Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965739	A. BUILDING: _____ B. WING _____	11/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERON CLUB AT PRESTANCIA (THE)	3749 SARASOTA SQUARE BLVD. SARASOTA, FL 34238

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A 000	Initial Comments An unannounced complaint survey for complaint #2019013660 and #2019015396 was conducted on at Heron Club at Prestancia, an assisted living facility in Sarasota, Florida. Complaint #2019013660 was substantiated at tag #Z814 and #2019015396 was substantiated at tag #A0053 and #A0054. The following deficiencies were found at the time of the visit.	A 000		
A 053 SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and chapter 483, part I, F.S. A valid copy of the State Clinical Laboratory License, if	A 053		

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A 053	Continued From page 1 required, and the federal CLIA Certificate must be maintained in the facility. A state license or federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the State Clinical Laboratory License and federal CLIA Certificate is available from the Laboratory Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on staff and resident interview and record review, 1 (Resident #1) of 3 residents reviewed for medications received the wrong resident's medication twice in two months by a licensed agency nurse working at the facility. Proper identification of the resident was not done by staff in accordance with professional standards of practice. The findings included: On [redacted] at 1:50 p.m., in an interview with Resident #1 she said she had been given the wrong person's medication twice in a two month time frame. She said the first time she needed to go to the hospital and the second time she refused to go because she was not having trouble. Someone told her it was some marijuana medication. She said she felt happy. She said the medication she got was supposed to go to another resident by the same first name who lived a couple of doors down on the same floor.	A 053		

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A 053	Continued From page 2 Record review of Resident #1's medical record records the resident received the wrong medication belonging to another resident on 2 separate occasions. The first instance was recorded on at 9:00 a.m., when she received medication belonging to another resident by an agency employee working at the facility. Resident #1 was later transferred to the emergency room for complaint of with a history of . The second incident happened on when Resident #1 was given , liquid by by another agency employee working for the facility. Resident Health Assessment dated records the resident has a known , to , . On at 2:27 p.m., the Director of Nursing (DON) said she was not at the facility on the first occurrence of Resident #1 receiving the wrong medication but she was aware of it. She said it had been an agency nurse who was working on the memory care unit and did not know the resident. She said she did not identify the resident by name or picture. The DON said the second incident on was also an agency nurse, a Licensed Practical Nurse (LPN) and she was approached by the medication technicians (Med Tech) to give a liquid , to a resident. The med tech had already removed the medication from the medication cart and had the medication book open to the page. The nurse then checked the medication to the page and proceeded to go give it to the wrong resident. The DON said she had spoken to the agency nurse about the error but could not produce the documentation. Class III	A 053		

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A 054	Continued From page 3	A 054		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain a complete medication observation record (MOR) for 4 (Resident #1, #2, #5, and #8) out of 9 residents reviewed.	A 054		

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A 054	Continued From page 4 The findings included: The facility's policy #5.03 for MAR/MOR - Change of Shift Accuracy Check, revised on ; purpose of the MAR/MOR is to track and control resident medications. A MAR/MOR will be completed and maintained for all residents who require supervision or administration of medications. There well be no holes in MAR/MOR's. 1. On , Resident #2's AHCA 1823 dated , indicated the resident needed assistance with self administration of medications. Resident #2's MOR from through was reviewed. The MOR indicated the resident was to take (an , medication) at 12:00 p.m. and 4:00 p.m., on . The MOR was left blank for those 2 doses. There was no indication on the MOR the resident took her , (a lowering medication) and (a , medication) at 7:00 p.m. on . 2. On , Resident #5's AHCA 1823 dated , indicated the resident needed assistance with self administration of medications. Resident #5's MOR from through was reviewed. The MOR indicated the resident was to take (a medication) at 4:00 p.m., on , , , and . The MOR was left blank for these 4 doses. The resident was to receive (an , for) at 8:00 p.m. on , , and . The MOR was blank for these 3 doses. The resident was to take a at 8:00 a.m., and , (a medication) at 8:00 p.m. on . There was no indication the resident took these 2 medications.	A 054		

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A 054	Continued From page 5 3. In an interview on at 4:47 p.m., the Director of Resident Care confirmed the missing entries in the MORs for Resident #2 and #5. 4. Record review of Resident #1's MOR for the month of showed the resident was ordered a that was to be given twice a day for her diagnosis of ( ). The order was to be held for 5 days and she was to be given the same treatment three times a day for those 5 days and then go to two times a day. The record showed the resident completed the 3 times a day treatment on and was to return to the previous order but did not. The resident had not received the doctor ordered for the last 7 days. On at 2:27 p.m., the DON acknowledged the medication for Resident #1 was not given as ordered for the last 7 days. 5. Record Review of Resident #8's MOR for the month of , it was noted the resident was not given 9 of her morning medications on . There was no explanation given to why the medication were not given or documented. The medication included (for), (an), D3 (a supplement), , (a medication), XL (a medication), , baby , and On at 2:27 p.m., the DON acknowledged the medications for Resident #8 were not documented as being given and no explanation was documented on the of the MOR. The DON acknowledged she had not gone	A 054		

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A 054	Continued From page 6 thru the MOR and identified issues with medications not being given and investigated why. Class III	A 054		

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CZ814 SS=D	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure initial employment was reported to the Agency for Health Care Administration (AHCA) Clearing House within 10 days of employment as required for 2 (Staff A and B) of 6 new staff sampled. The findings included:	CZ814		

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CZ814	Continued From page 1 1. On , review of the AHCA Clearing House revealed a date of hire for Food Services Staff A was . Review of the facility roster revealed Staff A was added to the facility roster on , 17 days after hire. 2..On , review of the AHCA Clearing House revealed a date of hire for Medication Technician Staff B was . Review of the facility roster revealed Staff B had not been added to the facility roster as of . 3. On at 4:15 p.m., the Business Office Manager (BOM) confirmed she was aware Staff A had not been added within 10 days to the facility roster. The BOM said she was not aware Staff B had never been added. Unclassified	CZ814		