STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910323	03/15/2016
NAME OF PROVIDER OR SUPPLIER **L'ARCHE HARBOR HOUSE, INC. I**	STREET ADDRESS, CITY, STATE, ZIP CODE **700 ARLINGTON ROAD** **JACKSONVILLE, FL 32211**	

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

0000 Initial Comments

On , 2016, and , 2016, an abbreviated biennial relicensure survey was conducted at L'Arche Harbor House 1. Deficient practice was identified during the survey.

0052 Medication - Assistance with Self-Admin

Based on observation, resident record review, and interview with staff, the facility failed to ensure that unlicensed staff did not have to use independent judgement regarding the indication for medication's use for 1 of 2 sampled residents observed to receive assistance with medications (Resident #3). In addition, the facility failed to ensure staff provided assistance with the self-administration of medications in accordance with procedures described in Section 429.256, F.S. and this rule for 1 of 2 residents observed (Resident #5) by failing follow the physician's instructions for the medications.

The findings included:

1. An observation of Resident #3 was conducted at 7:48 am on . He was sitting at the breakfast table, and was being assisted by Employee C, his assigned assistant. Employee C retrieved a bottle of Polyethylene , and filled the cap to the line marked "17 grams". He poured the substance into a cup of tea, stirred until dissolved, and gave it to Resident #3, who was able to drink it independently. A review of the label for this medication revealed the following instructions: "Polyethylene 3350 NF Take 17-34 grams 1 to 2 times daily, titrate to bowel movements." The order date was noted to be . An interview with Employee C at this time found he always measured 17 grams, and offered the medication only once daily.

The Medication Observation Record (MOR) for Resident #3 also instructed "Polyethylene 3350 NF, take 17-34 grams 1 to 2 times daily ". The MOR had two signature blocks for staff initials for this medication. The designated times for administration were noted to be 8:00 am and 8:00 pm. The entire line of signature blocks for the 8:00 pm dose, however, had a line drawn through it. Only the 8:00 pm doses for / and were initialed as given. There was no explanation as to why the signature boxes were lined out.

Record review for Resident #3 found a Resident Health Assessment (AHCA form 1823) signed by the examining practitioner on / . On the list of medications, the examiner noted Resident #3 was to

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receive 3350 NF once daily; however, there were no instructions regarding the dosage amount he was supposed to receive. Further review of the record found no change in direction for the Polyethylene.

An interview was conducted with the Administrator and the Nurse Consultant at 8:42 am on. They reviewed the MOR, label, and Resident #3's record. The Administrator explained this resident was having loose stools at some point, so they decided that the Polyethylene was indicated only once a day. She searched his record and found no order change for the Polyethylene to change to once daily, and no definitive order that prevented unlicensed staff to make a judgement on how much or how often to give the medication. They confirmed the instructions for this medication needed to be specifically clarified to remove any parameters.

2. An observation of Resident #5 was conducted in the medication. He was being assisted by Employee B, his assigned Assistant, with the self-administration of medications. With assistance, the resident dispensed 3 pills into a plastic lid, and told the resident what he would be taking. Resident #5 took all 3 pills independently.

A review of the labels for Resident #5's medications found he received a, and Tradjenta 5 milligrams (mg) 1 tablet by mouth once daily. The third label was for, an anti-depressant, 20 mg 1 every day after breakfast.

An interview with Employee B was conducted at 8:13 am on. When asked why the instructions ordered it to be given after breakfast, she stated she did not know. She confirmed that today she gave it before breakfast, explaining she did this so this surveyor could observe.

At 8:20 am on /, after Resident #5 had finished his breakfast, he returned to the medication. Employee B told him he would receive his medication for his foot. She donned gloves, and applied a white cream with a q-tip to Resident #5's left great toenail, and to the skin between all of the toes on his left foot. She then applied more white cream to the skin between all of his toes on his right foot. No other toenails received the application of ointment.

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A review of the MOR and the label for this ointment instructed Ketoconozole cream 2% apply to toenails (twice daily).

An interview was conducted with the Administrator and the Nurse Consultant at 8:42 am on . They reviewed the records for Resident #5 and confirmed the order for the instructed "after breakfast". When told Employee B gave the medication before breakfast, the Administrator explained this resident typically received all of his medications after breakfast. She acknowledged the staff likely gave it early to convenience this surveyor. In addition, she and the Nurse reviewed the order for the Ketoconozole, and confirmed it should be applied to the toenails, as directed, not to the skin between the toes.

Class III

0055 Medication - Storage and Disposal

Based on observation and interviews with staff, the facility failed to properly store in-use in accordance to the manufacturer's instructions for 1 of 1 sampled residents who self-administered , out of a total of 2 sampled residents (Resident #5) reviewed for medications.

The findings included:

An observation of the self-administration of ( ) by Resident #5 was conducted at 8:03 am on . The resident was observed to retrieve one flexpen from a pharmacy labeled box, self-administer his with supervision, and replace the flexpen back into the box. It was not observed where the box of used flexpens were stored.

Employee B was asked to show where the flexpens utilized by Resident #5 were stored, and at 8:25 am on , she retrieved the box from the kitchen refrigerator. It had been stored on the door shelf, alongside condiments and with resident's food. The label read inj (injection) flextouch inject 35 units ( ) qd (every day). Refrigerate until opened. The box was dated as dispensed by the pharmacy on . Inside, three black flexpens were observed. All were and all had the dials set to "0". There was no indication of which of the 3 pen(s) had been opened and used by Resident #5.

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Further inspection of the box found the manufacturer's instructions for use and storage of the Table 13: Storage conditions for FlexPen that was In-Use (opened). The recommendation was to store at (below 30 degrees centigrade). (Do not refrigerate). Storage duration for opened was 42 days.

An interview was conducted with Administrator and the Nurse Consultant at 8:42 am on . They reviewed the box and the storage instructions for the . They confirmed the refrigerated storage was not per the manufacturer ' s instructions. They were unable to determine how long, or which of the 3 flexpen(s) stored in the box, had been used.

Class III

0056 Medication - Labeling and Orders

Based on observation, resident record review, and interview with staff, the facility failed to ensure that unlicensed staff did not have to use his discretion when assisting residents with the self-administration of a medication that required independent judgement for it's indication for use, for 1 of 2 sampled residents observed for medication review (Resident #3).

The findings included:

An observation of Resident #3 was conducted at 7:48 am on . He was sitting at the breakfast table, and was being assisted by Employee C, his assigned assistant. Employee C retrieved a bottle of Polyethylene and filled the cap to the line marked "17 grams". He poured the substance into a cup of tea, stirred until dissolved, and gave it to Resident #3, who was able to drink it independently. A review of the label for this medication revealed the following instructions: "Polyethylene 3350 NF Take 17-34 grams 1 to 2 times daily, titrate to bowel movements." The order date was noted to be . The Medication Observation Record (MOR) for Resident #3 instructed the same. It had two signature blocks for staff initials for corresponding administration times of 8:00 am and 8:00 pm. The entire line of signature blocks for the 8:00 pm dose had a line drawn through it, but no explanation why.

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Record review for Resident #3 found a Resident Health Assessment (AHCA form 1823) signed by the examining practitioner on / . On the list of medications, the examiner noted Resident #3 was to receive 3350 NF once daily; however, there were no instructions regarding the dosage amount he was supposed to receive. Further review of the record found no change in direction for the Polyethylene .

An interview was conducted with the Administrator and the Nurse Consultant at 8:42 am on . They reviewed the MOR, label, and Resident #3's record. The Administrator explained this resident was having loose stools at some point, so they decided that the Polyethylene was indicated only once a day. She searched his record and found no order change for the Polyethylene to change to once daily, and no definitive order that prevented unlicensed staff to make a judgement on how much, or how often, to give the medication. They confirmed the instructions for this medication needed to be specifically clarified to remove any parameters.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and an interview with staff, the facility failed to ensure a safe, sanitary environment for 6 of 6 residents who resided in the home (Residents #1, #2, #3, #4, #5 and #6) by ignoring standard control practices when storing contaminated pens.

The findings included:

Resident #5 was observed at 8:03 am on in the medication . He was accompanied by Employee B, his assistant. Resident #5 retrieved an wipe , his glucose monitor, and lancet to check his sugar. Resident #5 independently opened the , wiped his finger and placed the test strip into the glucose monitor. He activated the lancet, and successfully pinched a sizeable drop of from his right pointer finger. He made two separate attempts at obtaining a reading, with success on the second try. With his bloody finger, he retrieved a sheet of paper from his bag, and unfolded it. There were multiple brown spots on the paper, which appeared to be dried . Fresh was observed to transfer from Resident #5's hand to the page during the observation. Employee B then handed Resident #5 a pen, which he retrieved with his bloody hand. He proceeded to

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record his sugar (152) onto the sheet of paper using the pen, and replaced the flexpen into it's box. He then departed the with the box in hand. It is unknown where the contaminated pen went.

At 8:25 am. Employee B was asked to show where the box was stored. The box was observed to be stored on the refrigerator door shelf, next to the condiments. On the outside of the box, a thumb-sized brown spot, which resembled dried , along with several other smaller spots on the face of the box, were observed (photographic evidence obtained).

An interview was conducted with Administrator and the Nurse Consultant at 8:42 am on . They observed the box and confirmed what appeared to be dried on the box, and it's unsanitary storage next to resident foods.

Class III

Z816 Background Screening-Compliance Attestation

Based on a review of employee files and the Agency's Internet Background Screening Unit website, and interview with the Administrator, the facility failed to obtain a new level 2 background clearance for 1 of 1 re-hired employee after his absence (Employee C), out of a total of 3 sampled employees whose files were reviewed.

The findings included:

A personnel file review for Employee C found he was rehired by the facility as as Assistant on . A Department of Children and Families background clearance letter dated was located in the employee's file. Further review found an application for employment dated . There was no updated application, and no documentation whether Employee C was employed at the time of re-hire. There was no documentation whether Employee C had a 90-day break in employment prior to his return to the facility.

An interview was conducted with the Administrator at 11:30 am on . She stated she believed this employee was working prior to re-hire in another state, but was unable to locate proof. She did not

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realize a new level 2 background clearance was needed for Employee C if he had a 90 day break in employment prior to returning.

This Surveyor checked the Agency's electronic background screening unit website (https://ahcanet.fdhc.state.fl.us/BGS2/SessionTimeOut.aspx) on at approximately 10:30 am. There was no level 2 baclground clearance located for Employee C.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

....., 2016

Administrator
L'Arche Harbor House, Inc. I
700 Arlington Road
Jacksonville, FL 32211

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,

Robert E. Dickson
Field Office Manager
Division of Health Quality Assurance

LL/JM/sm
Enclosure
XG90

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