STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964490	10/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sterling House Of Deland	1210 North Street Deland, FL 32724	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - N277 - 58a-5.031(2) Fac - Lns - Resident Care Standards S-S= D
St - A - N278 - 58a-5.031(3) Fac - Lns - Records S-S= D

Specific Tag Findings:

0000-Initial Comments
A Limited Nursing Services survey was conducted on .
Sterling House of DeLand had Licensure deficiencies found at the time of the visit.

N277-LNS - Resident Care Standards 58A-5.031(2) FAC

Based on observation, record review, and staff interview, the facility failed to have licensed staff to providing Limited Nursing Services for 1 of 1 sampled residents, Resident #1.

The findings include:

Resident #1 had a Health Assessment (1823) revealing a diagnosis of acute

Review of the facility's Limited Nursing Services log revealed Resident #1 begun services on for . There was a physician order for start E tanks for as needed at 2 liters per minute for

On at 11:15 a.m. Resident #1 was observed in the living an concentrator behind her set a 2 liters per minute. She was receiving the through a nasal cannula. She was breathing normally. She stated she was not having any . She stated she always has on and the staff help her with it.

Employee A, a non-licensed caregiver was interviewed on at 11:18 am. She stated she took care of Resident #1 yesterday and has taken care of her many times. She stated when she assisted with toileting or showering for Resident #1, she removed the tubing from the resident's nose and assisted her to the . The resident could tolerate being without the for minutes. She would tell staff if she needed her . When she assisted the resident back into her , she would attach the tubing from the E tanks , set it at 2 liters per minute and then put the nasal canula on under her nostrils.

The Health Wellness Director on 11:22 a.m. stated that she allowed non-licensed nurses to assist with the resident's as well as set the liters per minute. She stated she did have licensed nurses on staff for the day shift and evening shift but not on the night shift. If the unlicensed staff member needed assistance with a resident, she lived only 5 minutes away and would come right in.

Class III

N278-LNS - Records 58A-5.031(3) FAC

Based on record review and staff interview, the facility failed to conduct monthly assessment for each resident who receives limited nursing services , Resident #1, 1 of 1 sampled residents.

The findings include:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964490	**10/07/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sterling House Of Deland	**1210 North Street Deland, FL 32724**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Resident #1 had a Health Assessment (1823) revealing a diagnosis of acute

Review of the facility's Limited Nursing Services log revealed Resident #1 begun services on for There was a physician order for start E tanks for as needed at 2 liters per minute for

The clinical record did not reveal any monthly assessments.

The Health Wellness Director on 11:22 a.m. confirmed that there were not any monthly assessments for Resident #1.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Sterling House Of DeLand
1210 North _____ Street
DeLand, FL 32724

Dear Administrator:

This letter reports the findings of a state licensure Limited Nursing Services survey that was conducted on , 2014 by a representative 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 surveyor. Should you have any questions please call this office at .

Sincerely,

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

LW/JM/sm
Enclosure

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