STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964062	03/16/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sterling House Of Vero Beach	410 4th Court Vero Beach, FL 32962	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Limited Nursing Services Monitoring Visit was made to the Sterling House of Vero Beach Assisted Living Facility on . The facility had a deficiency at the time of the visit.

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation, record review and interview, the facility failed to ensure that expired was not used for administration to 1 of 5 sampled residents. (Resident #3).

Findings include:

1) An observation of medication assistance was conducted on at 8:32 AM; The Medication Nurse was observed to draw up 16 units of and inject it subqutaneously into the left upper arm of Resident # 3; Observation of the bottle of revealed that it had been opened on as evidenced by the "hand written" date on the bottle. The Medication Nurse was asked, during an interview on at approximately 8:32 AM, what the facility policy is for the storage of She stated that is good for 28 days after being opened and the bottle expired on .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Sterling House Of Vero Beach
410 4th Court
Vero Beach, FL 32962

Dear Administrator:

This letter reports the findings of a state Limiting Nursing Services Monitoring Visit survey that was conducted on 16, 2015 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dmb
Enclosure: State Form 5000-3547

XG90

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