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 _____	R

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 revisit survey to complaint CCR#2012008367 conducted on was conducted on / at Sterling House of Pensacola Assisted Living Facility. The facility had deficiencies found at the time of survey resulting in harm.	{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}		

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 _____	R

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 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 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

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 _____	R

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 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

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 _____	R

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 030}	Continued From page 3	{A 030}		

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 l, 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

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 _____	R

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 030}	Continued From page 4	{A 030}		

active in, and to associate with advocacy or special interest groups.

This Statute or Rule is not met as evidenced by:
Based on record review and staff interview the facility failed to provide access to adequate and appropriate health care by not administering pain medications as ordered by the physician and by not assessing the resident ' s need for pain medication and having the medication available for 1 of 8 sampled residents which resulted in harm. (#7)
The findings are:
Record review revealed the resident was previously admitted in 2012 for respite care. He was readmitted for respite care. Review of the health assessment indicated the resident had diagnosis of and . He was assessed to have behavioral issues and needed assistance with medication administration. He was independent with ambulation, dressing, eating, toileting and transfers. He needed supervision with bathing and and was not

Record review of his chart upon admission ( ) did not include an order for pain medication. Review of the medication observation record (MOR) did not reflect any pain medication orders. Review of the medication receipt (a receipt showing what medications are brought in from home) upon admission did not reflect an order for pain medication. Upon admission the daughter brought in his medication from home which included a bottle of 500 milligrams (mg) but this was not found on the receipt of medications brought in. Review of the previous

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 _____	R

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 030}	Continued From page 5	{A 030}		

admission / indicated an order for 500 milligrams.
Interview with medication technician (MT) on / at 3:33 pm stated the resident was alert, short term memory issues at times and toileted himself. I would lay out his clothes for him. He would walk the halls with his walker going to and from the dining meals and to the medication his medications. On occasion he would sit in the lounge. He stayed in his of the day. His grandson visited on occasion. She stated the night before he went out (/) she noticed his ankles were and he was complaining of pain in his back. She called the daughter and she stated his ankles are due to a history of back problems. The daughter stated she had brought in for pain upon admission. I told her we had the medication be didn't have an order to give it. The MT stated she took the resident to the medication a licensed practical nurse (LPN) was on duty and told her about his ankles and his pain. She thought the LPN called the physician for an order for the for pain. Further interview found the LPN did not call the physician for an order so the resident didn ' t receive any pain medication.
Record review of nursing notes dated / at 8:30 am noted feet with and notified physician. An order was given to send out for evaluation. The daughter was called. Interview with LPN on 2:30 pm who sent him to emergency the daughter was not happy that he was going out. She stated he had a back condition and we could give him for it. The LPN stated she told the daughter he was experiencing left shoulder pain and pressure. The daughter stated he had a murmur. At this time he was medicated for pain.
He did not receive any pain medication after

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 _____	R

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 030}	Continued From page 6 complaining to MT on on the evening shift and to the LPN on the morning of / / until he was sent out the ER on / at 10:00 AM. Review of ER record dated / / at 14:46 noted condition Lumbar spine compression : sacral (chronic compression and sacral insufficiency - non) and chronic lumbar radiculopathy. Orders were written to medicate for pain with prescription given for mg one every 4 hours as needed for pain (20 doses). Interview with LPN on at 2:30 pm stated the resident did not receive any pain medication. The resident returned to the facility on / / at 6:30 pm. The pain medication was filled for use. However the record does not reflect the resident was assessed for pain and the medication was not signed as given. Interview with Wellness Director on / at 2:10 pm stated upon admission the family brought in the but we didn't have an order to give it. She stated she did not call the physician to clarify orders and or ask for an order for any pain medication. She stated he did not have a in the facility unless he in his did not tell us. She confirmed the resident did not receive any pain medication during this stay. 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	{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 _____	R

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 7	{A 056}		

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, 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

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 _____	R

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 8	{A 056}		

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 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 record review and staff interview the facility failed to assess the resident ' s need for pain medication and failed to have the medication available and administer it per orders for 1 of 8

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 _____	R

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 9	{A 056}		

sampled residents which resulted in harm. (#7)
The findings are:
Record review revealed the resident was previously admitted in 2012 for respite care. He was readmitted for respite care. Review of the health assessment indicated the resident had diagnosis of , , and . He was assessed to have behavioral issues and needed assistance with medication administration. He was independent with ambulation, dressing, eating, toileting and transfers. He needed supervision with bathing and and was not

Record review of his chart upon admission ( ) did not include an order for pain medication. Review of the medication observation record (MOR) did not reflect any pain medication orders. Review of the medication receipt (a receipt showing what medications are brought in from home) upon admission did not reflect an order for pain medication. Upon admission the daughter brought in his medication from home which included a bottle of , 500 milligrams (mg) but this was not found on the receipt of medications brought in. Review of the previous admission indicated an order for , 500 milligrams.
Interview with medication technician (MT) on / at 3:33 pm stated the resident was alert, short term memory issues at times and toileted himself. I would lay out his clothes for him. He would walk the halls with his walker going to and from the dining meals and to the medication his medications. On occasion he would sit in the lounge. He stayed in his of the day. His grandson visited on occasion. She stated the night before he went out (/) she noticed his ankles were and he was complaining of pain in his

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 _____	R

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 10	{A 056}		

back. She called the daughter and she stated his ankles are due to a history of back problems. The daughter stated she had brought in for pain upon admission. I told her we had the medication be didn't have an order to give it. The MT stated she took the resident to the medication a licensed practical nurse (LPN) was on duty and told her about his ankles and his pain. She thought the LPN called the physician for an order for the for pain. Further interview found the LPN did not call the physician for an order so the resident didn ' t receive any pain medication.

Record review of nursing notes dated / at 8:30 am noted feet with and notified physician. An order was given to send out for evaluation. The daughter was called. Interview with LPN on / 2:30 pm who sent him to emergency the daughter was not happy that he was going out. She stated he had a back condition and we could give him for it. The LPN stated she told the daughter he was experiencing left shoulder pain and pressure. The daughter stated he had a murmur. At this time he was medicated for pain.

He did not receive any pain medication after complaining to MT on / on the evening shift and to the LPN on the morning of until he was sent out the ER on / / at 10:00 AM.

Review of ER record dated / at 14:46 noted condition Lumbar spine compression : sacral (chronic compression and sacral insufficiency - non) and chronic lumbar radiculopathy. Orders were written to medicate for pain with prescription given for mg one every 4 hours as needed for pain (20 doses). Interview with LPN on / at 2:30 pm stated the resident did not receive any pain medication.

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 _____	R

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 11 The resident returned to the facility on / / at 6:30 pm. The pain medication was filled for use. However the record does not reflect the resident was assessed for pain and the medication was not signed as given. Interview with Wellness Director on / at 2:10 pm stated upon admission the family brought in the , but we didn ' t have an order to give it. She stated she did not call the physician to clarify orders and or ask for an order for any pain medication. She stated he did not have a in the facility unless he in his did not tell us. She confirmed the resident did not receive any pain medication during this stay. Class II	{A 056}		

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

CCR # 2012008367

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 deficiencies deficiencies, identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than ', 2013.**

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 850-412-4540.

Sincerely,

Patricia McEntire RNC

for Bonah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure

BB17

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