STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968966	R **03/07/2018**
NAME OF PROVIDER OR SUPPLIER **GENTRY PARK ORLANDO**	STREET ADDRESS, CITY, STATE, ZIP CODE **3201 CENTER POINT DR** **ORLANDO, FL 32825**	

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

0000 - Initial Comments

A revisit to the re-licensure survey with Limited Nursing Service (LNS) and Extended Congregate Care (ECC) was conducted on , 2018. Gentry Park Orlando, license #12797, had deficiencies at the time of the revisit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

DEFICIENCY REMAINED UNCORRECTED

Based on observations, record review, and interviews the facility failed to follow an order from a health care provider for 1 of 2 sampled residents (#12).

Findings:
Observations made during a medication pass on at 9:02 am revealed staff G, an unlicensed caregiver, gave resident #12 an , 81 milligram (mg) chewable tablet.

Review of the 2018 Medication Observation Record (MOR) for resident #12 revealed she was to be given an , delayed release 81 mg tablet.

On at 9:45 am, staff G confirmed she gave resident #12 a chewable , and said she was unable to explain the discrepancy between the medication package that contained the chewable tablets and the MOR that indicated an -coated tablet was to be given.

Review of the record for resident #12 revealed a physician order sheet (POS) that was signed by a health care provider. The POS was dated on that indicated resident #12 was to receive an , -coated delayed release 81 mg tablet by mouth daily.

On at 12:30 pm, the director of nursing confirmed the health care provider's order was for resident #12 to receive an , delayed release tablet and not a chewable tablet.

Class III

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

DEFICIENCY REMAINED UNCORRECTED

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GENTRY PARK ORLANDO	**3201 CENTER POINT DR** **ORLANDO, FL 32825**

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

Based on observations, record reviews, and interview, the facility failed to ensure the unlicensed staff who assisted a resident (#12) with self-administered medications followed the correct procedure.

Findings:
Observations made during a medication pass for resident #12 on at 9:02 am revealed staff G, an unlicensed caregiver, unlocked a medication cart that was located in the hallway outside of the resident's apartment. She removed the medication packages from the cart and compared the prescription labels to the Medication Observation Record (MOR.) Staff G sanitized her hands then, while still standing at the medication cart, she popped the pills into a medicine cup. Staff G poured water into a drinking cup then she locked the cart. Staff G took the medication packages and the water to the resident, who was sitting on her bed. Staff G donned gloves then she placed one drop from an eye medication vial into the resident's left eye. Staff G said the name of each medication out loud and to the resident. Staff G poured all of the pills into the resident's hand. The resident took each one with water and without assistance. Staff G observed the resident take each pill.

Staff G returned to the medication cart in the hallway and she signed the MOR. Staff G unlocked the cart and removed a medication package and a bottle of from the cart. Using a measuring cup, Staff G poured 17 grams of powder into an 8 ounce drinking cup. Staff G popped a pill out of the medication package into a cup and then she poured water into the drinking cup that contained the powder. Staff G reentered the resident's , retrieved a spoon from the resident's kitchen, and then she stirred the water and powder. Staff G approached the resident and poured the tablet into the resident's hand. The resident took the pill with the and water mix. Staff G observed the resident take the pill and drink all of the liquid. Staff G returned to the medication cart and signed the MOR.

Staff G did not take the , in its previously dispensed, properly labeled container, from where it was stored, and bring it to the resident, as required.

In addition, staff G did not remove the prescribed amount of medication from the package while in the presence of the resident, as required.

On at 9:45 am, staff G confirmed the findings.

Review of the record for resident #12 revealed a health assessment form 1823 that was dated on . The form indicated that resident #12 required assistance with self-administration of her medications.

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SUMMARY STATEMENT OF DEFICIENCIES
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Class III

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

DEFICIENCY REMAINED UNCORRECTED

Based on observations, record reviews, and interview, the facility failed to ensure a medication container was properly labeled for a resident (#12) who received assistance with self-administered medications.

Findings:
Observations made during a medication pass observation for resident #12 on . . . . at 9:02 am revealed staff G, an unlicensed caregiver, gave the resident two tablets from a package that contained . . . 8.6 milligram (mg) tablets. The instructions for use on the prescription label were to take 2 tablets (17.2 mg) by mouth at bedtime as needed.

Review of the 2018 Medication Observation Record (MOR) for resident #12 revealed 17.2 mg by mouth daily was to be given.

The . . . medication package did not contain an alert label to direct the staff to examine the revised directions for use in the MOR, as required.

On at 9:45 am, staff G confirmed the findings.

Review of the record for resident #12 revealed a health assessment form 1823 that was dated on . . . . . . The form indicated that she required assistance with self-administration of her medications. In addition, a physician order review that accompanied the 1823 indicated the resident was to take 17.2 mg by mouth daily.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

DEFICIENCY REMAINED UNCORRECTED

Based on personnel record review and interview, the facility failed to ensure that 2 of 4 unlicensed staff (G and H) who provided assistance with the resident's medications, received the annual 2 hours of continuing education on providing assistance with self-administered medications and safe medication practices in an Assisted Living Facility (ALF).

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SUMMARY STATEMENT OF DEFICIENCIES
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Findings:
Review of the personnel records for staff G and staff H, both of whom provided assistance with the resident's medications, revealed each record contained 2 hours of continuing education on providing assistance with self-administered medications that were both dated on .

Personnel record review for staff G did not have documented evidence that 2 hours of continuing education was received in 2018.

Personnel record review for staff H did not have documented evidence that 2 hours of continuing education was received in 2018.

On at 10:55 am, the business office manager confirmed the findings and said neither staff member had received the training in 2018, as required.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview, the facility failed to provide documentation to indicate its emergency management plan was approved on an annual basis by the local emergency management agency.

Findings:
Review of the most recent approval letter from the local emergency management agency for the facility's emergency plan revealed the letter was dated on .

During an interview with the administrator on at 1:27 pm, he said the facility did not have an approval letter for its plan for the year 2017. He said the facility did not submit its plan to the local emergency management agency until because he did not know the plan had to be submitted annually for review.

Class III