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
	AL11968816	A. BUILDING: _____ B. WING _____	02/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SARAH HOUSE (THE)	30 FOREST CT ORMOND BEACH, FL 32174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number 2019017608 and 20200002012), was conducted at Sarah House on The facility had deficiencies found at the time of the visit.	A 000		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her (d) Applying , , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the (h) Using a to perform -	A 052		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 052	Continued From page 1 level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the prescribed settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with bags. (4) Assistance with self-administration does not include: (a) Mixing, converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) , , or preparations. (g) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or	A 052		

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A 052	Continued From page 2 discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] or older, trained to assist with self administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with	A 052		

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A 052	Continued From page 3 medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility	A 052		

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A 052	Continued From page 4 failed to assist with self-administration of physician ordered medication for 1 of 5 sampled residents. (Resident #1) The findings include: Record review of the Medication Observation Record (MOR) for Resident #1 revealed Resident #1 did not take his 8:00 AM dose of [redacted] 100 MG. A review of the [redacted] of the MOR revealed the Medication Tech gave the reason the medication was not given was due to the family refusing. Further review of the MOR revealed Resident #1 did not receive any of his 8:00 AM medication on [redacted] and [redacted]. The reason documented on the [redacted] of the MOR was "Sleep/Family Refused." Photographic evidence obtained. During a telephone interview with Resident #1's daughter on [redacted] at 11:30 AM, she stated she is never in the facility at 8:00 AM when the [redacted] is given. She would have not told the facility to hold the [redacted], or not give him any of his medication. She stated she visits the facility during her lunch hour and it is always after 11:00 AM. She stated the staff have told her at times they did not give her father his medication and she would acknowledge the information, but was not giving the facility. On [redacted] at 11:45 am, the operation manager was asked for documentation about medication being held at the request of the family. Further docmentation beyond the MOR could not be provided. Class III	A 052		

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A 054	Continued From page 5	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 interview, the facility failed to ensure the accuracy of medication observation records for 3 of 5 sampled residents, Resident #1, #2, and #8, and failed to ensure the	A 054		

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A 054	Continued From page 6 accuracy of a medication label for 2 of 5 sampled residents, Resident #1 and #9. The findings include: 1.Record review of the , Medication Observation Record (MOR) for Resident #1 revealed he was receiving , 100 milligram (MG) tabs with a directive to take 1 tab twice a day. Further review of the MOR revealed Resident #1 did not get his 8:00 AM dose on . A review of the of the MOR revealed the Medication Tech gave the reason the medication was not given was due to the family refusing. Further review of the MOR revealed Resident #1 did not receive any of his 8:00 AM medication on and . The reason on the of the MOR was documented as "Sleep/Family Refused." Photographic evidence obtained. During a telephone interview with Resident #1's daughter on at 11:30 AM, she stated she is never in the facility at 8:00 AM when the , is given. She would have not told the facility to hold the , or not give him any of his medication. She stated she visits the facility during her lunch hour and it is always after 11:00 AM. She stated the staff have told her at times they did not give her father his medication and she would say O.K. but that is not giving the facility permission to not give the medication, it is her acknowledging she heard the report. In an interview with the Operations Manager on at 11:43 AM, she stated they do not have further details on the missed dosages. During further interview with the Operations Manager on 2020 at 12:13 PM she was asked for the , that was in the medication	A 054		

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A 054	Continued From page 7 cart for Resident #1. Record review of the labels on the medication cards revealed the [redacted] was a 50 MG dose with directions to take 1 tablet by twice a day. The Operations Manager was asked if there was any more , for Resident #1 in the medication cart. Employee A provided a second medication card identical to the first one. Employee A stated they just give Resident #1 two 50 MG tablets instead of the one 100 MG tablet. The Operations Manager was asked to provide the physician orders for , . She provided an order dated [redacted] for [redacted] 50 MG 2 tabs twice a day. She confirmed the MOR did not match orders or the label. 2. Record review of the MOR for Resident #2 revealed he did not have his 8:00 PM dose of , 0.5milligrams (MG) and his [redacted] 25 MG take ½ tablet dose on . Record review of the of the MOR revealed it was blank. During an interview on [redacted] at 11:11 AM, with the Operations Manager was asked why Resident #2 did not take his medication. She stated she would have to check. On at 11:20 AM, she stated she could not find out why Resident #2 did not have his 8:00 PM medications on [redacted] because there were not any notes in his record. 3. During an observation of employee A providing assistance with self-administration of medication for Resident #8 on at 8:52 AM, the Medication Tech was observed taking a bottle of over the counter , 200 MG out of the medication cart for Resident #8. Employee A took three tablets out of the bottle and gave them to	A 054		

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A 054	Continued From page 8 Resident #8 to take. The bottle of . . , . . . did not have any written directions on the bottle. Record review the MOR at the time of the observation revealed the directions on the MOR were for 3 tablets three times a day for , . Employee A was asked if there were orders for the . . , ... She provided orders with directions for Resident #8 to take three tablets every 6 hours. 4. During an observation of Employee A providing assistance with self- administration of medication for Resident #9 on . . . . . at 9:11 AM, Employee A was observed taking a bubble pack of Lipo-Flavonoid Plus Capsules out of the medication cart. Employee A was observed taking two tablets out and giving Resident #9 both tablets. Record review of the label on the Lipo-Flavonoid revealed directions to take one tablet twice a day. Record review of the MOR revealed the directions stated to give two tablets by once daily. Employee A was asked for the physician orders for the medication. Record review of the physician orders found the directions for the resident to take 2 tablets once a day. During further interview with Employee A she stated she did not notice the label and the MOR did not match. She stated it was a pharmacy mistake that should have been caught. Class III	A 054		