| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11964216 | 02/29/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>SARAH HOUSE II (THE) | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1724 VALENCIA AVENUE<br>ORMOND BEACH, FL 32174 | |

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

**0000 Initial Comments**

An unannounced biennial survey was conducted on , 2016 at Sarah House II in Ormond Beach Florida. Deficiencies were identified during the visit.

**0010 Admissions - Continued Residency**

Based on record review and staff interview, the facility failed to ensure a new health assessment (1823) was completed for resident with significant change in condition for 1 of 6 sampled residents. (Resident #2)

The findings include:

Record review for Resident #2 revealed she was admitted to the facility on . Review of the Health Assessment (1823) dated revealed she required administration of medications. The record indicated she was ordered hospices services on . There was no new Health Assessment found.

An interview was conducted with the Director of Operations on at 12:20pm. When asked if Resident #2 was administered medications by a licensed nurse, she stated "no". She was asked to review the Health Assessment dated . After review she stated the physician had made an error when completing the form and stated I should have caught that.
She was asked if a new health assessment was completed when the resident was ordered hospice services, she stated "no".

Class III

**0053 Medication - Administration**

Based on record review and staff interviews the facility failed to provide licensed staff to administer as needed (PRN) medication that did not have specific peramteres for 1 of 2 sampled residents with orders for pain medication. (Resident # 2)

The findings include:

Review of the Medication Observation Record for Resident #2 revealed the following: an order for

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

/ milligram (mg) ( pain medication) every 6 hours as needed, 0.5mg ( ) three times a day as needed. The record revealed the medication technicians (MT) were documenting administration of doses of on / , and on Resident 32's Medication Observation Record (MOR). Review of the controlled substance log used to reconcile doses of controlled medications given revealed the MT's were giving the medication more frequently than recorded on the MOR.

An interview with the MT (Emp #2) was conducted on at 1:30pm. When asked how often Resident #2 received pain medication, she stated she had given the medication three times during . She provided the MOR to point out her initials. When asked if the medication was documented anywhere else, she stated "on the count sheet". Review of the document she referenced was reviewed and indicated Resident #2 received 1-2 times a day. When asked who had made the other entries on the count sheet she stated the MT that works when she is off.

An interview was conducted with the Director Of Operations on at 2:45pm. When asked if the MT's were administering pain medication as needed for Resident #2 without specific perameters, she stated the resident was on hospice and had orders for PRN (as needed) pain medication. She stated that if the resident needed the MT was to call the hospice nurse to obtain permission. When asked if the hospice nurse made a visit to determine if medication was needed, she said not usually. She was asked to review the MOR and controlled substance log. She stated that the MT was not documenting on the MOR after each dose of , nor indicate what time. She stated that she would call the hospice nurse to evaluate the need for routine doses of pain medication and discontinue the use of PRN medication, as the MT's are not allowed to use their discretion to assess or evaluate the resident's condition.

Class III

**0054 Medication - Records**

Based on record review and staff interview the facility failed to maintain accurate Medication Observation Records (MOR) for 1 of 2 residents reciving assistance with self administration of medications (Resident #2).

The findings include:

Review of the Medication Observation Record for Resident #2 revealed the following: an order for / milligram (mg) ( pain medication) every 6 hours as needed,

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| NAME OF PROVIDER OR SUPPLIER **SARAH HOUSE II (THE)** | STREET ADDRESS, CITY, STATE, ZIP CODE **1724 VALENCIA AVENUE ORMOND BEACH, FL 32174** | |

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

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An interview was conducted with the Director Of Operations on at 2:45pm. When asked if the MT's were administering pain medication as needed for Resident #2 without specific perameters, she stated the resident was on hospice and had orders for PRN (as needed) pain medication. She stated that if the resident needed the MT was to call the hospice nurse to obtain permission. When asked if the hospice nurse made a visit to determine if medication was needed, she said not usually. She was asked to review the MOR and controlled substance log. She stated that the MT was not documenting on the MOR after each dose of , nor indicating what time. She stated that she would call the hospice nurse to evaluate the need for routine doses of pain medication and discontinue the use of PRN medication, as the MT's are not allowed to use their discretion to assess or evaluate the resident's condition.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
The Sarah House II
1724 Valencia Avenue
Ormond Beach, FL 32174

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 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. **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 , 2016.** 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 surveyor. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering

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

KJ/JM/sm
Enclosure
XG90

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