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
	AL11942717	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEERWOOD PLACE	8700 A C SKINNER PARKWAY JACKSONVILLE, FL 32256

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A 000	Initial Comments An unannounced complaint survey, CCR# 2013002584, was conducted at Deerwood Place on , 2013. Deficiencies were identified as a result of the survey.	A 000		
A 027	58A-5.0182(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to needed health care, the facility shall, as needed by each resident: (a) Assist residents in making appointments and remind residents about scheduled appointments for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation for persons with (c) The facility may not require residents to see a health care provider. This Statute or Rule is not met as evidenced by: Based on a review of the resident records and interview with the charge nurse, the facility failed to ensure that medical care was arranged for one of nine residents reviewed (Resident #8) whose lab work was not obtained, as ordered, by the physician. The findings include: A review of Resident #8's record found she had written physician's orders for , a	A 027		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 027	Continued From page 1 thinner used to prevent ..... and ..... clots in the veins and ..... The physician's orders also instructed the facility to obtain ..... lab levels every week on Monday. Further review of Resident #8's record found that physician's ordered lab levels for the ..... were not completed on ..... or on ..... as ordered. An interview and additional record review was conducted with the Charge Nurse at 1:20 pm on ..... She confirmed the physician's ordered lab work for Resident #8 had not been completed on ..... and on ..... Class III	A 027		
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 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,	A 054		

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A 054	Continued From page 2 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 an observation , resident record reviews, and staff interviews, the facility failed to maintain an accurate daily medication observation record (MOR) that reflected missed medication or medication errors for 1 of 8 sampled residents (Resident #6). Resident #6 received assistance with self-administration of medications. The findings include: 1. During an observation of assistance with medication administration for Resident #6 at 9:31 am on the following medications were dispensed into a plastic cup by CNA #1 and taken by the resident: 40 mg tab daily (qd), 100 milligrams (mg) twice daily 30 mg qd, qd, 20 meq (milliequivalents) qd, 10-325 four times daily as needed. A review of the medication observation record (MOR) for Resident #6 found that 2.5 mg qd was also scheduled at 9:00 am. The box on the MOR for at 9:00 am was initialed, indicating the medication had been available and dispensed to the resident on the previous morning.	A 054		

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A 054	Continued From page 3 An interview was conducted with CNA#1 at 9:40 am on . She stated she did not administer the to Resident #6 because it was not in the med cart this morning. She stated the might be in with central supply. CNA #1 was accompanied to central supply to obtain a new card of at 10:20 am on . The CNA looked for a new card and stated the was not in stock, and would need to be ordered. Additional review of the MORs for Resident #6 found that in 2013, the was signed off as given from to each day at 9 am. A letter in the resident's record dated from AARP informed the resident that a temporary supply of was being provided, but that the drug had not been included on the covered drugs list. A handwritten note reading " 2.5 qd ", and signed by the attending physician was printed on the front of the notice. More handwriting at the top of the letter noted " required physician request or change to alternative drug list on back of this notice ". The entry was dated . An interview and review of the MOR was conducted with the Charge Nurse at 10:25 am on . When told there was no available this morning for Resident #6, she telephoned the pharmacy to determine when it had been delivered last. She was told the . (which was ordered to start 2013) had never been delivered to the facility. She could not explain why the medication was signed for, as administered, daily by the staff. She stated the CNAs should have circled the signature box upon realizing the medication was not available, indicated on the back of the MOR that the	A 054		

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A 054	Continued From page 4 medication was not available, and notified her immediately that it needed to be re-ordered. The Charge Nurse stated that she was unaware the [redacted] for Resident #6 had not been available for administration since it was ordered. Class III	A 054		
A 056	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, including the date they were obtained from the	A 056		

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A 056	Continued From page 5 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 package, they shall be kept in a container that	A 056		

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A 056	Continued From page 6 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 observations, record review and interviews with staff, the facility failed to ensure that new medication orders were promptly recorded on the medication observation record for 1 of 8 residents (Resident #4) who required assistance with medication self-administration. The findings include: An observation of assistance with administration of medication for Resident #4 was conducted at 9:45 am on . . . . . He stated he was preparing to leave for . . treatment. The following medications, according to the labels, were dispensed into a cup by CNA #1: . . . . 100 mg qd, ... 10 mg qd, torsemide 100 mg qd, ... 200 mg qd, ... 25 mg qd, . . . 81mg qd, ... 200 mg . . . . 10 mg qd, ... 800 mg 2 tablets . . with meals, and . . . . 100 mg tab . . . "skip dose on . . . days." Review of the MOR found the same instructions for the . . . . ; 100 mg tab . . . "skip am dose on . . . days."	A 056		

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A 056	Continued From page 7 CNA #1 was stopped by this writer prior to giving Resident #4 the cup of medications. CNA #1 checked the medication label and the MOR, and acknowledged the instruction to hold the on days. A review of the MOR for 2013 found that the corresponding signature box on Resident #4 ' s MOR had been " X " ed off on days for the 9:00 am dose of . This indicated the medication was not to be administered on those days at that specific time; however, the 2013 MOR was signed every day at 9:00 am, indicating the had been dispensed daily, including on days, from to . The MOR for the month of did not note the same 'hold on days' instructions noted on the 2013 and 2013 MORs. A telephone interview was conducted with the Nurse at 11:15 am on . She located the last order for Resident #4's written on . The order specified to hold the morning dose on days, and was authored by a nephrologist. She stated medication was typically held on days for all patients. Further record review for Resident #4 found a Resident Health Assessment dated confirming he had . The medication list at the time of the examination did not reflect use of the Further record review found hospital discharge records for Resident #4, dated , which noted " er 100 mg - start " There was no hold order on the hospital discharge record. While the medication was given as most recently ordered by the hospital physician, the MOR and the medication labels	A 056		

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A 056	Continued From page 8 were not updated with the new instructions. An interview was conducted with the Charge Nurse at 10:25 am. She confirmed the label and the MOR for Resident #4's ! did not match the most recent physician's order. She contacted Resident #4's physician for clarification, and the hold order for the ! was reinstated for . days. Class III	A 056		
A 092	58A-5.020(1) FAC Food Service - General Responsibilities Food Service Standards. (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator or a person designated in writing by the administrator shall: (a) Be responsible for total food services and the day to day supervision of food services staff. (b) Perform his/her duties in a safe and sanitary manner. (c) Provide regular meals which meet the nutritional needs of residents, and therapeutic diets as ordered by the resident ' s health care provider for resident ' s who require special diets. (d) Maintain the in-service and continuing education requirements specified in Rule 58A-5.0191, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation of the kitchen and interview with the Certified Dietary Manager (CDM), the	A 092		

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A 092	Continued From page 9 facility failed to ensure food was stored in a safe and sanitary manner in the reach in refrigerator. The fingings include: During an inspection of the kitchen's reach in refrigerator at 11:35 am on , a large square plastic container (approximatley 5 quarts in volume) holding prunes in juice was observed on the top shelf. The lid was partially open, and revealed a one inch gap that exposed the contents of the container to the air. The container was not labeled with the contents, or dated for expiration and safe use. In addition, five 2-quart pitchers of unlabeled colored fluids and water was observed sitting on a tray in the refrigerator. The CDM was interviewed at 11:40 am on She acknowledged the unsafe storage of the prunes and fluids, and stated all items should have been labeled with the contents and dated for use. She instructed dietary staff to discard all unlabeled items. Class III	A 092		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Deerwood Place
8700 A C Skinner Parkway
Jacksonville, FL 32256

Re: CCR #2013002584

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on . 2013 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 this office at

Sincerely,

Keisha Woods

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

JS/KW/sm
Enclosure

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