STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966826	11/13/2018
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

On , an abbreviated relicensure and emergency power plan survey was conducted at Heritage Crossing Assisted Living. Deficient practice was identified during the survey.

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

Based on family interview, observation, medical record review and staff interview the facility failed to ensure the unlicensed medication technician providing assistance with self-administration of medication was not administering medications to 3 out of 5 sampled residents (#1, #3 and #4). The facility failed to ensure the medication technician prepared the medication in the presence of the resident and read the label aloud to the resident during the assistance with medication administration for 5 out of 5 sampled residents (#1, #2, #3, #4 and #5).

The findings include:

During a family interview with Resident #3's daughter on at 9:25 am, she described the assistance with medication her mother receives. She stated the staff crush her medications and put them in applesauce and then spoon feed it to her. She will not feed it to herself if it is just handed to her. Sometimes she will feed herself food, but she refuses a lot too.

An observation of the medication pass for Resident #1 was conducted on at 10:00 am with Employee C, medication technician. She sanitized her and then reviewed the medication observation record (MOR) to verify medication orders. She unlocked the medication cart; took out two medication bottles; shook out 1 tablet from each bottle into the medication cup and returned the bottles to the cart. She put the two tablets in a small plastic bag and crushed them with a pill crusher. She took the plastic bag with the crushed tablets and dumped the powder into a small container of applesauce. She then took out a medication vial for liquid medication and mixed 2 drops of liquid medication into the applesauce with a small medication spoon. After locking the medication cart, she took the cup of applesauce to the resident who was seated at a table in the dining room and told her it was time for her medication. She told the resident to take hold of the spoon and the resident refused. The resident's were in her , under her clothing protector. She made no effort to take hold of the medication spoon. Employee C then took the medication spoon and spoon fed the applesauce to the resident. Resident #1 did not attempt to take hold of the medication spoon during the medication pass. Employee C did not read the label to the resident.

During an interview with Employee C on at 1:28 pm she stated that Resident #1 is

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and will not take hold of the medication spoon and feed it to herself so she has to feed it to her. She stated "There is no way she will feed the applesauce to herself. We have to feed it to her."

An observation of the medication pass for Resident #2 was conducted on at 12:03 pm with Employee C. She sanitized her and then reviewed the MOR to verify medication orders. She unlocked the medication cart and took out a medication bubble pack card; popped a tablet into a medication cup and returned the medication card to the cart. She locked the medication cart and then took the cup to the resident who was seated at a table in the dining room and told him it was time for his medication. The resident took the medication cup and dumped the pill into his . She offered him water which he drank. She then asked him if he wanted his . He said yes. She opened the vial containing the medication; removed the medication container; opened it and dropped one drop in each . She then put the lid on the container and put it into the vial. She did not read the label to the resident.

During an interview with Employee C on at 12:08 pm she stated she had received assistance with self-administration of medication training recently. She stated she had it last month. She was not aware that she needed to read the label aloud to the resident prior to assisting or that she was to take the prepackaged medication cards/vials to the resident and prepare the medication in front of the resident.

An observation of the medication pass for Resident #3 was conducted on at 12:10 pm with Employee C. She sanitized her , reviewed the MOR to verify medication orders; unlocked medication cart; took out medication bubble pack card; popped one tablet into a medication cup; returned the medication card to the cart. She then took a plastic cup and scooped three teaspoons of applesauce into it. She then took a plastic bag and dumped the tablet into the bag; crushed the tablet with a pill crusher and then mixed the crushed powder into the applesauce with small wooden spoon. She then took the cup of applesauce to the resident who was seated at a table in the dining room and told her it was time for her medication. She did not read the label to the resident. Resident #3 was holding a fork and feeding herself. Employee C did not attempt to have Resident #3 take the medication spoon and feed herself the applesauce. She spoon fed the resident the applesauce.

An observation of the medication pass for Resident #4 was conducted on at 12:20 pm with Employee C. She sanitized her and reviewed MOR to verify medication orders. She unlocked the medication cart; took out a medication bubble pack card; popped one tablet into a medication cup and returned the medication card to the cart. She took a plastic cup and scooped three teaspoons of

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applesauce into the cup. She then took a plastic bag and dumped the tablet into the bag; crushed the tablet with a pill crusher. She mixed the crushed powder into the applesauce with small wooden spoon. She then took the cup of applesauce to the resident who was seated at a table in the dining room and told her it was time for her medication. She then spoon fed the resident her medication. The resident did not attempt to take hold of the spoon and feed the medication to herself. Employee C did not read the label to the resident.

During an interview with Employee C on at 12:23 pm she stated that Resident #4 is and cannot take hold of the medication spoon and feed it to herself so she has to feed it to her.

On at 1:00 pm Resident #5 came to the medication cart near the main dining room. She requested her medication by name from Employee C.

Observed the medication pass for Resident #5 on at 1:15 pm with Employee C. She washed her with soap and water and then reviewed the MOR to verify medication orders. She prepared a small paper medication cup by writing the resident's name on it. She then unlocked the medication cart; took out a medication bubble pack card for 10-325mg. and popped one tablet into the medication cup. She returned the medication card to the cart and locked it. She took a small plastic cup, went to the sink and filled it with water. She then went to the resident's room with the medication and knocked on the door. She told the resident what the medication was and gave her the paper cup. The resident dropped the tablet in her She then picked it up and put the medication in her She then took the water cup and drank the water. She did not read the label to the resident.

During an interview with Employee C on at 1:15 pm, she confirmed she has to feed the medication to the residents because they won't feed it to themselves. She stated "Oh no, they will not take hold of the spoon and feed it to themselves."

Review of the Health Assessment form for Resident #1 dated revealed the resident was assessed as requiring assistance with self-administration of medications (Photographic evidence obtained).

Review of the Health Assessment form for Resident #2 dated revealed the resident was assessed as requiring assistance with self-administration of medications (Photographic evidence obtained).

Review of the Health Assessment form for Resident #3 dated revealed the resident was assessed as requiring assistance with self-administration of medications (Photographic evidence

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obtained).

Review of the Health Assessment form for Resident #4 dated revealed the resident was assessed as requiring assistance with self-administration of medications (Photographic evidence obtained).

Review of the Health Assessment form for Resident #5 dated revealed the resident was assessed as requiring assistance with self-administration of medications (Photographic evidence obtained).

Review of the personnel file for Employee C revealed she had received a two hour update training on Assistance with Medication Self-Administration on (Photographic evidence obtained).

During an interview with the Health and Wellness Director, RN on at 3:10 pm, she confirmed that her expectation is that all medications be given per provider orders. When informed of the observations of Employee C during medication pass, she acknowledged that what Employee C was doing was considered administration of medication. She acknowledged that unlicensed personnel cannot administer medication and can only assist with self-administration of medication. She stated that the sampled residents for medication pass that were spoon fed their medications in applesauce would not feed themselves the medication. She stated that the facility would need to have nurses pass medications to Residents #1, #3 and #4.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observation, staff interview, and record review, the facility failed to maintain an accurate Medication Observation Record (MOR) for 1 of 5 sampled residents (Resident #5) observed during medication pass. Additionally, the facility failed to appropriately use its Medication Record for PRN (as needed) Medications for a controlled substance count during administration of , medication for 1 of 5 sampled residents (Residents #5) observed during medication pass. These failures placed residents at increased risk for significant medication errors.

The findings include:

On at 1:00 pm Resident #5 came to the medication cart near the main dining room. She

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requested her , medication by name from Employee C.

Medication pass for Resident #5 was observed on at 1:15 pm with Employee C. She washed her with soap and water and then reviewed the MOR to verify medication orders. She prepared a small paper medication cup by writing the resident's name on it. She then unlocked the medication cart; took out a medication bubble pack card for 10-325mg. and popped one tablet into the medication cup. She returned the medication card to the cart and locked it. She took a small plastic cup, went to the sink and filled it with water. She then went to the resident's room with the medication and knocked on the door. She told the resident what the medication was and gave her the paper cup. The resident dropped the tablet in her , . She then picked it up and put the medication in her . She then took the water cup and drank the water.

Employee C returned to the medication cart and signed the MOR, initialing the box for . When asked why she was initialing tomorrow's date, she stated that the box for was already initialed so she had to use the one for . When asked what the Medication Record for PRN (as needed) Medications form for was for, she stated they mark the form when they give that medication. When asked why she had not done so, she looked at the form and confirmed she did not sign off the controlled medication log. She stated she signs the MOR only and does not sign the Medication Record for PRN (as needed) Medications form. She acknowledged that they do sign the controlled medication log and the sheet was full. She stated she would speak to the Health and Wellness Director about the log.

Review of the controlled medication/prn log for for Resident #5 revealed the last time it was signed was at 9:00 am. Review of the MOR for Resident #5 revealed she had received the every day in the month of (Photographic evidence obtained).

Review of the Health Assessment form for Resident #5 dated revealed the resident was assessed as requiring assistance with self-administration of medications (Photographic evidence obtained).

Review of the personnel file for Employee C revealed she had received a two hour update training on Assistance with Medication Self-Administration on (Photographic evidence obtained).

During an interview with the Health and Wellness Director, RN on at 3:10 pm, she confirmed that her expectation is that all medications be given per provider orders. She also verified that the actual count of a controlled substance should be verified against the controlled substance count sheet prior to administration. She confirmed that Employee C should be documenting on the Medication Record for

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PRN (as needed) Medications form each time she gives one to Resident #5.

Class III