then unlocked the medication cart and reviewed the medication cards filed. She selected a medication card and compared it to the MOR. She pushed the pill from the medication card into a pill cup on top of the cart, poured a cup of water, handed it to the resident, then handed the resident the pill cup. The resident took the medications then handed both of the empty cups to the MA. During the assistance with medication self administration for Resident #8, Employee C failed to inform the resident of the medication and what it was for, by reading the label of the medication aloud in the resident.

During an interview with Employee C, a Medication Assistant, on at 1:00pm she was asked if she had received the initial and continuing training for medication assistance. She responded she had. She was also asked to explain the process of assisting with medication self-administration. She responded; "I introduce myself. I tell them what I'm giving them and what it's for and answer any questions that they have."

An interview with Employee A, the Resident Care Facilitator on at 2:59pm during which she was asked about the facility's process of assisting with medication self-administration. She replied; "They (the nurses and medication assistants) go thru the process and tell the resident what they're taking and what it's for."

Class III

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

Based on observation, interview and medical record review the facility failed to obtain a revised label for two medications for Resident #7, 1 of 2 residents sampled for medication review.

The findings include:

During medication pass (med pass) on at 10:40am, Employee B, a Medication Assistant (MA), was observed as she assisted Resident #7 with medication self administration. The MA gave the resident , 40mg (1) capsule and Polyethylene , Powder 3350 NF, which she mixed in a

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

cup of water.

Review of the labels on the medication bottles revealed:

, DR 40mg capsule. Take (1) capsule by every evening.

Polyethylene , Powder 3350 NF. Mix 17gm (1 capful) in 8 ounces of liquid and drink by once daily. (photographic evidence obtained)

Review of the record for Resident #7 showed the following physician orders:

, Cap 40mg. Take (1) capsule by once daily. Schedule: Daily at 09:15. Orig date 25- -2018. Date written: 4- , -2018.

Polyeth Glyc Pow 3350 NF. Mix 17gm (1 capful) in 8 ounces of liquid and drink by once daily Monday, Wednesday and Friday. Schedule: Mon, Wed, Fri at 09:15. Orig date 15- -2018. Date written 15- -2018.

Review of the Medication Observation Record (MOR) revealed the following entries:

, Cap 40mg. Take (1) capsule by once daily.

Polyeth Glyc Pow 3350 NF. Mix 17gm (1 capful) in 8 ounces of liquid and drink by once daily Monday, Wednesday and Friday.

During an interview with Employee A, the Resident Care Facilitator, on at 2:59pm she was asked about the discrepancies found on the medication labels, the Medication Observation Record (MOR) and the physician's orders. She stated in regards to the Polyethylene , Powder 3350 NF, when it was written on the 6th it was to be given daily. It was updated on the 15th, and was supposed to be given three times a week. She confirmed they failed to put a change of direction sticker, and the label was wrong. In regards to the , DR 40mg capsule, she explained that when the order was written, it was for the evening but he wanted to take it in the morning. They did not put the change of direction sticker indicating he took it in the morning now instead of in the evening. She confirmed the order was correct, and the label was incorrect.

Class III