STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965402	10/02/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Port Orange	1675 Dunlawton Avenue Port Orange, FL 32127	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:
0053-Medication - Administratio
0054-Medication - Records-1

Revisit Repeat Tags:
0000-Initial Comments-
0030-Resident Care - Rights & Facility Procedures-58a-5.0182(6) Fac; 429.28 Fs
N276-Lns - Nursing Services-58a-5.031(1) Fac

Revisit New Tags:
0052-Medication - Assistance With Self-Admin-58a-5.0185(3) Fac
0055-Medication - Storage And Disposal-58a-5.0185(6) Fac
0057-Medication - Over The Counter (otc) Products-58a-5.0185(8) Fac

Specific Tag Findings:

0000-Initial Comments

A follow-up to the complaint licensure survey, CCR# 2013002672, was conducted on , 2013. Emeritus at Port Orange had licensure deficiencies found at the time of the visit. Two of the deficiencies (A0030 & N276) were previously cited on , 2013.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation and staff interview, the facility failed to provide adequate and appropriate health care consistent with established and recognized standards within their community for control by failing to sanitize hands during assistance with medication assistance between Residents #5 and #6, 2 of 6 sampled residents. This was previously cited on , 2013.

The findings include:

1. On at 6:08 a.m. Employee C was observed to assist with medication administration on the 2nd floor of the facility. Employee C prepared the medications for Resident #5 and entered into his Resident #5 was lying in bed wearing only his underwear. Employee C had to physically assist the resident up out of bed touching his bare legs and swinging them to the side of the bed. During medication assistance, the resident spilled his cup of water all over himself and also on to the floor. Employee C picked up the cup from the floor and retrieved another one for the resident from the medication cart in the hallway. She then watched the resident take his one medication. After finishing with Resident #5, Employee C left the proceeded to push the medication cart to the next resident's She was not observed washing her hands or sanitizing them in any way.

On at 6:15 a.m., Employee C was observed to assist with medication administration for Resident #6. Employee C prepared the medications and entered the resident's Employee C assisted the resident with her medication and then left the She did not wash her hands.

2. On at 6:20 a.m., Employee C was asked about the facility's policy on hand washing during

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medication assistance between residents. Employee C stated she was supposed to use hand sanitizer between residents. Employee C reached over to the side of the medication cart and squirted hand sanitizer on her hand. She did not respond when asked why she did not sanitize her hands between the two residents.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation and staff interview, the facility failed to properly assist with medication assistance for Residents #1, #2, and #3, 3 Memory Care Unit residents of 6 sampled residents.

The findings include:

On [redacted] at 5:29 a.m., Employee A (unlicensed staff member) was observed to assist with medication self-administration for Resident #1. Employee A crushed the medication [redacted] Extended Release) and mixed it in yogurt. She went into the resident's [redacted] fed the resident his medication with a spoon. She did not tell the resident what the medication was.

On [redacted] at 5:40 a.m, Employee A was observed to assist with medication self-administration for Resident #2. Employee A crushed the medication for the resident and mixed it into yogurt. She went into the resident's [redacted] fed the resident her medication with a spoon. She did not tell the resident what the medication was.

On [redacted] at 5:50 a.m, Employee A was observed to assist with medication self-administration for Resident #3. Employee A crushed the medication for the resident and mixed it into yogurt. She then went into the resident's [redacted] fed the resident her medication with a spoon. The medication was [redacted] 25 mcg and had instructions to give with a full glass of water. Employee A did not offer any water to the resident.

On [redacted] at 5:55 a.m., Employee A was interviewed about her medication techniques. She stated another employee at the facility told her that everyone in the [redacted] unit had their medications crushed and she usually mixed it with applesauce. She did not know that she should not have crushed the extended release for Resident #1. She did not tell the residents what their medications were because most had severe [redacted] and would not know the difference. She did confirm the physician's order for Resident #3 did say to give with a full glass of water. She had not read those directions and offered the water.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and staff interview, the facility failed to secure medications on 1 of 4 medication carts, Medication Cart #2.

The findings include:

On [redacted] at 5:44 a.m. , there were two medication carts located in the Memory Care Unit (residents with [redacted] resided on the unit) in the hallway right outside the living [redacted] One of the carts, Cart #2 was not locked.

Employee A assisted with medication administration for about 10 minutes and left the cart unattended. At 5:55

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a.m. when returning from a resident's , she noticed the cart was unlocked and locked it. She confirmed that it was unlocked. There were multiple resident medications in the cart and there was a very resident wandering throughout the facility at this time.

Class III

0057-Medication - Over The Counter (OTC) Products 58A-5.0185(8) FAC
Based on observation and staff interview, the facility failed to properly label an over the counter medication for Resident #1, 1 of 6 sampled residents.

The findings include:

On at 5:29 a.m., Employee A (unlicensed staff member) was observed to assist with medication self-administration for Resident #1. Employee A went into the medication cart and retrieved a bottle of Extended Release for Resident #1. It was an over the counter medication and did not have a name on it. Employee A confirmed it did not have a name on it. She stated she thought it belonged to this resident because it was in the same bin.

Class III

N276-LNS - Nursing Services 58A-5.031(1) FAC
Based on observation , record review, and staff and family interview, the facility failed to provide Limited Nursing Services(LNS) for 1 of 12 sampled residents, Resident #8.

The findings include:

Resident #8 was observed on at at 7:33 a.m. The resident was sitting in the the sink washing up. She did not have on. In her there was a hospice nursing assistant (Employee J) changing her bed linen. Employee J was asked about the resident's use. Employee J stopped changing the linen and went to the resident's wheelchair and removed her tubing from the portable tank hanging off the back of her chair and instructed the resident to put it on. The resident was very hard of hearing and first put the tubing in her mouth. Employee J loudly told her, "put it in your nose". Resident #8 then correctly put it on.

Review of the resident's most recent health assessment in the clinical record (dated no year) revealed the resident needed assistance with medication administration, was alert with some and required continuous A review of the resident's monthly nursing assessment dated revealed the resident needed administration of

Review of the facility staffing schedule revealed nurses only worked until 8:30 p.m. and there was not one scheduled for the night shift.

On at 7:26 p.m., the Resident Care Coordinator was interviewed. She confirmed that they did not have a nurse in the building during the night shift. She also confirmed that there was not a nurse scheduled on the night shift for management for Resident #8. She did confirm in 2013, the power was off for

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about an hour around midnight possibly due to a lightning storm and the two residents on oxgyen had to switched to portable tanks because there were no electrical outlets in the resident connected to the emergency generator.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Emeritus at Port Orange
1675 Dunlawton Avenue
Port Orange, FL 32127

Re: CCR #2013002672

Dear Administrator:

This letter reports the findings of a revisit survey conducted on 2013 by a representative of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and new deficiencies identified during the revisit.

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 (904) 798-4201.

Sincerely,

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

KW/sm
Enclosure

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