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 | A 000 | | |

A Limited Nursing Service monitoring visit was conducted on at Sterling House Assisted Living Facility. At the time of survey the facility had deficient practice cited.

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|---|---|---|---|---|
| AN278 SS=D | 58A-5.031(3) FAC LNS - Records | AN278 | | |

(3) RECORDS.
(a) A record of all residents receiving limited nursing services under this license and the type of service provided, shall be maintained.
(b) Nursing progress notes shall be maintained for each resident who receives limited nursing services.
(c) A nursing assessment conducted at least monthly shall be maintained on each resident who receives a limited nursing service.

This Statute or Rule is not met as evidenced by:
Based on observation, resident/family interview, staff interview and record review the facility failed to conduct a monthly assessment for each resident who receives limited nursing services for two of two sampled residents (# 5, 6).
The findings are:
1. Record review of the Limited Nursing Services log book indicated resident #5 was receiving nursing services for the use of .
Review of the health assessment dated indicated the resident was admitted with a diagnosis of , Hospice, , Mild Cachexia and Chronic .

Physician orders indicated to administer at 2 liters via nasal cannula at bedtime and as needed.

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| **STERLING HOUSE OF PENSACOLA** | **8700 UNIVERSITY PARKWAY PENSACOLA, FL 32501** |

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|---|---|---|---|---|
| AN278 | Continued From page 1 | AN278 | | |

Observation and interview with resident and her son on at 1:40 PM indicated the resident using her .
Record review of the limited nursing monthly assessments did not reflect an assessment completed for the month of . The last assessment was completed .
Interview with staff member "C" on / at 1:09 PM stated the corporate nurse said she completed the assessments. The facility was unable to locate the assessments.

2. Record review for resident #6 indicated she was admitted on . The most current health assessment was conducted which indicated diagnosis of Chronic , Atril , and deficiency.
Review of the most current physician orders indicate to give an injection of monthly. The last injection was given by licensed nurse on .
Review of the limited nursing service log indicated the resident was to receive limited nursing services for the monthly injections by licensed nurses.
Record review indicated the last monthly assessment was completed .
Interview with staff C on / at 1:09 PM stated the cooperate nurse said she did the assessments for . The facility was unable to find them.
Class III

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:

This letter reports the findings of a state licensure Limited Nursing Service 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 , 2013 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,

Patricia M Fuller, RNC

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

DH/pm
Enclosure
XG90

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