STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966826	06/03/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Heritage Crossings	2689 Art Museum Dr Jacksonville, FL 32207	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0057 - 58a-5.0185(8) Fac - Medication - Over The Counter (otc) Products S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced off-hours complaint survey, CCR# 2014003216, was conducted at Heritage Crossings in Jacksonville, Florida on 2014 at 8:00 p.m. Deficiencies were identified as a result of the survey.

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation, record review and staff interview, the facility failed to assist residents with self-administered medications in accordance with procedures described in section 429.256, F. S. for 6 of 6 sampled residents observed during assistance with self-administration of medication. (Residents #1, 2, 7, 8, 9, and 10)

The findings include:

A observation of the medication carts on both facility nursing units at approximately 8:05 p.m. revealed medications which were pre-poured in disposable, paper souffle cups. Five disposable paper souffle cups, each containing pills were observed sitting on a small plastic tray on top of the medication cart on the nursing unit nearest the front entrance to the facility upon entrance at approximately 8:05 p.m. Employee C was handling the souffle cups, and was observed placing the tray of paper cups containing pills in the bottom drawer of the medication cart. She was asked to unlock and open the drawer. Five numbered souffle cups containing various pills were observed. The cups were numbered 1, 2, 4, 5 and 7. The residents in 101, 102, 104, 105 and 107 were scheduled for 9:00 p.m. medications on per review of the Medication Observation Record (MOR).(Photographic evidence obtained)

An observation of Medication Cart #3 on at 8:15 PM revealed a small white soufflé cup with crushed medications inside, located in the top drawer. Resident #13's name was written in permanent marker on the outside of the cup. (Photographic evidence obtained)

An interview with Employee C at 8:06 p.m. revealed the following: When asked about the souffle cups with pre-poured medications in them sitting on a plastic tray, Employee C did not respond. When asked whether she thought it was appropriate to pre-pour medications, she replied that she knew she should not do that.

In an interview with Employee F on at 8:19 PM, she reported that she had placed Resident #13 ' s crushed Tablets in the soufflé cup and placed Resident #13 ' s name on the cup. She reported that she had placed the pills in the cup " earlier " and reported it was about an hour before the observation. She reported that she was unable to give the medication because Resident #13 was sleeping.

An observation of the medication pass process on beginning at 8:58 p.m. revealed that Employee C did not identify medications to each and every resident as she was providing them. Instead, Employee C presented a cup of medications to each resident and stated, "I have your medicine here." or "Here is your medicine."

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An interview with Employee C at approximately 9:20 p.m. revealed that she was unaware that she was required to identify each medication to each resident as she was providing it.

A review of the clinical record for Resident #4 revealed a current order for treatments twice daily. A review of Resident #4's 2014 MOR revealed that treatments were ordered daily at 9:00 a.m. and 5:00 p.m. The 2014 MOR was blank, indicating that no treatments had been provided to Resident #4 in

During a interview with the administrator at approximately 8:35 p.m., she confirmed that Resident #4's 2014 MOR had not been initialed indicating that the physician-ordered treatment had not been provided. She further stated, "I'll have to look into that."

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on record review and staff interview, the facility failed to ensure that the Medication Observation Record (MOR) was updated immediately each time a medication was offered or administered for 3 of 11 sampled residents. (Residents #3, #4 and #5)

The findings include:

A observation of the MOR for the nursing unit nearest the facility's front entrance at approximately 8:10 p.m. revealed that Resident #3's scheduled 9:00 p.m. patch removal was not signed off for the previous night's shift. Resident #4's scheduled 9:00 p.m. patch removal was not signed off for the previous night's shift. Resident #4's treatment which was ordered to be given at 9:00 a.m. and 5:00 p.m. daily was not signed off for the month of 2014 through and Resident #5's 9:00 p.m. 15 mg capsules, 1 cap at bedtime was not signed off for the previous night's shift. (Photographic evidence obtained)

An interview with Employee C on at approximately 8:15 p.m. confirmed that the MOR was not current. Employee C acknowledged that the MOR should have been initialed at the time the medication or patch removal was offered or completed.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation, record review and interview, the facility failed to store discontinued medications separately from medications in current use for 1 of 11 sampled residents. (Resident #13)

The findings include:

An observation of Medication Cart #3 on at 8:20 PM found Resident #13 had 5 vials of and 1 vial of Lantus in the top drawer of the medication cart. (Photographic evidence obtained)

In an interview with Caregiver E on at 8:15 PM, she reported that Resident #13 did not take any longer and that it had been discontinued.

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A record review for Resident #13 revealed an order to discontinue 20 units at breakfast and Lantus 28 units at bedtime on .

In an interview with the Administrator on at 10:50 PM, she confirmed that Resident #13 's was discontinued since . She reported that the should have been removed from the medication cart.

A review of the medication disposal policy dated revealed that " medications are to be disposed of on different occasions: discontinued orders, change of dosage orders and resident discharge " .

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation, record review and staff interview, the facility failed to refill prescribed medication in a timely manner for 1 (Residents #8) of 11 sampled residents.

The findings include;

On at 9:19 p.m., a medication observation was conducted with Employee C. She opened her Medication Observation Record (MOR) to give Resident #8 her medication. After observing the MOR, Employee C stated, 'Oh, I cannot give it; it is not available.' She explained that the facility had ordered the medication, but that it had not been delivered from the pharmacy yet.

A review of Resident #8's 2014 MOR revealed that the medication, Z 0.004% eye drops, 1 drop in each eye at bedtime was written on the 2014 MOR. The medication had not been signed off at all in as having been provided to resident #8. (Photographic evidence obtained)

A review of the clinical record for Resident #8 revealed a physician's order dated for Z 0.004% eye drops. One drop in each eye at bedtime.

An interview was conducted on at approximately 9:22 p.m. with Employee C. She confirmed that this medication had not been provided to Resident #8 since it was ordered on , as it had not yet been received from the pharmacy.

During a interview with the administrator at approximately 10:45 p.m., she acknowledged that the medication had not been provided and stated that she would follow up on the matter.

Class III

0057-Medication - Over The Counter (OTC) Products 58A-5.0185(8) FAC
Based on observation and interview, the facility failed to ensure that Over-The-Counter (OTC) medications were labeled with the resident's name for 1 of 11 residents sampled. (Resident #1)

The findings include:

During a observation of the medication cart on the nursing unit nearest the facility's front entrance at approximately 8:30 p.m., an over-the-counter bottle of Fish Oil capsules (1000 mg) was observed without a resident's name labeled on it. (Photographic evidence obtained)

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A interview with Employee C at approximately 8:30 p.m. confirmed that the medication belonged to Resident #1. Employee C acknowledged that the medication bottle should have been labeled with the resident's name.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Heritage Crossings
2689 Art Museum Drive
Jacksonville, FL 32207

RE: CCR #2014003216

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2014 by representatives of this office.

Attached 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 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 surveyors. Should you have any questions please call this office at .

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JG/JM/sm
Enclosure

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