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 _____	R 08/18/2020

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 revisit to a complaint investigation (complaint #s 2019017608 and 20200002012) was conducted at Sarah House on . Deficiencies were found to be uncorrected at the time of the survey.	{A 000}		
{A 054}	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 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 , 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.	{A 054}		

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{A 054}	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on a review of resident records and interviews with staff, the facility failed to maintain accurate and complete medication observation records for 1 of 6 sampled residents whose medication was reviewed (Resident 8). The findings include: 1. A record review for Resident 8 revealed she had an AHCA 1823, Resident Health Assessment, dated . . . . She required assistance with the self-administration of medications. Resident 8 had a physician's order for , (used to treat movement . . . . .) 1 tablet by . . . every 12 hours for , , symptoms (involuntary movement). A review of the medication observation record (MOR) found her , was scheduled for 8:00 am and 8:00 pm daily. During the month of , the signature box was initialed and circled (indicating the medication was held or not given) on the following dates and times: 8:00 am on , 4, 5, 6, 10, 11, 12, 13, 14, 15, 16, 17. 8:00 pm on , 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17. Review of the . . . of the MOR found several entries that the medication was not available; however, there were no notes indicating why the medication was not given at these times: 8:00 am on , or 14. 8:00 pm on , ... , 5, 6, ,11, 12, 13, 14, 15, 16, or 17.	{A 054}		

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{A 054}	Continued From page 2 An interview was conducted with the Medication Technician on [redacted] at 1:10 pm. She reviewed the MOR and confirmed the multiple missed doses of [redacted] and the omitted explanations on the [redacted] of the MOR. She stated the family provided Resident 8's medication and had not refilled it. She confirmed missed doses should have been noted with the reason why the medication was not taken. An interview was conducted with the Community Director on [redacted] at 2:05 pm. She reviewed the MOR for Resident 8 and confirmed the missing documentation regarding the missed medication. Photographic evidence obtained. Class III	{A 054}		
A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no	A 056		

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A 056	Continued From page 3 individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , . , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who	A 056		

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A 056	Continued From page 4 receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on a review of resident records and interviews with staff, the facility failed to ensure medications were refilled timely for 2 of 6 residents who recieved assistance with self-administration of medications (Residents 8 and 13). The findings include:	A 056		

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A 056	Continued From page 5 1. A record review for Resident 8 revealed she had an AHCA 1823, Resident Health Assessment, dated . . . . . She required assistance with the self-administration of medications. She required daily oversight for well-being, whereabouts and reminders for important tasks. Resident 8 had a physician's order for , (used to treat movement . . . . .) 1 milligram tablet by . . . every 12 hours for , , symptoms (involuntary . . . . movements). A review of the medication observation record (MOR) found Resident 8's . . . . . , was scheduled for 8:00 am and 8:00 pm daily. During the month of . . . . . , the signature box was initialed and circled (indicating the medication was held or not given) on the following days: 8:00 am on , 4, 5, 6, 10, 11, 12, 13, 14, 15, 16, 17. 8:00 pm on , 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17. Review of the of the MOR found the medication was not available to give 13 times. There were also instances where the MOR was circled indicating the medication was not available, with no written description as to why. Resident 8 also had a physician's order for . . . (used to treat) 0.5 milligram tablet once daily at 8:00 am. Review of the MOR found the signature box for the was initialed and circled on , 4, 5, 6, and 7. The notes on the of the MOR all indicated that the	A 056		

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A 056	Continued From page 6 resident was out of this medication for those days. Photographic evidence was obtained for both medications. An interview was conducted with the Medication Technician on at 1:10 pm. She reviewed the MOR and confirmed the multiple missed medication doses. She explained the family provided this resident's medication and had not refilled it. She stated she notified the physician in person on Thursday when he came in. He came in every Thursday. 2. A record review conducted for Resident 13 found he had an AHCA1823 dated . He had diagnoses of and . He required assistance with self-administration of medication. Daily oversight was required for whereabouts and important tasks. Resident 13 had a physician's order for (an used to treat) 64.8 milligrams, take one tablet daily. Review of the MOR found the signature boxes were initialed and circled, indicating the medication was not given, on , 4, 5, 6, and 10. On the of the MOR, notes explained Resident 13 was out of this medication. Photographic evidence was obtained. There was no note in the resident's record indicating the physician had been notified that Resident 13's medication was not available for 5 days. An interview was conducted with the Medication Technician on at 1:30 pm. She stated she	A 056		

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A 056	Continued From page 7 notified the resident's physician of Resident 13's missed medication on or around Thursday . She stated she did not document when she spoke to the physician about either of the residents medications being out. An interview was conducted with the Community Director (CD) on at 2:05 pm. She reviewed the MORs for Resident 8 and confirmed the missing documentation for her omitted , . She stated she would expect the communication log for each of the residents to be completed to reflect the nurse practitioner being notified so he could discontinue the medication or order a hold. She explained Resident 8's and Resident 13's families ordered their medications due to insurance and cost reasons. The CD did not know why Resident 13's was out. Nobody had told her. A telephone interview was conducted with the Nurse Practitioner on at 2:10 pm. He confirmed staff told him on that first Thursday ( ) that Resident 8's son had not provided her medication and they were out. He did not recall being advised at his next visit a week later that Resident 8 was still out of her , . The NP stated that not receiving this medication could result in increased outbursts, as Resident 8 has a diagnosis of , . Had he known the medication was not being provided he could have ordered something different. The NP stated he was not aware Resident 13's medication had not been available. Had he known, he could have ordered something else. Resident 13 has a so requires this medication. He said was in the facility almost every week and was available by phone. Typically, when they run out of a	A 056		

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A 056	Continued From page 8 medication and cannot get it, the staff need to let him know immediately. Class III	A 056		