AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Emeritus at Oak Park
650 East Minnehaha Avenue
Clermont, FL 34711

Dear Administrator:

Re: CCR #2013002409

This letter reports the findings of a complaint survey that was conducted on , 2013 by a representative of this office.

Enclosed 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 this office at (386) 462-6201.

Sincerely,

Kriste J. Mennella
Field Office Manager

KJM/amw

Enclosure
XG90

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Tallahassee, FL 32308
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Alachua, FL 32615-5669
Phone (386) 462-6201; Fax (386) 418-5300

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
	AL11964596	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT OAK PARK	**650 EAST MINNEHAHA AVENUE CLERMONT, FL 34711**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint investigation, CCR# 2013002409 was conducted on . Citations were issued as a result of the investigation as the facility was not in compliance.	A 000		
A 054 SS=D	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 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:	A 054		

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A 054	Continued From page 1 Based on record review and interview the facility failed to ensure that the Medication Observation Record (MOR) accurately documented that the resident did or did not received the medication at the time the medication was offered or administered for 1 (#1) of 5 sampled residents. Findings: 1. Medical record review of resident #1's medical record revealed that she had a physician order written on to receive 20 MEQ once a day at 9:00 AM, and this order was transcribe to the Medication Observation Record for Review of the Medication Observation Record (MOR) dated for Resident #1 revealed that the resident did not receive the physician order dated of 20 MEQ once a day at 9:00 AM. Further review revealed that CNA #1 documented on that he had assisted resident #1 with self-administration of 20 MEQ, and signed that this medication was given on the MOR, when there was not any 20 MEQ on the medication cart, since LPN #3 had failed to fax the order to the pharmacy. 2. Interview on at 10:00 AM with Licensed Practical Nurse #2 (LPN) revealed that he found that the physician's order for this medication of 20 MEQ was not faxed to the pharmacy as ordered on therefore this medication was omitted and not administered to resident #1 as ordered. The LPN stated that he called the pharmacy and confirmed that they had not	A 054		

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A 054	Continued From page 2 received an order for resident #1 for [redacted] 20 MEQ. Further interview with LPN #2 revealed that he stated " when I questioned CNA#1 about signing that he had given the medication of [redacted] 20 MEQ to resident #1 when it was not on the medication cart, that he had signed that he had given it, even though he had not, and also failed to alert nursing staff that it was not available. 3. Interview on [redacted] at 10:30 AM with the Resident Care Director, LPN #1, and she stated that she had spoken with CNA#1 that had documented that he had given the physician order for [redacted] 20 MEQ, and he had informed her that he that he had signed that he had given it, even though he had not, and also failed to alert nursing staff that it was not available. Therefore he had falsified the Medication Observation Record. Class III	A 054		
A 056 SS=D	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	A 056		

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A 056	Continued From page 3	A 056		

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 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.

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A 056	Continued From page 4 (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 observation, review of the medical record, and interview the facility failed to ensure that a medication was filled in a timely manner for 1 (Resident #1) of 5 sampled residents. Finding: 1. Medical record review of resident #1's medical record revealed that she had a physician order written on [redacted] to receive [redacted]	A 056		

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A 056	Continued From page 5 : 20 MEQ once a day at 9:00 AM, and this order was transcribe to the Medication Observation Record for . Review of the Medication Observation Record (MOR) dated for Resident #1 revealed that the resident did not receive this physician order of : 20 MEQ once a day at 9:00 AM. 2. Interview on at 10:00 AM with Licensed Practical Nurse #2 (LPN) revealed that he found that the physician's order for this medication of : 20 MEQ was not faxed to the pharmacy as ordered on , therefore this medication was omitted and not administered to resident #1 as ordered. The LPN stated that he called the pharmacy and confirmed that they had not received an order for resident #1 for : 20 MEQ. 3. Interview on at 10:30 AM with the Resident Care Director, LPN #1, and she stated that she had spoken with LPN#3 that had transcribe the physician order for : 20 MEQ, and she had informed her that she had failed to fax the order to the pharmacy. Therefore a medication was made due to LPN #3's failure to submit a physicians order to the providing pharmacy to fill, resulting in resident #1's omission of 4 days. Class III	A 056		
A 160 SS=D	58A-5.024(1) FAC Records - Facility Records. The facility shall maintain the following written	A 160		

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A 160	Continued From page 6 records in a form, place and system ordinarily employed in good business practice and accessible to Department of Elder Affairs and Agency staff. (1) FACILITY RECORDS. Facility records shall include: (a) The facility ' s license which shall be displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident ' s: 1. Date of admission, the place from which the resident was admitted, and if applicable, a notation the resident was admitted with a pressure ; and 2. Date of discharge, the reason for discharge, and the identification of the facility to which the resident is discharged or home address, or if the person is , the date of ..... Readmission of a resident to the facility after discharge requires a new entry. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intends to return pursuant to Rule 58A-5.025, F.A.C. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) An up-to-date record of major incidents occurring within the last 2 years. Such record shall contain a clear description of each incident; the time, place, names of individuals involved; witnesses; nature of injuries; cause if known; action taken; a description of medical or other services provided; by whom such services were provided; and any steps taken to prevent recurrence. These reports shall be made by the individuals having first hand knowledge of the	A 160		

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A 160	Continued From page 7 incidents, including paid staff, volunteer staff, emergency and temporary staff, and student interns. (e) The facility ' s emergency management plan, with documentation of review and approval by the county emergency management agency, as described under Rule 58A-5.026, F.A.C., which shall be located where immediate access by facility staff is assured. (f) Documentation of radon testing conducted pursuant to Rule 58A-5.023, F.A.C.; (g) The facility ' s liability insurance policy required under Rule 58A-5.021, F.A.C.; (h) For facilities which have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C. (i) The admission package presented to new or prospective residents (less the resident ' s contract) described in Rule 58A-5.0182, F.A.C. (j) If the facility advertises that it provides special care for persons with or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (k) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C. (l) All food service records required under Rule 58A-5.020, F.A.C., including menus planned and served; county health department inspection reports; and for facilities which contract for catered food services, a copy of the contract for catered services and the caterer ' s license or certificate to operate. (m) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last two (2) years.	A 160		

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A 160	Continued From page 8 (n) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (o) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (p) Additional facility records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. (q) The facility ' s resident elopement response policies and procedures. (r) The facility ' s documented resident elopement response drills. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to they followed their own policies and procedures regarding the resolution of 1 out of 5 (#1) patients' grievances. Findings: 1. Review of the Grievances policy and procedure revealed it became effective and revised on . . . . Further review of this policy and procedure revealed the following: Our Practice: We value open communication and encourage any concerned party to first discuss matters with the Executive Director or other manager within the community. They may also do this verbally or in writing using a Feedback Form. Resident/Family/Visitor Grievances: Upon receipt of a concern,the staff member who has	A 160		

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A 160	Continued From page 9 knowledge of this issue is to bring it to the immediate attention of their supervisor or the Executive Director. 2. Review of the medical record and Medication Observation Record (MOR) revealed that the facility had failed to order the [redacted] 20 MEQ from the pharmacy as ordered on [redacted], therefore this medication was omitted and not administered to resident #1 as ordered. 3. Interview on [redacted] at 10:00 AM with Licensed Practical Nurse #2 (LPN) revealed that he found that the physician's order for this medication of [redacted] 20 MEQ was not faxed to the pharmacy as ordered on [redacted], therefore this medication was omitted and not administered to resident #1 as ordered. The LPN stated that he called the pharmacy and confirmed that they had not received an order for resident #1 for [redacted] 20 MEQ. The LPN #2 stated that he called the physician that prescribed this order and informed her of this error on [redacted] at 10:00 AM. The physician told the LPN#2 to inform the Executive Director that she (the physician) wanted an answer in writing or for her call the physician and explain this error, and how it will be prevented from reoccurring. LPN #2 spoke on [redacted] with the Resident Care Director, LPN #1, and informed her of this conversation with resident #1's physician, and that she wanted a response to this medication error for resident #1 by Wednesday, [redacted] 4. Interview on [redacted] at 10:30 AM with the Resident Care Director, LPN #1, and she stated that LPN#2 had informed her that resident #1'	A 160		

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A 160	Continued From page 10 physician had told him on to let the Executive Director know that she (the physician), wanted an answer in writing or for her call the physician and explain this error, and how it will be prevented from reoccurring. LPN #1 stated that she spoke with the Executive Director that next day and informed her of this message from resident #1's physician that she wanted a response to this medication error for resident #1. 5. Review of the Verbal and Written Complaint (Grievance) log revealed that there was not a filed a complaint from resident #1's physician regarding the order of 20 MEQ, that was omitted and not administered to resident #1 as ordered. 6. Interview on at 10:45 AM with the Executive Director revealed that she had spoken with the Resident Care Director, and was given the message that resident 1's physician wanted an answer in writing or for her call the physician and explain this error, and how it will be prevented from reoccurring. The Executive Director stated that she did not log this into the Grievance Log, fill out a grievance Feedback Form, or write or call the physician about this complaint/incident. Class III	A 160		