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
	AL11964216	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SARAH HOUSE II (THE)	1724 VALENCIA AVENUE 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 An abbreviated licensure survey with control visit was conducted at the Sarah House on . The provider had deficiencies at the time of the visit.	A 000		
A 052	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, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (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	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 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 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) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific	A 052		

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A 052	Continued From page 2 parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (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 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 , 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,	A 052		

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A 052	Continued From page 3	A 052		

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 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

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A 052	Continued From page 4 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 observation, record review and interviews, the facility failed to assist 3 of 5 sampled residents with self-administration of medication according to the requirements in 429.256, F.S. (Residents #1, #2, and #4). The findings include: 1. An observation was conducted of Employee A assisting Resident #4 with a check at 8:40 AM on in the living room on the couch. Employee A prepared the supplies, used on the resident's , held lancet at which resident pushed the button on the lancet, was applied to test strip and was cleaned again with . The resident's was 103. A review of the current Medication Observation Record (MOR) for Resident #4 noted checks were not on the MOR. A record review of the 1823 Health Assessment for Resident #4 was conducted which noted a diagnosis of . Review of the medication list did not not an order to check . There was an order to check the every morning. The profile was reviewed which was filled out by staff, that stated to check and every	A 052		

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A 052	Continued From page 5 morning before he eats. The Tru Metrix Test strips were reviewed which noted to use twice a day as directed which was written on . (photographic evidence obtained) An interview was conducted with Employee A at 2:55 PM concerning the checks for Resident #4. She reported the are written in a notebook, and she was not told anything else. Reviewed the documentation for the which average around 105-106. She did not know what to do if they were high or too low. 2. At 9:00 AM on Employee A, caregiver, was observed opening the medication cart. 5 cups of medications were observed in juice cups with resident names written on the outside of cup. Employee A reported she prefilled the cups when she arrived this morning because it was easier for the residents to take the medications during breakfast. A medication observation was conducted for Resident #1 at 9:00 AM on . The caregiver took the prefilled cup of medications out with resident's name written on it. Review of the original prescription packaging the medications came in showed the following medications were dispensed: 20 milligrams (mg) everyday, 75 mg everyday, 40 mg everyday, 50 mg everyday, relief 600 mg twice a day, Nitrofur 50 mg everyday with food, 20 mg everyday, Oxybutnin 5 mg everyday, 10 milliequivalents (meq) everyday, 20 mg everyday, D3 125 mg everyday, and 500 mg twice a day for 7 days for ( ). Employee A took the prefilled cup to the resident,	A 052		

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A 052	Continued From page 6 and told her about the . . . . . she was receiving for the . Resident #1 was not told about any of her other medications. Resident #1 took the medications with her coffee. A second medication observation was observed for Resident #2 on . . . . . at 9:10 AM. Employee A pulled out the prefilled juice cup with resident's name written on it and again was asked to see the original containers for medications. The prescription bottles were reviewed which noted the following medications were dispensed: Centrum 1 everyday, . . . 10 meq everyday, 100 mg 2 tabs everyday, . . . 20 mg everyday, . . . , 20 mg everyday, ... 0.1 mg tablet twice a day scheduled in morning and at 12 noon, and , . . 650 mg as needed for . Employee A took the med's in the prefilled cup to the resident at the breakfast table and told the resident about the , . . and a memory pill being part of the medications. She did not tell resident what the rest of her med's were and a memory pill was not part of the medications. (photographic evidence obtained) An interview was conducted with Employee A on at 1:05 PM with the Operations Manager present. She confirmed the medications were not explained to the resident and she prefilled the cups with medications. The Operations Manager reiterated the medications cannot be prefilled in cups, and needs to take medications in packets or bottles to resident and tell them what each medication is for. Class III	A 052		

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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 allergies 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 restraints, 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 observation, record reviews, and interviews, the facility failed to have an accurate Medication Observation Record (MOR) for 2 of 5 residents (Resident #2, Resident #4).	A 054		

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A 054	Continued From page 8 The findings include: 1. On at 9:10 AM, Employee A was observed assisting Resident #2 with medical self-administration. Employee A pulled out the prefilled juice cup with resident's name written on it and was asked to produce the original containers for the medications. The prescription bottles were reviewed which noted the following medications to be given orally: Centrum 1 everyday, 10 meq everyday, 100 mg 2 tabs everyday, 20 mg everyday, , 20 mg everyday, 0.1 mg tablet twice a day scheduled in morning and at 12 noon, and , 650 mg as needed for . A review of the MOR for Resident #2 showed Clonoidine 0.2 mg was listed as being given twice a day, in morning and at bedtime. The prescription bottle for the 0.2 mg noted it was to be given at bedtime. At the time of the observation at 9:10 AM on , both times were signed off as given. The pills were counted in the prescription bottle and based on the number of pills still present, the resident was only receiving the at night. Photographic evidence obtained. An interview was conducted with Employee A on at 1:05 PM concerning Resident #2's medications. She reported the was written wrong by the other employee and the resident only receives the 0.1 mg in the morning. She confirmed it was being initialed as given when it was not given. Employee A reported she was going to go to MOR and circle all the morning initials for the 0.2 mg and document it was not given, it was a mistake.	A 054		

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A 054	Continued From page 9 2. A record review of the 1823 Health Assessment for Resident #4 was conducted which noted a diagnosis of . . . . . The medication list did not note an order to check . . . . . There is an order to check the . . . , every morning. The profile sheet was reviewed which was filled out by staff. It gave directions to check the . . and , ... every morning before he eats. A review of the MOR for Resident #4 revealed checks every morning were not documented. The Tru Metrix Test strips were reviewed which noted to use twice a day as directed which was written on . (photographic evidence obtained) An interview was conducted with the Operations Manager on . . . . . at 1:45 PM. She confirmed the Tru Metrix strips directions on 11/6 note to use twice a day as directed. The old order written on on Tru Metrix strips was once a day. An interview was conducted with Employee A at 2:55 PM concerning the . checks for Resident #4. She reported the . . . . . are written in a notebook, and she was not told anything else. Reviewed the documentation for the which average around 105-106. She does not know what to do if they were high or too low. Class III	A 054		
A 057	59A-36.008(8) FAC Medication - Over The Counter (OTC) Products (8) OVER THE COUNTER (OTC) PRODUCTS. For purposes of this subsection, the term over	A 057		

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A 057	Continued From page 10 the counter includes, but is not limited to, over the counter medications, , nutritional supplements and nutraceuticals, hereafter referred to as OTC products, that can be sold without a prescription. (a) A facility may keep a stock supply of OTC products for multiple resident use. When providing any OTC product that is kept by the facility as a stock supply to a resident, the staff member providing the medication must record the name and amount of the OTC product provided in the resident's medication observation record. All OTC products kept as a stock supply must be stored in a locked container or secure room in a central location within the facility and must be labeled with the medication's name, the date of purchase, and with a notice that the medication is part of the facility's stock supply. (b) OTC products, including those prescribed by a health care provider but excluding those kept as a stock supply by the facility, must be labeled with the resident's name and the manufacturer's label with directions for use, or the health care provider's directions for use. No other labeling requirements are required. (c) Residents or their representatives may purchase OTC products from an establishment of their choice. (d) A health care provider's order is required when a nurse provides assistance with self-administration or administration of OTC products. When an order for an OTC product exists, the order must meet the requirements of paragraphs (b) and (c) of this subsection. A health care provider's order for OTC products is not required when a resident self-administers his or her medications, or when unlicensed staff provides assistance with self-administration of medications.	A 057		

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A 057	Continued From page 11 This Statute or Rule is not met as evidenced by: Based on observation and interviews, the facility failed to properly label an over-the-counter medication for 1 of 5 residents sampled (Resident #2). The findings include: A medication observation was observed for Resident #2 on at 9:10 AM. The medication bottles of what Resident #2 was dispensed were reviewed which noted the following medications: Centrum 1 everyday, 10 meq everyday, 100 mg 2 tabs everyday, 20 mg everyday, , 20 mg everyday, 0.1 mg tablet twice a day scheduled in morning and at 12 noon, and , 650 mg as needed for . The bottle of , did not have Resident #2's name written on it. An interview was conducted with Employee A on at 1:05 PM with the Operations Manager present. The Operations Managers confirmed the , should have the resident's name on the bottle. Class III	A 057		
A 160	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce	A 160		

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A 160	Continued From page 12	A 160		

the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request.
(1) FACILITY RECORDS. Facility records must include:
(a) The facility's license displayed in a conspicuous and public place within the facility.
(b) An up-to-date admission and discharge log listing the names of all residents and each resident's:
1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a , , ; and,
2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of .
(c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b).
(d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff.
(e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C.
(f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by

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A 160	Continued From page 13 rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing	A 160		

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
	AL11964216	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 160	Continued From page 14 services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to have an up-to-date admission and discharge log listing the names of all residents, a substitution log for menu items which were substituted during meal time, and documentation of training for 1 of 2 sampled employees. The findings include: 1. Observations conducted on showed the facility had a census of 5 residents. After reviewing the log it was noted there were 4 residents listed on the admission discharge log. Resident #3 was admitted on and was not listed on the admission discharge log. (photographic evidence obtained). An interview was conducted with the Operations Manager on at 11:34 AM. She confirmed Resident #3 was not listed on the admission discharge log and she would need to add her. 2. A review of the employee file for Employee A, hired on , revealed the Incident Reporting and ( ) training was missing. An interview was conducted with the Operations Manager at 12:07 PM. She confirmed Incident reporting and training was not in the employee record for Employee A. She reported Employee A has been here for a long time, and	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 160	Continued From page 15 received training, they just can't find it. 3. An interview was conducted with Employee A on at 12:20 PM. She was asked where the substitution log was kept. Employee A looked around the kitchen and reported "I don't know, I can't find it." An interview was conducted with the Operation Manager on at 12:30 PM. She reported they were unable to find a substitution log. Class III	A 160		