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
	AL11964959	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF PENSACOLA	8700 UNIVERSITY PARKWAY PENSACOLA, FL 32501

(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 CCR #2012008367 was investigated :- at Sterling House of Pensacola Assisted Living Facility. At the time of survey the facility had deficient practice cited and the complaint was partially substantiated.	A 000		
A 030 SS=G	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 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	A 030		

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A 030	Continued From page 1	A 030		

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.
(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 buildi 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

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A 030	Continued From page 2	A 030		

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 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

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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 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

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A 030	Continued From page 4 active in, and to associate with advocacy or special interest groups. This Statute or Rule is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide access to adequate and appropriate health care. Medications were not available from the contracted pharmacy for 5 of 5 sampled residents (#1, 2, 3, 4, 5,) The findings are: 1. Review of resident #5 medication record dated indicated the resident did not receive ER 10 MEQ on , 21, 22, . The order was written to give one 10 MEQ daily to replace his due to diagnosis of in which he takes a which depletes . On the physician increased the to 20 MEQ due to low lab levels. Resident #5 received this dose for 4 days up until . Then the physician ordered another increase to 20 MEQ two times a day due to low lab levels. Review of level results dated indicated low at 3.3 (3.4-5.5). The resident was on one pill a day at 10 MEQ. The resident didn't receive his medication for 4 days ( ). The physician was not aware so he ordered an increase in his to 20 MEQ one time a day. The next lab results dated indicated a Critical low level of at 2.6 (3.4-5.5) in which the physician again ordered an increase to 20 MEQ two times a day and one Capsule ordered "now" which the resident did not receive. Still the physician was not aware that the resident	A 030		

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had not been receiving his medications.
Review of orders indicated the residents to have another level drawn on . Review of the record lacked evidence of the results. The regional nurse stated she would take care of this right way.
Review of resident #5's mediation record for the month of indicated on 9/5, 6, for 9:00 am, 1:00 pm and 9:00 pm 325 milligrams was not available to be given. The order was written to give 2 pills three times a day. The record lacked evidence the physician was notified.

2. Review of resident #1 medication record dated indicated an order for 7.5 milligrams for mood stabilization to be given two times a day. On the following days the resident did not receive the medication because it was not available from the pharmacy: 8/1, 2, 7,8,15, 16, 17, .
2 milligrams one at bedtime was not given 6/1-
OsCal 500 mg. one daily was not given 6/1-
81 mg. one daily was not given 6/1-
The record lacked documentation the physician was notified.

3. Review of the medication record for resident #2 indicated an order to receive 60 milligrams (mg.) for the , one pill three times per day. The residents did not receive the medication on and indicating not available from the pharmacy. The resident did not receive inhalation solution 0.02% treatment three times a day for tract on two times. Review of the record indicated she did not

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receive D 50,000 units once a month for the month of due to not available from the pharmacy. On , 26, the resident did not receive , inhalation treatment three times per day due to not available from the pharmacy. Medication record dated indicated an order to receive 21,000 units by injection on . The box was not marked as given by staff with a note attached saying injection ordered, awaiting pharmacy.

4. Resident #4 was to receive 500 mg. one per day for . On 9/6, 7, 8, 9, the resident did not receive due to waiting from pharmacy.

5. Review of resident #3 mediation record for indicated an order to receive XL 100 mg one daily for . The resident did not receive the medication on indicating not available from the pharmacy. On the resident was to receive injection for . The box was not signed as given by staff. The record indicated the medication was not available from the pharmacy. The resident had an order to receive the injection every 3 weeks. The month of indicated the resident did not receive the following medication due to not available from the pharmacy: 15 mg. on , 20 mg. one pill two times a day on 4/3- and XL 50 mg. one daily for on 4/3-
Record review and interview with Wellness Director, regional nurse at 4:00 pm concerning missing med's, syringes and correct count of medications, lacked evidence that the facility could accurately account for medications ordered by staff and family and medication

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delivered by pharmacy and family. It was not clear during the resident stay exactly who was in charge of ordering and receiving medications due to family request to be involved. The facility did not give medication as ordered and did not have supplies to give injections.
Record review indicated the resident was admitted with a diagnosis of [redacted] and [redacted]. Review of lab order dated [redacted] for urinalysis (UA) had no results in record. The physician ordered it again on [redacted]. The results finally showed up on [redacted]. Another UA result dated [redacted] showed up in the record without an order. The record had UA results dated [redacted] without an order. An order for a UA dated [redacted] did not have results in the record and one for [redacted]
Interview with the Wellness Director and the regional nurse on [redacted] at 4:00 pm indicated they have had some problems with the contracted lab company and had spoken to them regarding the problems several months ago. The regional nurse stated the policy is for the facility to receive an order from the physician, make out a request form and call the lab. The lab will pick up the specimen the same day or the following day. We usually get the results within a day or two. She stated just last week the lab came to draw [redacted] on a resident that had already had their [redacted] drawn earlier that morning by another lab tech. They confirmed the findings.
Further interview with the regional nurse and the wellness director stated they have had problems with the delivery of medication from the pharmacy. We changed pharmacy a few months ago. the staff were trained on how to order and receive medication from the new pharmacy. During survey medications were noted not available and the staff was not aware. The staff

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A 030	Continued From page 8 passing the med's were writing med's not available and not following up on the where the medications were. The wellness director stated he spoke to the new pharmacy owner of the problems last night. The regional nurse and the wellness director confirmed the findings. Class II	A 030		
A 056 SS=G	58A-5.0185(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) No prescription drug shall be kept or administered by the facility, including assistance with self-administration of medication, unless it is 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. Identification of each medicinal drug product in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no person 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 shall 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 shall be specified; for example, " as needed for pain, not to exceed 4 tablets per day. " The revised instructions,	A 056		

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including the date they were obtained from the health care provider and the signature of the staff who obtained them, shall be noted in the medication record, or a revised label shall be obtained from the pharmacist.
(d) Any change in directions for use of a medication for which the facility is providing assistance with self-administration or administering medication must be accompanied by a written medication order issued and signed by the resident ' s health care provider, or a faxed copy of such order. The new directions shall promptly be recorded in the resident ' s medication observation record. The facility may then place an " alert " label on the medication container which directs staff to examine the revised directions for use in the MOR, or obtain a revised label from the pharmacist.
(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 copy of a signed order is acceptable.
(f) The facility shall make every reasonable effort to ensure that prescriptions for residents who 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 64F-12.006, 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 shall also 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

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A 056	Continued From page 10	A 056		

package, they shall 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 shall provide the resident with a written prescription, or a fax copy of such order.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and staff interview the facility failed to provide medications as ordered by the physician as they were not available from the contracted pharmacy for 5 of 5 sampled residents (#1, 2, 3, 4, 5,)

The findings are:

1. Review of resident #5 medication record dated indicated the resident did not receive ER 10 MEQ on , 21, 22, . The order was written to give one 10 MEQ daily to replace his due to diagnosis of , in which he takes a which depletes . On the physician increased the to 20 MEQ due to low lab levels. Resident #5 received this dose for 4 days up until . Then the physician ordered another increase to 20 MEQ two times a day due to low lab levels. Review of level results dated indicated low at 3.3 (3.4-5.5). The resident was on one pill a day at 10 MEQ. The resident didn't receive his medication for 4 days (- '). The physician was not aware so he ordered an

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A 056	Continued From page 11 increase in his [illegible] to 20 MEQ one time a day. The next lab results dated [illegible] indicated a Critical low level of [illegible] at 2.6 (3.4-5.5) in which the physician again ordered an increase to 20 MEQ two times a day and one Capsule ordered "now" which the resident did not receive. Still the physician was not aware that the resident had not been receiving his medications. Review of orders indicated the residents to have another [illegible] level drawn on [illegible]. Review of the record lacked evidence of the results. The regional nurse stated she would take care of this right way. Review of resident #5's mediation record for the month of [illegible] indicated on 9/5, 6, [illegible] for 9:00 am, 1:00 pm and 9:00 pm [illegible] 325 milligrams was not available to be given. The order was written to give 2 pills three times a day. The record lacked evidence the physician was notified. 2. Review of resident #1 medication record dated [illegible] indicated an order for [illegible] 7.5 milligrams for mood stabilization to be given two times a day. On the following days the resident did not receive the medication because it was not available from the pharmacy: 8/1, 2, 7,8,15, 16, 17, [illegible] [illegible] 2 milligrams one at bedtime was not given 6/1- [illegible] OsCal [illegible] 500 mg. one daily was not given 6/1- [illegible] [illegible] 81 mg. one daily was not given 6/1- [illegible] The record lacked documentation the physician was notified. 3. Review of the medication record for resident #2 indicated an order to receive 60 milligrams (mg.) for the [illegible], one pill three times	A 056		

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A 056	Continued From page 12	A 056		

per day. The residents did not receive the medication on and indicating not available from the pharmacy. The resident did not , , inhalation solution 0.02% treatment three times a day for tract on two times. Review of the record indicated she did not receive D 50,000 units once a month for the month of due to not available from the pharmacy. On , 26, the resident did not receive , , inhalation treatment three times per day due to not available from the pharmacy. Medication record dated indicated an order to receive 21,000 units by injection on . The box was not marked as given by staff with a note attached saying injection ordered, awaiting pharmacy.

4. Resident #4 was to receive 500 mg. one per day for . On 9/6, 7, 8, 9, the resident did not receive due to waiting from pharmacy.

5. Review of resident #3 mediation record for indicated an order to receive XL 100 mg one daily for . The resident did not receive the medication on indicating not available from the pharmacy. On the resident was to receive injection for . The box was not signed as given by staff. The record indicated the medication was not available from the pharmacy. The resident had an order to receive the injection every 3 weeks. The month of indicated the resident did not receive the following medication due to not available from the pharmacy: 15 mg. on , 20 mg. one pill two times a day on 4/3- and XL 50 mg. one daily for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF PENSACOLA	8700 UNIVERSITY PARKWAY PENSACOLA, FL 32501

(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 056	Continued From page 13 on 4/3- . Record review and interview with Wellness Director, regional nurse at 4:00 pm concerning missing med's, syringes and correct count of medications, lacked evidence that the facility could accurately account for medications ordered by staff and family and medication delivered by pharmacy and family. It was not clear during the resident stay exactly who was in charge of ordering and receiving medications due to family request to be involved. The facility did not give medication as ordered and did not have supplies to give injections. Record review indicated the resident was admitted with a diagnosis of , , and . Review of lab order dated for urinalysis (UA) had no results in record. The physician ordered it again on . The results finally showed up on . Another UA result dated showed up in the record without an order. The record had UA results dated without an order. An order for a UA dated did not have results in the record and one for . Interview with the Wellness Director and the regional nurse on at 4:00 pm indicated they have had some problems with the contracted lab company and had spoken to them regarding the problems several months ago. The regional nurse stated the policy is for the facility to receive an order from the physician, make out a request form and call the lab. The lab will pick up the specimen the same day or the following day. We usually get the results within a day or two. She stated just last week the lab came to draw on a resident that had already had their drawn earlier that morning by another lab tech. They confirmed the findings. Further interview with the regional nurse and the	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964959	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF PENSACOLA	**8700 UNIVERSITY PARKWAY PENSACOLA, FL 32501**

(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 056	Continued From page 14 wellness director stated they have had problems with the delivery of medication from the pharmacy. We changed pharmacy a few months ago. the staff were trained on how to order and receive medication from the new pharmacy. During survey medications were noted not available and the staff was not aware. The staff passing the med's were writing med's not available and not following up on the where the medications were. The wellness director stated he spoke to the new pharmacy owner of the problems last night. The regional nurse and the wellness director confirmed the findings. Class II	A 056		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

[redacted], 2012

[redacted] Tracy Schall
6521 El Presideo
Pensacola, FL 32504

CONFIDENTIAL
CCR# 2012008367

Dear [redacted] Schall:

A representative from the Agency for Health Care Administration (AHCA) completed an unannounced visit at Sterling House Of Pensacola on [redacted], 2012. While at the facility, our staff thoroughly reviewed your concerns. The representative observed care, interviewed resident(s)/patient(s) and staff, as well as completed medical chart reviews.

The representative(s) found that rules and laws were violated at the time of our visit. The facility received a statement of deficiencies and will be required to correct the deficiencies.

Thank you for bringing your concerns to our attention. You may view previous inspection results at http://apps.ahca.myflorida.com/[redacted]web. Your feedback is important to us and we invite you to complete a survey at http://tinyurl.com/ahcasurvey.

Sincerely,

Donan Heiberg, MSW
Field Office Manager

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone 850-412-4540; Fax (850) 922-9162

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

. . . . . , 2012

Administrator
Sterling House Of Pensacola
8700 University Parkway
Pensacola, FL 32501

Dear Administrator:

Re: CCR #2012008367

This letter reports the findings of a state licensure survey that was conducted on , 2012 by a representative 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.

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 me at 850-412-4540.

Sincerely,

Donah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
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