

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER ELDERLY LIVING CENTER OF HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 810 OLEANDER HOLLY HILL, FL 32117		
(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 unannounced follow-up to the licensure survey was conducted on 2012. Elderly Living Center of Holly Hill had deficiencies found at the time of the visit.	{A 000}			
{A 052}	58A-5.0185(3) FAC Medication - Assistance with Self-Admin (3) ASSISTANCE WITH SELF-ADMINISTRATION (a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. (b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container. (c) Staff shall observe the resident take the medication. Any concerns about the resident's reaction to the medication shall be reported to the resident's health care provider and documented in the resident's record. (d) When a resident who receives assistance with	{A 052}			

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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TLPS12

If continuation sheet 1 of 4

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{A 052}	Continued From page 1 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 which coincides with the resident's presence in the facility; 2. The medication container may be given to the resident or 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; (e) Pursuant to Section 429.256(4)(h), 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. (f) Pursuant to Section 429.256(4)(i), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (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 through	{A 052}			

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(A 052)	Continued From page 2 intermittent positive pressure breathing machines or a _____ (d) Administration of medications by way of a tube inserted in a cavity of the body. (e) Administration of _____ preparations. (f) Irrigations or debriding agents used in the treatment of a skin condition. (g) _____ or _____ preparations. (h) 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. (i) 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. This Statute or Rule is not met as evidenced by: Based on a review of resident records and staff interview, the facility failed to ensure that physician-ordered prn (as needed) medications included specific parameters for use for 2 of 8 sampled residents who were prescribed prn medications (Residents #2 and #6). The findings include: A review of the medication observation record (MOR) for Resident #2 (admitted 1993) revealed an order for Acetomenophen 500 mg (milligrams) tab/ _____ EX-STR (extra strength) 500 mg gel then 1 tablet every 8 hours as needed. There was no indication for its use on the MOR or in the resident's record. Record review for Resident #6 (admitted	(A 052)			

Agency for Health Care Administration

PRINTED: 08/21/2012
FORM APPROVED

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{A 052}	Continued From page 3 2011) found an order for relief-nasal decongenstant/Cla . . . 24 hour tab 1 tablet by mouth daily as needed. No documentation could be located in the MOR or Resident #6's record regarding why the medication should be administered. During an interview with staff at 12:10 pm on . . . 2012, she acknowledged the missing indications or specific parameters for when the medications should be given to both residents. Class III Correction Date: . . . 2012	{A 052}			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11911145	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 8/1/2012
Name of Facility ELDERLY LIVING CENTER OF HOLLY		Street Address, City, State, Zip Code 810 OLEANDER HOLLY HILL, FL 32117

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0076</u> Reg. # <u>58A-5.0186 FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0090</u> Reg. # <u>58A-5.0191(11) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0092</u> Reg. # <u>58A-5.020(1) FAC</u> LSC _____	Correction Completed
ID Prefix <u>A0152</u> Reg. # <u>58A-5.023(3) FAC</u> LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>[Signature]</u>	Reviewed By <u>[Signature]</u>	Date: <u>8/21/2012</u>	Signature of Surveyor: <u>[Signature]</u>	Date: <u>8/21/2012</u>
State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
CMS RO				
Followup to Survey Completed on: ☒		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <u>YES</u> <u>NO</u>		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Elderly Living Center of Holly
810 Oleander
Holly Hill, FL 32117

Dear Administrator:

This letter reports the findings of a revisit survey conducted on 2012 by a representative of this office.

Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references the uncorrected deficiency, identified during the revisit.

The deficiency should be corrected no later than 2012.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (904) 798-4201.

Sincerely,

Keisha Woods, MPH
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

KW/sm
Enclosure

