STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911196	04/13/2017
NAME OF PROVIDER OR SUPPLIER **SUGARMILL MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **8985 S. SUNCOAST BLVD.** **HOMOSASSA, FL 34446**	

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

0000 - Initial Comments

On through , an unannounced Biennial Survey with Limited Nursing Services (LNS) was conducted at Sugarmill Manor (facility license number 5561). The facility had deficient practice at the time of the survey.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review and interview, the facility failed to follow their policy and procedure for control during meal service for 1 of 5 sampled staff (Staff A)

Findings

On at 12:18 PM, an observation was made of the lunch meal. Staff A was observed in the memory care dining a resident with the lunch meal. Staff A was observed wearing blue gloves. A resident in the dining Staff A for ice. Staff A, still wearing the blue gloves, got up from the table, took a styrofoam cup from the resident that had asked for ice, exited the memory care unit, walked to the kitchen area, handed the styrofoam cup to a kitchen staff member. Staff A then removed her gloves, and while talking to another resident picked a piece of food off of the resident's chest and threw it in the trash. The kitchen staff handed the styrofoam cup back to Staff A who them proceeded toward the memory care unit. Staff A stopped at a medication cart, removed a pair of blue gloves, and put the gloves on. She then entered the memory care unit by entering the code on the key-, , and opened the door with her gloved hand. Staff A returned the styrofoam cup to the resident that asked for ice, opened and poured a can of soda into the cup, then proceeded to sit down and continue assisting the resident to eat. Staff A was not observed to wash her hands after taking off her gloves, or before putting a new pair of gloves on.

On at 12:25 PM, an interview was conducted with Staff A. Staff A confirmed that she had not washed her hands after taking off her gloves, and before putting on a new pair.

On , a record review was conducted of the facility's policy and procedure regarding control. A policy titled, " Control," not dated, states, "2. Hand washing before and after resident care, between medication passes, after toileting, and between tasks to avoid cross contamination."

On at 12:48 PM, an interview was conducted with the facility Administrator. The Administrator stated, "Staff should wash their hands before putting on gloves and after taking them off."

Class III

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SUGARMILL MANOR	8985 S. SUNCOAST BLVD. HOMOSASSA, FL 34446

SUMMARY STATEMENT OF DEFICIENCIES
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0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, record review and interview, the facility failed to provide assistance with self-administration of medication as required for 1 of 4 residents (Resident #5) by unlicensed staff (Staff B) dialing an pen for the resident.

Findings

On at 11:50 AM, during an observation of assistance with medication self-administration, Staff B, a Medication Technician (MT) was observed assisting Resident #5 with performing his glucose monitoring. After the resident completed checking his glucose, Staff B was observed applying a syringe to the tip to a FlexPen. Staff B then dialed the pen to 10 units. The surveyors asked how many units of the resident was to receive. Staff B stated, "10 units." Staff B then handed the pen to the resident; the resident looked at the pen, and then self-administered the into his right upper arm. The resident then removed the syringe tip, placed it in a sharps container, and handed the FlexPen back to Staff B.

On at 2:33 PM, an interview was conducted with Staff B. Staff B was asked how she would assist a resident with self-administration of an pen. Staff B stated, "Normally, it's exactly like what you saw and we dial in the pen for him (Resident #5). I know I'm not supposed to do that."

On , a record review was conducted of Resident #5's Resident Health Assessment (AHCA Form 1823). The record revealed on page 4, section B, the box for needs assistance with self-administration of medication is marked. Further, there is a comment written by the Physician Assistant that filled out the form stating, "Patient able to self-administer after checking sugar. Staff brings to patient and stores in medication cart."

On at 9:45 AM an interview was conducted with the facility Assistant Administrator (AA). The AA stated "(Resident #5) is more than capable of doing his own ."

On , a review of a facility policy titled, "Supervision of self-administered medications," not dated, states: "Assistance with self-administration medication may include: 1. Preparing items such as juice, water, cups, spoons. 2. Reminding the resident that it is time to take the medication. 3. Opening or closing medication containers or package. 4. Steadying the resident's arm, hand, or other part of the resident's body. 5. Placing unused, uncontaminated, doses of solid medication back into the medication container. 6. Ensuring prescriptions are refilled in a timely manner."

On at 12:48 PM, an interview was conducted with the facility Administrator. The administrator

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was asked about the policy for staff dialing an pen for a resident. The Administrator stated, "They're not supposed to do that, she's been told that."

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, record review, and interview, the facility failed to ensure that physician orders were followed for a Flexpen for 1 of 5 sampled residents (Resident #5).

Findings:

On at 11:50 AM, during an observation of assistance with medication self-administration, Staff B, a Medication Technician (MT) was observed assisting Resident #5 with performing his glucose monitoring. After the resident completed checking his glucose, Staff B was observed applying a syringe to the tip to a FlexPen. Staff B then dialed the pen to 10 units. The surveyor asked how many units of the resident was to receive. Staff B stated, "10 units." Staff B then handed the pen to the resident; the resident looked at the pen, and then self-administered the into his right upper arm. The resident then removed the syringe tip, placed it in a sharps container, and handed the FlexPen back to Staff B. Staff B returned to the Medication Cart and entered into the electronic Medication Observation Record (MOR) that the resident took 10 units of . Staff B then noticed that the order for the Flexpen on the MOR stated 13 units of .

On at 11:55 AM, an interview was conducted with Staff B. Staff B stated, "I screwed that up. I'm going to talk to Assistant Administrator (AA) about that (discrepancy in units of that the resident is to receive). It's different than what it normally is." Upon returning from speaking with the AA, Staff B stated, "Okay, I guess what's going on is the order was changed on the 27th of I guess everyone is asking if he wants 13 (units of), but he always just wants 10."

On , a review of Resident #5's clinical record revealed an order dated and signed by an Advanced Registered Nurse Practitioner (ARNP) that states, "Increase Flexpen, take 13 units 3 times a day with meals." There is a note on the paper indicating that the order was added to the facilities electronic MOR on . The note was initialed by the AA.

On , a review was conducted of Resident #5's clinical record. A printout of the resident's electronic MOR showed that from until the resident continued to receive 10 units of for each dose.

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On at 9:45 AM, an interview was conducted with the Assistant Administrator (AA). The AA was asked about Resident #5's Flexpen order. The AA stated, "I honestly was not aware that he was still taking ten until my aide came and asked me yesterday about his . I asked the aide, "You know he gets 13 (units)." They're supposed to observe him testing his sugar and giving himself . They're supposed to check how many units he's taking." The AA was asked if the ARNP had been notified that the resident had not been receiving his ordered 13 units of . The AA stated, "No, I did not notify the ARNP yesterday when I found out."

On at 1:28 PM, an interview was conducted with Resident #5's ARNP. The ARNP was asked if she had been notified that the resident had not been receiving the ordered 13 units of . The ARNP stated that she was not notified.

Class III