STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911203	07/01/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Avery's Home Care	134 West 23rd Street Jacksonville, FL 32206	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:
L243-Lmh - Training-

Revisit Repeat Tags:
0000-Initial Comments-
0052-Medication - Assistance With Self-Admin-58a-5.0185(3) Fac
0054-Medication - Records-58a-5.0185(5) Fac
0056-Medication - Labeling And Orders-58a-5.0185(7) Fac
0080-Training - Core & Competency Test-58a-5.0191(1) Fac

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 - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0080 - 58a-5.0191(1) Fac - Training - Core & Competency Test S-S= D
St - A - L243 - 58a-5.0191(8) Fac - Lmh - Training S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced second revisit to the biennial re-licensure survey with Limited Mental Health standards was conducted at Avery's Home Care, Inc., in Jacksonville, Florida on , 2014. Uncorrected deficiencies were identified as a result of the survey.

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation, interview and record review, the facility failed to ensure that assistance with self-administration of medication was provided in accordance with procedures described in Section 429.256, F. S., by failing to provide medication as prescribed for 1 of 4 sampled residents. (Resident #5)

The findings include:

Observation of assistance with self-administration of medication for Resident #5 on revealed that she received 5 mg tablets, 1 tablet orally at 8:48 a.m.

Observation of Resident #5's labeled medication bottle on revealed the following instructions: 5 mg tablets, 1 tablet orally (twice daily) (Photographic evidence obtained)

A review of Resident #5's 2014 and 2014 Medication Observation Records (MORs) revealed the following instructions: 5 mg, 1 tab at 5:00 p.m. The medication was signed off once daily at 5:00 p.m.

During an interview with Employee B on at approximately 10:45 a.m., she acknowledged that the MOR indicated Resident #5 was receiving this medication once daily when it was ordered twice daily. She acknowledged that she had not yet signed for the dose that she had provided, because there was no space to sign for it. When asked, Employee B stated that she was administering the medication twice daily per the instructions

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on the medication bottle, but was unable to answer when she was asked where she documented that she had provided the medication. Employee B confirmed she did not compare the MOR to the medication label. She confirmed that the MOR stated 5PM and she was giving the medication at 8:48 AM. Resident #5 was not interviewable due to

A0052 was previously cited on and

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on observation, interview and record review, the facility failed to ensure that the Medication Observation Record (MOR) included accurate directions for use of each medication for 2 of 4 sampled residents. (Resident #2 & #5)

The findings include:

1) A observation of Resident #2's medication bottle for revealed that the pharmacy label read: 1 milligram (mg) tablets, 1 tab orally twice daily as needed for .

A review of Resident #2's clinical record revealed a current order for dated . It read: 1 mg orally twice daily as needed.

A review of Resident #2's 2014, 2014 and 2014 MORs revealed the following: 1 mg 1 tab prn (as needed) for , which did not correspond with the instructions on the pharmacy label or the physician's order for this medication. No maximum dosage was indicated on the MOR as was indicated on the pharmacy label or in the physician's order. (photographic evidence obtained)

During a interview with Employee B at approximately 12:30 p.m., she acknowledged that she should complete the MORs accurately according to the orders, and that the MORs should be consistent from month to month unless there was a change in the medication orders.

2) Observation of assistance with self-administration of medication for Resident #5 on revealed that she received 5 mg tablets, 1 tablet orally at 8:48 a.m.

Observation of Resident #5's labeled medication bottle on revealed the following instructions: 5 mg tablets, 1 tablet orally (twice daily) (Photographic evidence obtained)

A review of Resident #5's 2014 and 2014 Medication Observation Records (MORs) revealed the following instructions: 5 mg, 1 tab at 5:00 p.m. The medication was signed off once daily at 5:00 p.m.

During an interview with Employee B on at approximately 10:45 a.m., she acknowledged that the MOR indicated Resident #5 was receiving this medication once daily when it was ordered twice daily. She acknowledged that she had not yet signed for the dose that she had provided, because there was no space to sign for it. When asked, Employee B stated that she was administering the medication twice daily per the instructions on the medication bottle, but was unable to answer when she was asked where she documented that she had provided the medication. Employee B confirmed she did not compare the MOR to the medication label. She confirmed that the MOR stated 5PM and she was giving the medication at 8:48 AM. Resident #5 was not

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interviewable due to

A0054 was previously cited on and

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 medication was ordered and filled timely to ensure medication was given as prescribed for 5 of 6 sampled residents. (Residents #2, #3, #4, #5 and #6)

The findings include:

Observation of assistance with self-administration of medication for Resident #6 on at 8:44 a.m. revealed that he was scheduled to receive 5 mg at that time. Resident #6's medication bottle read 5 mg tablets, 1 tablet twice daily. The medication bottle was empty.

A review of Resident #6's 2014 and 2014 MORs revealed the following instructions: 5 mg, 1 tablet at 8:00 a.m., 1 tablet at 5:00 p.m. The 2014 MOR was not yet signed, and the 2014 MOR was marked with an "X" every day at 8:00 a.m. and 5:00 p.m. (Photographic evidence obtained)

A interview with Employee B at 8:46 a.m. revealed, "He hasn't had this medication this month or in We haven't been able to get it."

A interview with Employee B at 12:12 p.m. revealed that an "X" marked in a resident's MOR meant that the medication listed was not available on that date at that time.

A complete review of the 2014 Medication Observation Records (MORs) on revealed that the following residents' medications were not available to them during that time:

Resident #3 - 2 mg - An "X" was marked between & , indicating that the resident did not receive her medication during that time, because it was not available.

Resident #5 - 10 mg daily - An "X" was marked between and , indicating that the resident did not receive her medication, because it was not available.

Resident #4 - 10 mg daily - An "X" was marked between & , indicating that the resident did not receive her medication, because it was not available.

Resident #2 - 7.5 mcg daily - An "X" was marked between and 600 + D3 400 - An "X" was marked between and . Per Employee B, the "X" indicated that the resident did not receive the medication, because it was not available.

Resident #6 - .5 mg - An "X" was marked through the entire month of 2014, indicating that the resident did not receive the medication, because it was not available. At approximately 12:26 p.m., Employee B stated that the medication had not yet been obtained.

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During a interview with the Administrator and Employee B at approximately 1:30 p.m. the above-mentioned results of the 2014 MOR review were discussed. The administrator stated that she was having a hard time getting Resident #2's son to bring in his mother's medication, but the Administrator was unable to respond regarding the other medications which had not been provided to Residents #3, #4, #5 and #6.

A0056 was previously cited on .

Class III

0080-Training - Core & Competency Test 58A-5.0191(1) FAC
Based on record review and staff interview, the facility failed to ensure that the Administrator had retaken and passed the Assisted Living Facility Core competency test after failing to maintain the continuing education requirement.

The findings include:

On , the facility was cited for failing to have the Administrator receive the required 12 hours of continuing education. Florida Administrative Code 58A-5.0191 requires that a Core trained Administrator must receive 12 hours of continuing education every two years. If the Core trained Administrator completed and passed the competency test, but failed to maintain the continuing education requirements, they must retake the Assisted Living Core training and retake and pass the competency test. Upon review of the personnel file of the Administrator on , it was revealed that there was no documentation of the Administrator having retaken and passed the Core competency test. Documentation of completion of the Assisted Living Facility Core training was dated " 24-25, 2014 and 7-8-14, 2014".

An interview with the Administrator on at 9:35 a.m. revealed the following: When asked whether she had retaken the Core competency test, the Administrator stated she had not, and added that as far as she was aware, she only needed to have one employee in the facility who was Core trained and had passed the competency test. She referred to Employee B. Employee B was asked at 9:37 a.m. whether she had completed the Core training and competency test. She replied that she had completed the Core training, but had not taken the competency test yet. She added that she was scheduled to take it on , 2014. A review of Employee B's personnel file revealed that she had completed the Core training on 7 -10, 2014.

A0080 was previously cited on and .

Class III

nurse's license and a signed and a dated recommended corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit.

2) The facility must ensure all unlicensed staff providing assistance with self-administered medications complete a minimum of 2 hours of continuing education training on providing assistance with self-administration of medications. The consultant must use the training course approved by the Department of Elder Affairs that is posted on their website at http://elderaffairs.state.fl.us/doea/pubs/pubs/2012Med_Guide.pdf. All unlicensed staff must complete this training no later than , 2014.

The consultant is to ensure that unlicensed staff can perform these duties correctly by conducting weekly audits observing staff while performing this duty for a minimum of 4 weeks and documenting the results of the audits. The results of these audits must be forwarded to the Field Office for review.

3) The facility shall provide the agency with, at a minimum, monthly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required.

Nothing in this Directed Plan of Correction limits the Agencies authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call . Kim Smoak, Survey and Certification Support Branch, at 850-412-4516.

Sincerely,

Jana L. Meyering
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JD/JM/RED/sm

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

Administrator
Avery's Home Care
134 West 23rd St.
Jacksonville, FL 32206

Dear Administrator:

This letter reports the findings of a biennial licensure survey conducted on , 2014 by a representative of the Agency for Health Care Administration. Attached is the provider's copy of the State (5000) Form, which indicates there were deficiencies noted during the inspection.

You are hereby directed to provide a written plan of correction to the Jacksonville Field Office for the deficiencies identified during the inspection, within five calendar days of receipt of this directed plan of correction (DPOC). The plan should be directed to the attention of Mrs. Jana Meyering, Health Facility Evaluator and mailed to:

Agency for Health Care Administration
Health Quality Assurance, Jacksonville Field Office
Attention: Jana Meyering
921 N. Davis Street, Bldg. A, Suite 115
Jacksonville, FL 32209
Phone: (904) 798-4201
Fax: (904) 359 - 6054

The inspection resulted in findings of non-compliance in the following areas:

1) A0052- Assistance with self-administration of medication. Class III. Previously cited on & .

The Assisted Living Facility failed to provide assistance with self-administration as outlined in Florida Statute 429.256. The failure to accurately and appropriately assist with self-administration of medication resulted in ....

Your plan of correction must include the following:

1) The facility must employ, on staff or by contract, the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse to address auditing medication observation records in comparison with physician orders and storage and disposal of medications. The consultant must develop a written plan of action for addressing the deficient medication practices identified in the statement of deficiencies. The consultant must conduct monthly audits of the medication observation records in comparison to current physician orders for each resident for a minimum of 3 months. The results of these audits must be sent to the Field Office for review. You must provide the agency a copy of the pharmacist's or registered