STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966826	05/18/2016
NAME OF PROVIDER OR SUPPLIER **HERITAGE CROSSINGS**	STREET ADDRESS, CITY, STATE, ZIP CODE **2689 ART MUSEUM DR** **JACKSONVILLE, FL 32207**	

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

0000 Initial Comments

An unannounced complaint survey, CCR# 2016001929, was conducted at Heritage Crossings (License #10950) in Jacksonville, Florida, on , 2016. Deficient practice was identified as a result of the survey.

0055 Medication - Storage and Disposal

Based on observation and interview, the facility failed to ensure that centrally stored medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, area at all times.

The findings included:

During an unannounced complaint investigation conducted on , observation of assistance with self-administration of medication was completed.

During assistance with self-administration of medication with Resident #1 on at 7:50 a.m., Employee A was observed locking the medication cart, walking into the dining , and providing Resident #1 her medication while leaving all of Resident #1's medication cards containing her medication on top of the medication cart unattended.

During assistance with self-administration of medication with Resident #3 on at 8:20 a.m., Employee A was observed locking the medication cart with all of Resident #3's medications left sitting on top of it. Employee A went to the dining assist Resident #3 with her medications, leaving the cart unattended. When he returned to the cart, he unlocked it, and put Resident #3's medications away. When asked whether he was aware that he left the medications unattended on the cart, Employee A smiled and asked whether the surveyor was going to "get him" for that.

During assistance with self-administration of medication with Resident #4 on at 8:27 a.m., Employee A was observed standing at medication cart #1 which was unlocked. Employee A moved over to medication cart #2 and unlocked it. Both medication carts were now unlocked. Employee A sanitized his hands and donned clean gloves. He pulled all of Resident #4's medications and placed them in a plastic medication cup. He put all of Resident #4's medications away in the cart. He locked cart #2, but

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left cart #1 unlocked with the medication observation record (MOR) left open exposing Resident #4's medication information.

During an interview with Employee A at 10:35 a.m., and after a discussion regarding medications left unattended on top of medication carts, and medication carts being left unlocked while unattended, Employee A stated that he should have locked the medications away, and then should have locked the cart when he was not using it. He stated that he normally did that, but this day he was nervous.

Class III

0056 Medication - Labeling and Orders

Based on record review and staff interview, the facility failed to obtain written medication orders from a healthcare provider within ten (10) working days of receiving a telephone order for six (6) of six (6) sampled residents (Residents #1, #2, #3, #4, #5 and #6)

The findings included:

During an unannounced complaint investigation conducted on , a review of residents' clinical records was completed.

A review of Resident #1's clinical record revealed the following:

An order written on for half side rails for mobility was signed by the facility's Registered Nurse (RN), Director of Nursing (DON) for the Advanced Registered Nurse Practitioner (ARNP), but it was never signed by the physician or the ARNP.

An order written on to crush medication in applesauce was signed by the facility's DON, but was never signed by the physician or ARNP.

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An order written on to increase to three times a day for pain was signed by the facility's DON, but was never signed by the physician or ARNP.

A review of Resident #2's clinical record revealed the following:

An order written on for 50 milligrams (mg) by mouth daily was signed by the facility's DON, but was never signed by the physician or ARNP.

An order written on for 25 mg by mouth at bedtime was signed by the facility's DON, but was never signed by the physician or ARNP.

A review of Resident #3's clinical record revealed the following:

On , Resident #3 was ordered 400 mg twice daily for five (5) days, for a by telephone order. It was signed by the DON, but there was no signature from an ARNP or a physician.

A review of Resident #4's clinical record revealed the following:

On , there was an order in Resident #4 ' s chart to discontinue twice a day, every other day, and start S twice a day every other day for . The telephone order was signed by the DON but not by the physician or ARNP.

On , a clarification order for Resident #4 stated to give 81 mg every day, chewable, and the resident may have crushed medications. This was a telephone order from the ARNP that was transcribed by the DON with no signature by the ARNP or Physician.

A review of Resident #5's clinical record revealed the following:

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An order written on to discontinue 81 mg until seen by the physician was signed by the facility's DON, but was never signed by the physician or ARNP.

An order written on / for a chest x-ray was signed by the facility's DON, but was never signed by the physician or ARNP.

A review of Resident #6's clinical record revealed the following:

An order written on to send the resident to the emergency an evaluation was signed by the facility's DON, but was never signed by the physician or ARNP.

An order written on for lab work (basic panel (BMP) was signed by the facility's DON, but was never signed by the physician or ARNP.

During a interview with the Administrator at 9:45 a.m., she confirmed that the signature on the physicians' orders was that of the DON. She acknowledged that there was no physician's signature accompanying the orders. The regulation was reviewed with the Administrator, and she stated that she would have the physician start signing off on all of the telephone orders during visits. The Administrator stated that the physician was expected this day, so she would flag all of the orders for them to sign.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Heritage Crossings
2689 Art Museum Drive
Jacksonville, FL 32207

RE: CCR #2016001929

Dear Administrator:

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

Sincerely,

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

JG/JM/sm
Enclosure
XG90

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