STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969069	R 01/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATIONAL CHURCH RESIDENCES OF BRADENTON	**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 second revisit to a biennial relicensure survey was conducted on for National Church Residences of Bradenton. At the time of the survey, the facility had deficient practice.

License #12926.

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview and record review, the facility failed to ensure that medications for two of two residents (Resident #1 and Resident #2)were correctly administered in accordance with orders from the health care provider and failed to ensure that licensed nurses were performing all necessary steps to ensure the residents received the correct medications in the correct dosages.

Findings included:

During a medication cart audit at 11:20am on , the medications for Resident #1 were observed. Staff A, a licensed practical nurse (LPN) pulled Resident #1's medications from the cart and displayed Resident #1's Medication Administration Records (MAR) on the computer screen. It was noted one of Resident #1's medications had a label that was missing the ordered dose. The label read, simply, "Florastor 250 milligrams (mg) capsules - twice daily". The prescription label on the medication was dated . The preprinted of the box (that contained the medication, not the prescription label) read "suggested use - 2 capsules 1 - 2 times per day." The resident's MAR, for the medication Florastor, read "Florastor 250 mg, as directed, 1 tablet by 2 times per day".

In an interview with the Director of Nursing (DON) at 11:30am, on , the DON stated that the nurses who are present when the pharmacy delivers the medications, put the medications on the carts. The DON could not explain why a medication with an incomplete label (missing the dose) was put on the cart without making sure the label was correct and matched the MAR and the medication orders.

At 11:45am on , the medication cart audit revealed that Resident #2's medication came in prepackaged bubble packs that were sent by the pharmacy. The bubble packs contained medications already portioned out for 4 medication times per day and for 7 days. The prepackaged bubble pack came with a list of Resident #2's medications, which included in the orders/instructions and a description

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of each pill, since they would have several pills in the bubble for each medication time. It was noted that there was a medication listed on the orders/instructions and was noted to be included in the bubbles for the morning medication time, (also known as Pepsid) 20 mg tablet 1 tablet by 1 time per day. The medication (also known as Pepsid) was not listed on Resident #2's MAR. A review of Resident #2's records revealed an order for dated which read " 20mg tablet, 1 tablet by 1 time per day."

Staff A, the DON and the Regional Nurse were all present at the time Resident #2's medications were audited and none of them could explain why the medication label and MAR did not match or why it was appeared that the medication had been given for the previous 6 days (the bubble packs were empty) when it was not listed on the MAR.

Class III