Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING _____ B. WING _____	C

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint investigation survey was conducted from 24 to 25, 2012 for CCR# 2012009591 at Emerald Gardens. Deficient practice was found at the time of the survey.	A 000		
A 052 SS=G	58A-5.0185(3) FAC Medication - Assistance with Self-Admin (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least 18 to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. (b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container. (c) Staff shall observe the resident take the medication. Any concerns about the resident ' s reaction to the medication shall be reported to the resident ' s health care provider and documented in the resident ' s record.	A 052		

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A 052	Continued From page 1	A 052		

(d) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule which coincides with the resident ' s presence in the facility;
2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident ' s medication record;
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident ' s medication record; or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging;
(e) Pursuant to Section 429.256(4)(h), F.S., the term " competent resident " means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.
(f) Pursuant to Section 429.256(4)(i), F.S., the terms " judgment " and " discretion " mean interpreting vital signs and evaluating or assessing a resident ' s condition.
(4) Assistance with self-administration does not include:
(a) Mixing, converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
(b) The preparation of syringes for injection or the administration of medications by any injectable route.

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A 052	Continued From page 2 (c) Administration of medications through intermittent positive pressure breathing machines or a (d) Administration of medications by way of a tube inserted in a cavity of the body. (e) Administration of preparations. (f) Irrigations or debriding agents used in the treatment of a skin condition. (g) , or preparations. (h) Medications ordered by the physician or health care professional with prescriptive authority to be given " as needed, " unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (i) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. This Statute or Rule is not met as evidenced by: Based on observation of medication pass, staff interviews, and resident records review the facility failed to assist with medications according to physician orders, failed to confirm physician orders, and prevent contamination of resident medication for one resident reviewed for medication orders (#4) and two residents observed for medication pass (resident # 1 and #5). The findings are: The Medication Observation Record (MOR) and chart for Resident #4 was reviewed beginning 9/2 3 pm. The MOR does not match the newest Resident Health Assessment Agency	A 052		

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A 052	Continued From page 3 for Health Care Administration Form 1823 (1823) which has discharge medications from the hospital. There are 6 pages of Medication Observation Records (MOR) with numerous cross outs and additions. The Administrator was interviewed on about 3:15 pm. She was told of the difficulty in reconciling the medications on the physician discharge orders on the 1823 with the MOR. She was asked what the facility process was when a person comes in with a new 1823 with new medications. She said the Med Tech would review and compare the orders then verify any discrepancies with the primary care physician. She was requested to contact the primary physician regarding the medications at approximately 3:30 pm. The Med Tech (employee #1) was interviewed about Resident #4 at approximately 3:30 pm on She was asked to explain the process for new physician orders coming to the facility. She stated, " I compare the old orders with the new orders. When there are differences I would verify the differences with the attending physician. She was asked if she verified resident #4's new orders. She said, " No " . The Advanced Registered Nurse Practitioner (ARNP) in the office called back at approximately 3:50 pm. and talked with the administrator and the Med Tech (employee #1) at that time. A follow-up interview was conducted with Employee #1 on at approximately 4:15 pm. She said that the second sheet of orders from the hospital were not supposed to be continued, (some of these medications are on the current MOR). The first sheet of medications are the ones the resident should be taking. She was asked if	A 052		

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A 052	Continued From page 4 Resident #4 was currently receiving [illegible] 1mg, for a total of 4 mg daily as the physician order directs, employee #1 stated, " No " . The physicians order sheet was reviewed and the following medications were not given correctly per physician orders: [illegible] 1 mg give 4 mg orally was not given from [illegible] until [illegible] according physician orders. [illegible] 70 mg once weekly which the physician orders discontinued-- one dose was given on [illegible] 200 mg Monday, Wednesday, and Friday to be given on [illegible] days were given on [illegible] and [illegible] when the medication had been discontinued. [illegible] 100 mg on non-d [illegible] days: Tuesday, Thursday, and Saturday were given on [illegible] 22 and 23 when the medication had been discontinued. [illegible] 500 mg one tablet by mouth three times daily was to be discontinued on [illegible] and was given three times a day [illegible] thru 9/ 23 and one dose on [illegible] [illegible] 50 mg one tablet by mouth twice daily was to be discontinued on [illegible] and was given two times a day [illegible] thru [illegible] with one dose on the 24. The administrator was not sure when the comparison of the MOR actually occurred. She said Employee # 1 did the reconciliation. The ARNP was scheduled to come to the facility on Thursday [illegible] 20. The administrator stated she requested that the ARNP see resident #4. The administrator stated she faxed the 1823 to the Dr's office for confirmation on [illegible] 20. The administrator called the primary physician's office and requested that the ARNP call and verify all medications that Resident #4	A 052		

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A 052	Continued From page 5 should currently be taking. On at approximately 5:30 pm a call back from the ARNP with confirmation of orders. The administrator read all the medications out to the ARNP over the phone and the ARNP confirmed which medications the resident should be taking or not taking. The administrator wrote out a new MOR and approximately 5:45 pm on and stated, "I have reduced the MOR down from 5 pages to 1 ½ pages. The Administrator faxed the new MOR and is now waiting for the ARNP to fax the confirmation of the new orders to her so she can give the MOR to staff to implement. On at 6:30 pm the ARNP had not sent the new written orders confirming the new MOR. The Administrator stated resident #4 will not receive medications until the MOR has been confirmed by written order from the ARNP A follow-up interview with the administrator occurred at approximately 10:30 am on Resident #4 was admitted to the facility on With a diagnosis of and Resident #4 goes to three times a week. The resident was discharged to Sacred Hospital for chest pain and elevated and low saturation of 81% on While in the hospital the resident had a and returned to the facility on On the resident was sent back to the hospital again. The notes are not specific as to why. The resident was found to have On the resident returned to the facility and on he received the new 1823 with updated physician orders.	A 052		

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A 052	Continued From page 6 Resident #4's ARNP was interviewed at approximately 12:34 on [redacted]. She stated, " I was not aware he had been to the hospital until yesterday which was [redacted]. He has [redacted] and was on [redacted] now he is on [redacted] and [redacted] for his [redacted] The ARNP was asked if the facility received orders from the hospital on resident #4's return, which should they follow. The ARNP said, " I would consider the orders from the hospital to be the orders to follow. Yes, they are discharge orders from the hospital and are written by a physician. She related the process for verifying medication orders. The facility is suppose to send the new orders to us (the primary physician/ARNP). We did not receive the orders until [redacted] 20. This information was sent to me by another ARNP working in the office via email on [redacted] 20. "After we receive the 1823, I would reconcile the patients medications and determine which he should continue and which to discontinue". He was on [redacted] and [redacted] in the hospital , I discontinued the [redacted] on [redacted] when I was approached about it. The ARNP was asked if she feels the resident was harmed because of the medications. She stated, "It is standard protocol to use [redacted] and [redacted] for [redacted] instead of [redacted]. A medication pass was observed on Resident #5 at approximately 9:15 am the Med Tech Employee # 6 was observed to give one tablet of [redacted] 600 +D to the resident when the MOR and the medication label reads take two tablets by mouth daily. An interview was conducted with Employee #6 about 11:15 am on [redacted]. She read the MOR and confirmed she should have given two tablets.	A 052		

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A 052	Continued From page 7 A medication pass was observed on at approximately 9:44 am for Resident # 1. Employee #6 was observed to drop one tablet of onto the MOR. She picked up the pill with her bare hands and placed the pill back into the bottle. Employee #6 was asked if the pill should have been picked up with bare hands and placed back in the bottle. She stated, " No ". Class II	A 052		

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Emerald Gardens Properties, Llc
1012 N 72 Avenue
Pensacola, FL 32506

Dear Administrator:

Re: CCR #2012009591

This letter reports the findings of a state licensure survey that was conducted on , 2012 by a representative of this office.

Attached is the provider's copy of the State (3020) 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. Staff from this office will conduct a review after , 2012 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 me at 850-412-4540.

Sincerely,

for Donah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure
XG90

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