STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968269	09/12/2018
NAME OF PROVIDER OR SUPPLIER **SARAH HOUSE III, THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1001 OLD TOMOKA RD** **ORMOND BEACH, FL 32174**	

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

0000 - Initial Comments

A complaint investigation (CCR #2018009238) was conducted at The Sara House III (License Number: 12175) on . . . . The Sara House III had deficiencies at the time of the investigation.

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on observations, resident record review, and interview with staff, the facility failed to provide assistance with self-administration of medications by unlicensed staff in accordance with section 429.256(3), F.S. by failing to read the label in the presence of the resident for 2 of 2 residents observed receiving medications (Residents #1 and #2), and for 1 of 1 residents who required medication administration (Resident #3).

The findings include:

1. An observation of Resident #2 was conducted on at 8:57 am. She was in the small beauty parlor off of the common area of the facility, having her hair done by a hairdresser. Medication Technician (MT) A was observed at this time to prepare her medications at the medication cart, and take them in a small medicine cup to Resident #2 in the beauty parlor . . . Resident #2 took the medications, placed them in her mouth, and washed them down with a cup of water. MT A did not read the medication labels, or tell Resident #2 what she was receiving.

Review of the medication observation record (MOR) revealed Resident #2 had received , 81 milligrams (mg), Centrum Silver tablet, . . , (treats high . . . , ...) 20 mg, . . D3, (cognition enhancer) 10 mg, (anti-) 5 mg, and (anti- ,) 0.5 mg.

2. MT A then returned to the medication cart, and at 9:02 am, called for Resident #1. Resident #1 walked over to the medication cart. MT A dispensed her medication into a small cup, then handed the cup to the resident. Resident #1 placed the medications into her mouth and washed them down with a small cup of water, also provided by the MT. MT A did not read the labels to the resident, or tell the resident what she was taking.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968269	09/12/2018
NAME OF PROVIDER OR SUPPLIER **SARAH HOUSE III, THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1001 OLD TOMOKA RD** **ORMOND BEACH, FL 32174**	

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

Review of the medication observation record (MOR) for Resident #1 revealed had received 500 milligrams (mg) 2 tablets, 81 mg, (treats and hay) 10 mg, Donzepil (a cognition enhancer) 10 mg, Quietapine (anti-) 25 mg (½ tablet) and (anti-depressant) 50 mg.

A second interview was conducted with MT A on at 12:43 pm. When asked why she did not read the labels in the presence of the residents, or tell Residents #1 or #2 what medications they were receiving, she stated she had no reason. She acknowledged the requirement to read the label in front of the resident each time she assisted with the self-administration of medications. When told only a licensed staff member could administer medications to residents, she stated she did not know. MT A confirmed Resident #3 was unable to assist at all with the self-administration of her medication.

3. An interview was conducted with the Caregiver on at 10:07 am. She stated Resident #3 was totally dependent on staff for eating, and had to be fed.

MT A was interviewed on at 11:25 am. She stated Resident #3 was "feeder". She was totally dependent on staff for eating and had to be fed. She also had a crush order for her medication. MT A stated she had to place Resident #3's crushed medications in food such as applesauce, and feed them to her. She confirmed Resident #3 could not take the medications herself or assist with her medications. When asked if Resident #3 could place her spoon in her mouth when handed to her in order to take her medications, she responded "No", she had to feed them to this resident.

Resident #3 was observed at lunch on at 12:05 pm. The Caregiver was seated next to her, and fed her a pureed lunch. Resident #3 made no effort to feed herself. The Caregiver stated at this time that Resident #1 simply was not able to feed herself, and would refuse. When asked to attempt to place the spoon into Resident #3's hand and attempt to have her place the spoon in her mouth, Resident #3 resisted. She refused to take the spoon.

Record review for Resident #3 revealed an AHCA form 1823 (Resident Health Assessment) dated . She had a diagnosis of advanced , and required 24/7 care. Resident #3 was assessed as requiring assistance with the self-administration of her medications. Further review of the record found she received the following medications: , 2.5 mg daily at bedtime for ; Senekot-S tablet each night at bedtime for ; and, DS ( ) mg 2 tablets twice daily.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968269	09/12/2018
NAME OF PROVIDER OR SUPPLIER **SARAH HOUSE III, THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1001 OLD TOMOKA RD** **ORMOND BEACH, FL 32174**	

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

An interview was conducted with the Community Director (CD) on . . . at 1240 pm. She stated Resident #3 recently went on hospice, and she used to be able to feed herself. She was asked how Resident #3 was assisting with the self-administration of her medications if she could not bring her spoon or cup to her mouth. The CD did not have a response. She was asked to have the resident demonstrate her ability to assist with taking her crushed medications by bringing the spoon to her mouth. The CD attempted to have Resident #3 do so, without success. She confirmed Resident #3 was no longer able to assist with the self-administration of her medications. The CD confirmed her knowledge of the requirement that a licensed nurse was required for medication administration.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observations, resident record review, and staff interview, the facility failed to ensure staff was available to carry out services requiring licensure, for 1 of 3 residents sampled.

The findings include:

An interview was conducted with the Caregiver on . . . . at 10:07 am. She stated Resident #3 was totally dependent on staff for eating, and had to be fed.

In an interview with Medication Technician (MT) A on . . . . at 11:25 am, she stated she had to place Resident #3's crushed medications in food such as applesauce, and feed them to her. She confirmed Resident #3 could not take the medications herself or assist with the self-administration of her medications.

Observations were conducted of Resident #3 on . . . . from 9:45 am to approximately 12:45 pm. She did not engage in any of the activities offered. During lunch at 12:05 pm, the Caregiver fed Resident #3. Resident #3 made no effort to feed herself. The Caregiver stated at this time that Resident #1 simply

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968269	**09/12/2018**
NAME OF PROVIDER OR SUPPLIER **SARAH HOUSE III, THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1001 OLD TOMOKA RD** **ORMOND BEACH, FL 32174**	

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

was not able to feed herself, and would refuse. When asked to attempt to place the spoon into Resident #3's hand and attempt to have her place the spoon in her mouth, Resident #3 resisted. She refused to take the spoon.

An interview was conducted with the Community Director (CD) on at 12:40 pm. She stated Resident #3 recently went on hospice, and she used to be able to feed herself. She was asked how Resident #3 was assisting with the self-administration of her medications if she could not bring her spoon or cup to her mouth. The CD did not have a response. She was asked to have the resident demonstrate her ability to assist with taking her crushed medications by bringing the spoon to her mouth. The CD attempted to have Resident #3 do so, without success. She confirmed Resident #3 was no longer able to assist with the self-administration of her medications. The CD confirmed her knowledge of the requirement that a licensed nurse was required for medication administration. In a second interview at 1:00 pm, the CD stated she had only 2 MTs working in the building at the time of survey; MT A and MT B.

Review of Resident #3's MOR revealed MT A provided assistance with medications on , , 3, 4, 5, 11 and 12, 2018. MT B provided assistance on , , 2 and 9, 2018.

A second interview was conducted with MT A on at 12:43 pm. . When told only a licensed staff member could administer medications to residents, she stated she did not know. She confirmed Resident #3 was unable to assist at all with self-administration of her medication.

A personnel file review conducted for MT A reveled she received training in assistance with the self-administration of medications on , but was not a licensed nurse.

A personnel file for MT B revealed she received training in assistance with the self-administration of medications on , but was not a licensed nurse.

Class III