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
	AL11910312	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAYSPRING VILLAGE, INC.	542301 US HIGHWAY #1 HILLIARD, FL 32046

(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 Two unannounced complaint surveys, CCR# 2012006449 and CCR# 2012008911, were conducted at Day Spring Village on 2012. Deficiencies were identified as a result of CCR# 2012008911.	A 000		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following. (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	A 025		

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A 025	Continued From page 1	A 025		

This Statute or Rule is not met as evidenced by:
Based on observation and staff interview, the facility failed to provide the appropriate care and services by lack of supervision for [redacted] residents who needed to check their [redacted] sugar levels, (Residents # 9, #10, #15, #17, #22, and #8) and for residents who needed assistance with medication administration (Residents #2, #3,#7, and # 21). The Medication Technician (Employee #2) allowed all [redacted] residents to use the same glucometer without [redacted] the device and also did not watch residents actually take the medications.

The findings include:

A medication observation was conducted on [redacted] at 8:41 a.m. The residents stood in line and walked up to the medication window to receive their cup of medications. Each time Employee #2 handed the residents their medication cups (Residents #2, #3, #7, and #21), the resident walked away from the window with the medication. Employee #2 would immediately turn her back to retrieve the medication bin for the next resident and begin to prepare it. Employee #2 did not actually see if the residents took their medications. When Employee #2 was asked their policy about medication assistance and watching residents take their medications on [redacted] at 9:35 a.m. she did not respond.

During this same medication pass observation on [redacted] at 9 a.m. , While Employee #2 was assisting with the medication for Resident # 6, Resident #10 walked up to the counter and began using an unknown glucometer device. The device did not have any name on it to determine

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A 025	Continued From page 2 who it belonged to. Resident #10 used the machine, threw a lancet (sharp device used to draw [illegible] from fingertip) on the floor, hollered out 182 and walked away. Employee #2 stated that the glucometer belonged to Resident #10. At 9:10 a.m., Employee #2 was assisting with medication for Resident #8, when Resident #9 walked up to the counter and used the same glucometer. Resident #9 walked away from the window and it was unknown what she did with her lancet and she did not call out any number. Employee #2 was asked why Resident #9 used Resident #10's glucometer device. She stated she was not sure whose it was but every person used that same one. When asked if she thought that was a problem, she deferred the question to the Resident Care Director (RCD). The Exective Director (ED) was interviewed on [illegible] at 2:50 p.m. He confirmed that Residents #9 and #10 used glucometers. He also confirmed that Residents #15, #17, #22, and #8 also used glucometers to check their [illegible] sugars levels. There were a total of 6 residents. He confirmed that there were two glucometer devices in the medication [illegible] a common drawer, neither were labeled with a resident's name. The ED stated he did not think that residents using the same glucometer device was an [illegible] control issue. Class II Correction Date: [illegible], 2012 (Immediate)	A 025		
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as	A 030		

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described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.
(b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.
(d) The statewide toll-free telephone number of the Florida Hotline " 1(800)96 or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.

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A 030	Continued From page 4 (f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law. (g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside. (h) Pursuant to Section 429.41, F.S., the use of physical . . . . . shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical . . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and	A 030		

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with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a . . . his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Access to adequate and appropriate health

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care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

This Statute or Rule is not met as evidenced by:
Based on observation and staff interview, the facility failed to provide appropriate health care consistent with recognized community standards for ..... control procedures during medication assistance with self administration of medications by touching medications with bare her hands for

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A 030	Continued From page 7 four of eight residents (Residents #1, #2, #6, and #7) observed for medication assistance, and not glucometer devices in between resident use for two of six residents observed for glucose monitoring (Residents #9 and #10). The findings include: 1. On from 8:41 a.m until 9:15 a.m, Employee #2 was observed to prepare medications for Residents # 1, #2, #6, and #7. She was observed to touch the residents' medications with her bare hands before placing them in the small plastic cup. Employee #2 never washed her hands or sanitized them after touching the medications with her bare hands and preparing medications for the next resident. There was a bottle of hand sanitizer next to the employee which she failed to use. The Executive Director was interviewed on at 3 p.m. did not have a concern with Employee #2 touching medications with her hands and not sanitizing afterwards before going onto the next resident and touching their medications. Employee #2 on at 3:10 p.m. was not sure if it was ok to touch the resident's medications with her hands or if she needed to wash or sanitize between residents. 2. During this same medication pass observation on at 9 a.m. , While Employee #2 was assisting with the medication for Resident # 6, Resident #10 walked up to the counter and began using an unknown glucometer device. The device did not have any name on it to determine who it belonged to. Resident #10 used the	A 030		

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machine, threw a lancet (sharp device used to draw [illegible] from fingertip) on the floor, hollered out 182 and walked away. Employee #2 stated that the glucometer belonged to Resident #10. At 9:10 a.m., Employee #2 was assisting with medication for Resident #8, when Resident #9 walked up to the counter and used the same glucometer. Resident #9 walked away from the window and it was unknown what she did with her lancet and she did not call out any number. Employee #2 was asked why Resident #9 used Resident #10's glucometer device. She stated she was not sure whose it was, but every person used that same one. When asked if she thought that was a problem, she deferred the question to the Resident Care Director (RCD).

The Exective Director (ED) was interviewed on [illegible] at 2:50 p.m. He confirmed that Residents #9 and #10 used glucometers. He also confirmed that Residents #15, #17, #22, and #8 also used glucometers to check their [illegible] sugars levels. There were a total of 6 residents. He confirmed that there were two glucometer devices in the medication [illegible] a common drawer, neither were labeled with a resident's name. The ED stated he did not think that residents using the same glucometer device was an [illegible] control issue.

3. According to the Centers for [illegible] Control and Prevention ' s website located at <http://www.cdc.gov/injec -monitoring.htm#Unsafe>

last reviewed on [illegible], 2011 and last updated on [illegible], 2012, an article posted read:

"Unsafe Practices during [illegible] Glucose

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Monitoring and Insulin A

An underappreciated risk of glucose testing is the opportunity for exposure to bloodborne viruses , and through contaminated equipment and supplies if devices used for testing and/or administration (e.g., glucose meters, fingerstick devices, pens) are shared.

Outbreaks of associated with glucose monitoring have been identified with increasing regularity, in long-term care settings, such as nursing homes and assisted living facilities, where residents often require assistance with monitoring of glucose levels and/or administration. In the last 10 years, alone, there have been at least 15 outbreaks of associated with providers failing to follow basic principles of control when assisting with glucose monitoring. Due to under-reporting and under recognition of acute , the number of outbreaks due to unsafe care practices identified to date are likely an underestimate ... Unsafe practices during assisted monitoring of glucose and administration that have contributed to transmission of or have put persons at risk for include:

1. Using fingerstick devices for more than one person

2. Using a glucose meter for more than one person without cleaning and it in between uses

3. Using pens for more than one person

4. Failing to change gloves and perform hand

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A 030	Continued From page 10 hygiene between fingerstick procedures " The article went on to read that the best practices for assisted glucose monitoring and administration were as follows: " 1. Whenever possible, glucose meters should be assigned to an individual person and not be shared. 2. If glucose meters must be shared, the device should be cleaned and after every use, per manufacturer ' s instructions, to prevent carry-over of and agents. If the manufacturer does not specify how the device should be cleaned and then it should not be shared. " It was unknown whether or not the glucometer being used by Residents # 9 and #10 had manufacturer's instructions about the device for mutiple person use. Class II Correction Date: 2012 (Immediate)	A 030		
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	A 052		

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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 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

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A 052	Continued From page 12 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 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	A 052		

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(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 052	Continued From page 13	A 052		

discretion on the part of the unlicensed person.

This Statute or Rule is not met as evidenced by:
Based on observation and staff interview , the facility failed to properly assist with the self administration of medication for Residents #2, #3,#7, and #21 by failing to watch the residents actually take the medications, by not describing to the resident what medications they were receiving for all residents (Residents # 1, #2, #3, #6, #7, and #21) and by failing to administer a scheduled pain medication for Resident # 8, seven of eight residents observed during medication pass.

The findings include:

A medication observation was conducted on [redacted] from 8:41 a.m to 9:15 am. The residents stood in line and walked up to the medication window to receive their cup of medications. For each resident (Residents # 1, #2, #3, #6, #7 and #21), Employee #2 would put the medications into a small plastic cup and hand it to the residents. She did not read the prescription label to the residents to explain what medications they were being dispensed.

Each time Employee #2 handed the residents their medication cups for (Residents #2, #3, #7, and #21), the resident walked away from the window with the medication. Employee #2 would immediately turn her back to retrieve the medication bin for the next resident and begin to prepare it. Employee #2 did not actually see if the residents took their medications. When Employee #2 was asked about their policy about medication assistance and watching residents take their medications on [redacted] at 9:35 a.m. she did not respond.

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
	AL11910312	A. BUILDING _____ B. WING _____	

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A 052	Continued From page 14 On ... at 9:15 a.m. Employee #2 was observed to assist with medication administration for Resident #8. Resident #8 walked up to the window and Employee #2 asked her if she was in pain. The Resident stated "no". Employee #2 stated that she did not give Resident #8 her ... 50 mg. Employee #2 wrote on the resident's Medication Observation Record "R" by the ... 50 mg at 9 am on ... Employee #2 stated that the "R" meant the resident refused the medication. Employee #2 was questioned why she withheld the medication and she stated because she knew the medication was for pain and the resident was not in pain. Review of the ... 2012 MOR revealed the ... was scheduled at 9 a.m. It was not "as needed", so Employee #2 should have been given the pain medication. It was not at the discretion of the Medication Technician to make a decision as to whether or not to give the medication. Employee #2 stated she could withhold the medication because the resident was not in pain. Employee #2 was questioned why she wrote wrote "R" down on the MOR because the resident did not refuse it, she just stated she was not in pain. Employee #2 repeated because the resident was not in pain. Further review of the ... 2012 MOR also revealed ... 500 mg tab was scheduled to be given twice a day at 9 am and 9 pm. On ... at 9 a.m. Napoxen had a "R" in the box. The resident did not refuse the medication. On ... at 9:32 a.m., the Resident Care Coordinator (RCD) stated that it was alright that the residents walk away from the window with their medications because she was in the ... observe them take it. When asked her if she was there the entire time, she stated no. She confirmed that at times she did leave the	A 052		

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A 052	Continued From page 15 medication area. The Executive Director (ED) was interviewed on [redacted] at 2:50 p.m. He stated that although the residents step away from the window to take their medications it was alright because they have other staff standing nearby to watch them take it, one of which was the RCD. During the medication observation, the RCD was observed walking throughout the facility and did not remain nearby at all times during the medication pass. When the ED was told that the RCD was seen leaving the medication area several times during medication assistance, he stated there was another employee present, but the employee was not identified nor seen by the surveyor during the medication observation. Class III Correction Date: 2012	A 052		
A 054	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall 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 shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known the resident may have; the name	A 054		

Agency for Health Care Administration

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A 054	Continued From page 16 of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical . the facility shall, 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 review and staff interview, the facility failed to accurately maintain a daily medication observation record (MOR) for each resident who received assistance with self administration of medications for Residents #1 #5 and #8, three of eight sampled residents for medication assistance observation. The findings include: 1. On . . . : at 8:41 a.m. Employee #2 was observed to assist with medication self-administration for Resident #1. Employee #2 stated she did not give the resident his . . . 10 mg or the l 325 mg (2) because they were out of it. Review of the . . 2012 MOR revealed an "R" daily since . 2012. Employee #2 stated she puts an "R" for all entries on the MOR when she did not give a medication regardless of the reason. The code on the bottom of the MOR revealed an "R" meant refusal. The resident never refused the medications, they were just out of it.	A 054		

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A 054	Continued From page 17 2. On . . . . at 8:52 a.m. , Employee #2 was observed to assist with medication self-administration for Resident #5. She reached into the resident's medication bin and pulled out two over-the-counter (OTC) medications, ... C and a . . . . . Neither OTC had the resident's name on it. Employee #2 confirmed this and immediately wrote the resident's name on them. She also stated that these two medications were not on the . 2012 Medication Observation Record (MOR) and questioned if she should write it on there now. Employee #2 stated that he (Resident #5) had been taking these OTC medications for a while. The Executive Director was interviewed on . . at 10:30 a.m. He stated that if the OTC was centrally stored it should be labeled with the resident's name and the Medication Technician should have it the MOR. 3. On at 9:15 a.m. Employee #2 was observed to assist with medication self-administration for Resident #8. Resident #8 walked up to the window and Employee #2 asked her if she was in pain. The Resident stated "no". The Resident never stated that she did not want to take the medication. Employee #2 stated that she did not give Resident #8 her 50 mg because she was not in pain. Employee #2 wrote on the resident's Medication Observation Record "R" by the . . . . . 50 mg at 9 am on . . . . . Employee #2 stated that the "R" meant the resident refused the medication. The resident did not refuse the medication. The MOR was incorrectly filled out. Class III Correction Date: , 2012	A 054		

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A 057	58A-5.0185(8) FAC Medication - Over The Counter (OTC) Products (8) OVER THE COUNTER (OTC) PRODUCTS. For purposes of this subsection, the term OTC includes, but is not limited to, OTC medications, , nutritional supplements and nutraceuticals, hereafter referred to as OTC products, which can be sold without a prescription. (a) A stock supply of OTC products for multiple resident use is not permitted in any facility. (b) OTC products, including those prescribed by a licensed health care provider, must be labeled with the resident ' s name and the manufacturer ' s label with directions for use, or the licensed health care provider ' s directions for use. No other labeling requirements are necessary nor should be required. (c) Residents or their representatives may purchase OTC products from an establishment of their choice. (d) A facility cannot require a licensed health care provider ' s order for all OTC products when a resident self-administers his or her own medications, or when staff provides assistance with self-administration of medications pursuant to Section 429.256, F.S. A licensed health care provider ' s order is required when a licensed nurse provides assistance with self-administration or administration of medications, which includes OTC products. When such an order for an OTC product exists, only the requirements of paragraphs (b) and (c) of this subsection are required. This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to properly label over the counter medications (OTC) for Resident #5, one of eight sampled residents for medication assistance	A 057		

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A 057	Continued From page 19 observation. The findings include: On . . . . . at 8:52 a.m. Employee #2 was observed to assist with medication assistance for Resident #5. She reached into the resident's medication bin and pulled out two OTC medications, ... C and a . . . . . Neither OTC had the resident's name on it. Employee #2 confirmed this and immediately wrote the resident's name on them. She also stated that these two medications were not on the Medication Observation Record (MOR) and questioned if she should write it on there now. The Executive Director was interviewed on . . . . . at 10:30 a.m. He stated that if the OTC was centrally stored, it should be labeled with the resident's name and the Medication Technician should have it the MOR. Class III Correction Date: 2012	A 057		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Dayspring Village, Inc.
542301 U. S. Highway #1
Hilliard, FL 32046

Re: CCR #2012006449 and CCR #2012008911

Dear Administrator:

This letter reports the findings of a state licensure compliant survey that was conducted on , 2012 by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2012** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey. **A recommendation for sanction has been forwarded to the Central Office in Tallahassee for the Class II deficiencies. This action, if taken, will be a matter of separate correspondence from the Central Office in Tallahassee.**

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 surveyors. Should you have any questions please call this office at

Sincerely,

Keisha Woods

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

LW/KW/sm
Enclosure

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