AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Sterling House of Gainesville
4601 N.W. 53rd Avenue
Gainesville, FL 32606

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2013 by representative(s) of this office.

Enclosed is the provider's copy of the State (5000-3547) 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(s). Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Kriste J. Mennella
Field Office Manager

KJM/amw

Enclosure
XG90

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

Alachua Field Office
14101 N W Hwy 441, Suite 900
Alachua, FL 32615-5669
Phone (386) 462-6201; Fax (386) 418-5300

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964436	07/02/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sterling House Of Gainesville	4601 N.W. 53rd Avenue Gainesville, FL 32606	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

List of Tags Cited:

St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - N278 - 58a-5.031(3) Fac - Lns - Records S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced Biennial licensure survey and a Limited Nursing survey was conducted at Sterling House in Gainesville on 1 & 2, 2013. The facility was not in compliance with 429.01-429.54, Part I & 408, Part II, Florida Statutes, and 58 A-5 & 59A-35, Florida Administrative Code.

0053-Medication - Administration 58A-5.0185(4) FAC
Based on observation, interview and record review, the facility failed to ensure that the medication administration is in accordance with the health care provider's order or prescription label in 5 of 6 residents observed during medication pass observation. Res. # 2, # 3, # 4, # 5, # 6.

Findings:

1. During medication reconciliation review, was not administered by Staff F during the morning medication pass to Res. # 2. Interview with Staff F on at 3:03 PM revealed and concurred that she did not administer the medication because "it has been out for days and have already requested a refill". Medication pass observation on at 9:40 AM revealed that Staff F, LPN administered 40 mg with the rest of the 9 AM medications to Res. # 2. Review of Res. # 2's Medication Observation Record (MOR) revealed an order for to be given 30 minutes before morning and evening meals. Interview with Staff F on at 3:22 PM revealed and stated that the nurse practitioner is coming today and have her change the administration time schedule.

2. Review of health care provider order for 50 mcg. 1 by mouth every morning for Res. # 3. Review of the MOR revealed the scheduled time to administer the is at 7:30 AM. Medication was administered on at 9:20 AM by Staff F with the rest of her 9 AM medications.

3. Observation during medication administration time on at 8:45 AM revealed Staff F , LPN administered 1 drop of to Res. # 4 right eye, then administered one drop to left eye. Interview with Staff F, LPN on at 3:20 PM after medication reconciliation revealed when asked why she only administered one drop when the order reads 2 drops, she replied; " oh really". Staff F checked the medication observation record (MOR) and concurred that the order is for 2 drops of to each eye.

4. Review of the health care provider order revealed an order for 25 mcg. by mouth every morning for Res. # 5. Review of the MOR revealed the scheduled time to administer the is at 7:30 AM. Medication

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964436	07/02/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sterling House Of Gainesville	4601 N.W. 53rd Avenue Gainesville, FL 32606	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

was administered on at 9:30 AM with the rest of the 10 AM medications. Medications were crushed and mixed with apple sauce. Review of MOR revealed that there are no orders to crush the medications. During medication reconciliation on at 2:00 PM revealed that was not administered as ordered to Res. # 5. Interview with Staff F, LPN on at 3:30 PM revealed and concurred that she did not administer the . Nurse stated that the Resident has been out of for days. was circled on and in the MOR indicating that it was not administered. Review of the back page of the MOR revealed an entry that reads at 9 A 20 mg. out of med. Pharmacy contacted.

5. Staff F administered 40 mg. 1 by mouth at 9:38 AM to Res. # 6. Review of MOR revealed the order for is to be given at 7:30 AM.
Observation during medication administration on at 9:38 AM revealed that Staff F administered Prandin 2 mg 1 tab with the rest of 9 AM medications. Review of MOR revealed the scheduled time to give Prandin is at 7:30 AM before breakfast. Interview with Staff F, LPN on at 9:38 AM revealed and stated that Res. # 6 already had her breakfast. Interview with Staff F, LPN on at 3:10 PM revealed and stated that she is aware of the order and will ask the Nurse Practitioner to change the administration time.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation, interview and record review, the facility failed 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 in 2 of 6 residents observed during medication pass observation. Res.# 5 and Res. # 2.

Findings:

1. During medication reconciliation on at 2:00 PM revealed that was not administered as ordered to Res. # 5. Interview with Staff F, LPN on at 3:30 PM revealed and concurred that she did not administer the Staff F stated that Resident # 5 has been out of for days. Review of incoming pharmacy order for Wise Parkwood Pharmacy revealed that the was faxed for refill on . Review of the medication observation record (MOR) for Res. # 5 revealed that 20 mg has been initialed indicating that it has been given daily in 2013 except for and . Phone interview with RPH from Wise Pharmacy on at 3:30 PM revealed and stated that was last dispensed on and stated that Resident # 5 should have 3 more tablets left. When asked if the Pharmacy have received a refill order via fax on , RPH replied; 'it is too soon to reorder, the insurance only pays for 30 days supply".
Interview with Staff F on at 8:05 AM revealed and stated that has not been delivered from the pharmacy. Staff F searched in the medication cart drawers and was unable to locate the for this resident. was circled on and in the MOR indicating that it was not administered. Review of the back page of the MOR revealed an entry that reads at 9 A 20 mg. out of med. Pharmacy contacted.

2. During medication reconciliation review, was not administered by the nurse during the morning medication pass to Res. # 2. Interview with Staff F, LPN on at 3:03 PM revealed and concurred that she did not administer the medication because "it has been out for days and have already requested a refill". Review

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964436	07/02/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sterling House Of Gainesville	4601 N.W. 53rd Avenue Gainesville, FL 32606	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

of the incoming Pharmacy order for Wise Parkwood Pharmacy dated revealed a hand written refill order for 160-4.5 mcg faxed to pharmacy on . Interview with RPH of Wise Pharmacy at 3601 SW 2nd Ave. Gainesville,Florida on at 3:30 PM revealed that 160-4.5 mcg was last dispensed on . Review of the Medication Observation Record (MOR) revealed that was initialed indicating that it was administered daily at 10:00 AM except on and .

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC

Based on observation, interview and record review the facility failed to provide a safe environment and clean equipments for 3/6 residents using the sugar glucometer equipment. Res. # 6, # 10, # 12,

1. Observation on at 9:41 AM revealed that Staff F, LPN obtained an sugar check on Res. # 12 in the medication a glucometer. Nurse donned a pair of gloves. Needlestick done on residents right middle finger and obtained 112 mg/dl sugar reading. Staff F wiped off excess from site with an prep. Staff F returned the glucometer machine back to the blue box designated for this resident and placed it back in the medication cabinet. Staff F did not ct/clean the equipment. Interview with Staff F on at 10:01 AM revealed that she had worked here for 3 years and she is not aware of a policy on cleaning the glucometer. When asked how does she cleans or the glucometer, she replied; "with I guess". The glucometer machine of Res. # 12 has a visible red stain on it and Staff F concurred that it is stained. Observation of 6 individual glucometer machines on at 10:10 AM revealed that 3 of 6 glucometers (115, 103,147) have red stain on them. Interview with Health Wellness Director (HWD) on at 1:20 PM revealed and stated that he does not know the policy on glucometer cleaning. When asked if the nurses or cleans the machine at all, he replied; " I don't know, I would hope so". Interview with Staff G, LPN on at 3:30 PM in the presence of the HWD revealed that she works from 11 AM-11 PM 2 times per week and stated she has not cleaned the glucometers. She stated; " I guess the morning nurse cleans them". She stated that she is not aware of a glucometer cleaning policy.

Review of Brookdale Senior Livings' " How To Clean and Maintain a Glucose Glucometer" revealed:

Purpose: To provide associates with guidelines on how to clean/d and maintain glucometer equipment.

Equipments:

Glucometer

Gloves

PDI Super SaniCloth -Purple Top (recommended product) wipe/cloth or Clorox wipes (do not contain bleach)

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964436	07/02/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sterling House Of Gainesville	4601 N.W. 53rd Avenue Gainesville, FL 32606	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Suggested Guidelines:

1. Resident should have their own glucose meter and it be intended for individual use only.

2. Associates should wear gloves when cleaning the surface of the glucometer or any other parts of the device containing

3. When using the PDI Super Sani-Cloth product on the equipment, wait 2 minutes afterwards until the bactericidal , tuberculocidal, and virucidal properties can be effective.

4. Clean the glucometer when visible or bloody fluids are present by wiping with a cloth dampened with soap and water to remove any visible organic material.

5. If no visible organic material is present, after each use the exterior surfaces following the manufacturers directions using a cloth / wipe with an EPA-registered detergent/germicide with a tuberculocidal or HBV label claim.

6. should never be used because it can damage the light emitting diodes (LED) readout, causing fogging of the plastic screens. is also not an EPA -registered detergent/c

Observation on at 8:05 AM revealed that the 3 of 6 glucometer machines (115, 103, 147) identified yesterday has not been cleaned or sanitized. Visible stain was observed at the exterior surface of the machines. Interview with Health Wellness Director on at 9:05 AM revealed and stated that he ordered the purple wipes yesterday.

2. Observation on at 9:50 AM revealed Staff F, LPN left the medication give "something" to another resident. There were 2 medication carts in the medication urses station. The Nurse left one of the medication cart unlocked that is filled with residents medications. There were 2 residents seated in the medication the Surveyor and 3 residents seated just outside the medication Interview with Staff F on at 9:57 AM upon her return to the medication and concurred that she left the medication cart unlocked. She stated; "we all make mistakes"

3. Observation on at 9:00 AM revealed the medication refrigerator in the medication a large of ice in the freezer. There are suppositories and one vial stored in the refrigerator. Interview with Staff F on at 9:02 AM revealed and stated that the HWD is responsible for cleaning/defrosting the refrigerator. Interview with the HWD on at 12:35 PM revealed and stated that the maintenance department cleans the refrigerator every 2 months. He later stated that the medication storage refrigerator is cleaned as needed.

4. Observation on at 8:40 AM during medication observation pass, Staff F administered a nasal spray to Res. # 4. Staff F inserted approximately 1/2 inch of the nozzle inside the residents right and left nostrils and administered 1 spray per nostril. Staff F failed to clean the nozzle of the nasal spray after resident use. She

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964436	07/02/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sterling House Of Gainesville	4601 N.W. 53rd Avenue Gainesville, FL 32606	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

placed the lid back and stored the spray back to the medication cart.

Class III

N278-LNS - Records 58A-5.031(3) FAC
Based on observation, interview and record review the facility failed to conduct a nursing assessment for 1 of 2 residents receiving limited nursing service. Res. # 2

Findings:

1. Review of Res.# 2 's record revealed a physicians order for at 2 liters/min. per nasal cannula at night only. Review of daily nurses progress notes revealed that Resident is able to self manage and treatments. Interview with Staff G on at 5:02 PM revealed and stated that she works 11 Am-11 PM 2x / week. She stated that she assists the resident at night as needed with her tanks. Review of monthly Limited Nursing Service (LNS) Nursing Assessment from to revealed that the assessments were completed by the designated LNS nurse. There is no evidence of LNS monthly nursing assessment for 2013 in the chart. Interview with the Health Wellness Director (HWD) on at 11:15 AM revealed and stated that he saw the RN complete the monthly assessment. He stated that it is probably in the LNS binder. HWD checked the LNS binder and was unable to find the 2013 nursing assessment. He stated that the LNS designated nurse is on vacation. Observation in res.# 2 's at 2 PM revealed a concentrator and is set at 2 liters/min.

Class III