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
	AL11910326	A. BUILDING: _____ B. WING _____	R-C 01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L'ARCHE JACKSONVILLE, INC III	700 ARLINGTON ROAD NORTH JACKSONVILLE, FL 32211

(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 the relicensure survey was conducted at L'Arche Jacksonville, Inc III on . Deficient practice was identified at the time of the survey.	{A 000}		
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 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	A 054		

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A 054	Continued From page 1 medication. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the Medication Observation Record (MOR) was accurate for one of four residents reviewed (Resident #1). The findings include: Upon entry to the facilty on [redacted] at 8:30am, Resident #1 was observed in bed. The Administrator confirmed Resident #1 had not yet gotten her morning medications and her med pass would happen at 9:00am. While Resident #1 was being assisted with ADL's, and prior to the 9:00am med pass, Resident #1's MOR was reviewed. The following medications were initialed as already being given: Tears, Clearlax Powder, Cranberry, [redacted], Probiotic, [redacted], and [redacted]. Photographic evidence obtained at 9:05am. Resident #1 was taken to the medication room at 9:17am on [redacted]. After preperation, Employee A was observed dropping Resident #1's [redacted] Tears into each [redacted]. Employee A reviewed the MOR and began taking out the medication packages. Resident #1's medications were then crushed or poured into a bowl of pureed food. Employee A explained it was a puree of milk, toast, water, ketchup, cheese, and turkey. The bowl was filled with the pureed food and Employee A mixed the medications in with a standard table spoon.	A 054		

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A 054	Continued From page 2 Employee A stood in front of Resident #1's wheelchair and began spooning the mixture onto the spoon at 9:26am on . . . . . She tried to get Resident #1 to take the spoon to participate in the process but Resident #1 spilled a large amount of the mixture when she tried to take the spoon, or did not take the spoon, or only consumed half the mixture and spilled the other half during the process. Employee A was observed wiping the mixture from her glove when it spilled, as well as Resident #1's . . . and/or sweater, and putting the wipe to the side. Resident #1's medication/food mixture was spilled from the spoon or dripped off the spoon prior to reaching Resident #1 thirty times during the med pass. At the end of the pass there was a large pile of wipes which contained medication laced pureed food, and the bowl still contained food that was not consumed at the end of the med pass. Food was also observed along the side and rim of the bowl. Photographic evidence obtained. Employee A finished spooning the mixture for Resident #1 at 9:59am on . . . . . She was asked how she knew how much medication Resident #1 consumed if so much was spilled and wiped up. She explained that since she only mixed the medication on the top of the pureed mixture to ensure Resident #1 consumed everything. Following this, at 10:07am on . . . . . , Employee A was seen reviewing the MOR for Resident #1 but not documenting anything. When asked when she usually wrote that Resident #1 got her medication, she said she initials as she goes. It was pointed out that these medications were initialed as being given prior to Resident #1 entering the medication room today,	A 054		

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A 054	Continued From page 3 and she expressed surprise. The Administrator was asked about facility practices on at 12:20pm. She explained they don't usually assist Resident #1 with a large bowl of pureed food; they use applesauce or something smaller to avoid dripping/spilling the medication. She acknowledged the discrepancies and need for more education. Class III	A 054		