STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968601	09/25/2015
NAME OF PROVIDER OR SUPPLIER **HB ANDERSON HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **127/131 WEST BLUE HERON BOULEVARD** **RIVIERA BEACH, FL 33404**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced initial Limited Mental Health services licensure survey was conducted on and at HB Anderson Home Assisted Living Facility. The facility had deficiencies found at the time of the visit.

0052 Medication - Assistance with Self-Admin

Based on observation and interview, it was determined that the facility failed to ensure the appropriate steps are followed when assisting a resident with his/her self-administered medications, for 12 out of 12 residents. This is evidenced by the facility staffing pre-pouring the residents medications all at one time without the resident present and acknowledging the medications prescribed independently.

The findings include:

On at 2:25 PM, two surveyors noted an unlocked medication cart in the office area of the facility. Upon opening the top drawer of the unlocked medication cart, the registered nurse surveyor noted a muffin tin like container with 12 cup shaped indentations. At the bottom of each indentation a name was written in black marker. In one of the indentations, a small silver colored metal cup containing a white medication tablet was observed. Photographic evidence was obtained. The administrator was asked if facility staff are "pre-pouring medications". The Administrator, who is also a licensed practical nurse (LPN), stated that they are not pre-pouring medications.

During a / / interview with Staff #A (medication tech), she stated that medications are removed from the individual dose pharmacy card or pharmacy labeled bottle and placed into a metal cup that is then put into the indentation with the Resident ' s name on it. Staff #A further stated that medications are transferred to the metal cups for up to four residents at one time and are kept in the cups for storage until the residents ' medication times. This is in conflict with an earlier statement by the facility Administrator.

Class III

0055 Medication - Storage and Disposal

Based on observation, interview, and record review, it was determined that the facility failed to safely store medications for 12 of 12 residents (R#1-#12) with centrally stored medications. This is evidence by the facility failing to lock the medication cart, failing to keep the medication cart and medication containers clean, failing to dispose of abandoned or expired medications in a timely manner, and failing

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to store medications in an area free of excessive temperatures.

The findings Include:

1) The surveyor noted a medication cart to the immediate left of the storm door. The cart lock was protruding, indicating the cart was not locked, confirmed upon further observations of the cart. The registered nurse surveyor pulled on the top drawer of the medication cart and found that the cart was, indeed, unlocked. The observation was confirmed by the Administrator and Staff #A. Two residents, Resident #1 and Resident #2 were observed to enter the area where the cart was kept during the time the surveyors were present.

2) The medication cart was noted to have a heavy accumulation of dust and dirt on the bottom lip of the cart, as well as numerous areas of a brown substance on the front of the cart in a splash-like pattern. The window unit style air conditioning unit located directly over the medication cart was noted to be heavily laden with dust. Photographic evidence was obtained.

3) In the bottom drawer of the medication cart the surveyor noted the following:

a) An unopened bottle of for injection. The pharmacy label indicated the prescription was filled on / . The resident for whom the prescription was filled was discharged from the facility on per the Administrator. The Administrator was unable to explain why the had been neither returned to the discharged resident nor destroyed.

b) A pharmacy single dose "bingo" style medication card containing 76 tablets. The pharmacy label on the medication date had an expiration date of . The resident for whom the medication was prescribed was discharged from the facility on / per the Administrator. The Administrator was unable to explain why the expired medication of the discharged resident remained in the medication cart.

4) Both surveyors immediately noted the facility to be uncomfortably hot, causing both surveyors to sweat profusely. Staff #A was asked about the heat and responded that the air conditioner was broken. The Administrator came into the office area shortly thereafter and stated that she would call a staff member to replace the broken window unit type air conditioner. The Administrator was asked whether she had checked the manufacturer's recommendations concerning acceptable temperatures for storing the medications in the cart. She replied that she had not. The National Institutes of Health National Library of Medicine storage recommendations for 3 of the medications stored in the cart the following:

3 of 3 medications reviewed for storage temperatures indicate that the medication should be kept from

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excessive heat:

a) 50mg tab- "Store it at room temperature and away from excess heat and moisture"
b) 300mg tab- "Store it at room temperature and away from excess heat"
c) Atenelol 50mg tab- "Store it at room temperature and away from excess heat and moisture"

5) Upon opening the bottom drawer of the medication cart, the registered nurse surveyor noted 2 undated pharmacy "bingo" type medication cards containing 50mg tabs. One contained 2 tablets, and the other contained six tablets. The Administrator was asked if the medications in the first section of the bottom drawer were expired and discontinued medications or current medications. The Administrator stated that they were expired or discontinued medications. The Resident name on the medication card was noted to be that of Resident #1, who is a current resident. Review of Resident #1 ' s Medication Observation Record (MOR) confirmed that Resident #1 is currently prescribed 50mg 1 tablet three times a day. The Administrator was asked to open the lockbox which she did. The surveyor noted that that Resident #1 also had tablets stored in the lockbox. The Administrator was asked to give an explanation as to why Resident #1 ' s medications were not all safely stored in the lockbox, with 8 tablets being stored in the unlocked cart in a section designated for discontinued or expired medications. The Administrator was unable to provide an explanation.

Class III

0057 Medication - Over The Counter (OTC) Products

Based on observation and interview, it was determined that the facility failed to properly label and store over the counter medications in 1 of 1 medication carts observed, by not properly labeling over the counter medications and by maintaining a stock supply of over the counter medications.

The findings include:

On / / at 2:25 PM, two surveyors noted an unlocked medication cart in the facility office area. Upon noting the cart to be unlocked, the registered nurse surveyor proceeded to observe the contents of the medication cart. Three large containers of over the counter medications were noted, including a 375 gel cap size of with HCl 25mg (milligrams), a 600 caplet size bottle of 220 mg , and a 250 caplet size container of 500mg. Photographic evidence was obtained. There were no resident names or any other facility identification on any of the bottles.

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During an interview on at 3:00 PM with the Administrator, she stated that the aforementioned medications were stored in the medication cart for employee use. The bottles had no labeling to indicate that they were for staff use only. The Administrator confirmed that there was no labeling on the bottles to indicate for whom they were to be used.

Class III

0084 Trainina - Assis Self-Admin Meds & Med Mamt

Based on observation, interview, and record reviews , it was determined that the facility failed to provide the required training , 3 of 3 unlicensed facility staff who assist with the self-administration of medications (Staff A, B and C).

The findings Include:

On / at 2:25 PM, upon review of the Medication Observation Records (MOR), the initials of three staff (Staff A, Staff B, and Staff C) were noted as having charted that they had provided assistance with the self-administration of medications. The Administrator was asked to provide the names of the employees whose initials appeared on the MOR, which she did.

Review of the employee records of Staff A, Staff B, and Staff C revealed that none of the employees had documentation of having received the required four hours of registered nurse or registered pharmacist led training in assistance with the self-administration of medications. The Administrator confirmed that the documents were not present in the employee records.

During a / / 2:50 PM interview with Staff A, the staff member stated that she had received her training in assistance with the self-administration of medications from the Administrator, who is also a licensed practical nurse (LPN). Staff A confirmed that she had not taken the 4 hour required training, and stated that she had been unaware that the training existed.

Class III

L240 LMH - Licensina

Based on record review and observations, it was determined the facility failed to obtain a Limited Mental Health (LMH) license prior to accepting one or more mental health residents, for 2 out of 2 residents identified as a lmh residents (Resident #4 and #5).

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The findings include:

During an interview with the Administrator on / at 4:30 PM, she was asked if she currently had any limited mental health residents. She stated yes, that she only had three residents (Resident #3, #4 & #5). She was asked if she was aware that she was required to obtain a license once she had a census of one or more mental health residents. The Administrator further stated, that she was not aware of this requirement. The Administrator stated she is not aware if she possibly has more LMH residents as she is not aware of the montly income source of the resident and if any are receiving . She stated that all income goes directly to the Case Managers for the residents and she is paid directly by the LMH providers. During an interview with the Administrator and random interviews with residents on residing at the facility, it was revealed many of the residents attend a LMH day program as part of their treatment plan. According to the Administrator, many of the residents at the program from around 7:30 AM to 3 PM daily.

The Administrator during an interview at 5 PM on , provided the Community Living Support Plan and Agreement for Residents #4 and #5. Upon review of each agreement, it was noted that both were signed by the Case Manager and the Administrator. However, the resident had not signed the agreements.

During an interview with the Case Manager on at approximately 10 AM , it was confirmed that at least two residents were currently receiving SSI and . The Case Manager confirmed Resident #4 and Resident #5 both receive SSI and monthly.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
HB Anderson Home
West Blue Heron Boulevard
Riviera Beach, FL 33404

RE: Limited Mental Health Survey

Dear Administrator:

This letter reports the findings of an initial Limited Mental Health (LMH) survey that was conducted on , 2015, , 2015 and , 2015 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than 26, 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure
XG90

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