STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964585	08/15/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Jane Adams House (the)	1550 Nectarine Street Fernandina Beach, FL 32034	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - E210 - 58a-5.0191(7) Fac - Ecc - Training S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced biennial survey was conducted at The Jane Adams House Assisted Living Facility in Fernandina Beach, Florida on , 2013. Licensure deficiencies were identified as a result of the survey.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on resident record review and staff interview, the facility failed to ensure that resident health assessments contained complete information regarding whether the individual will require any assistance with the administration of medication for 1 of 2 sampled residents. (#2).

The findings inlcude:

A review of Resident #2's record and health assessment, revealed that Section 2-B of the form regarding self-care and general oversight was not completed Subsection (B.) regarding assistance with medication was not checked to indicate whether the resident required assistance. The form was not marked to indicate if the resident required assistance with "self-administration" or "medication administration".

An interview with assistant administrator was conducted on at 10:55 AM. The administrator confirmed that the information was missing from the health assessments.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation, staff interview and record review, the facility failed to ensure that a medication was administered as ordered by the physician for 1 of 3 sampled residents. (#1)

The findings include:

On at 12:10 PM, Employee #3 was observed assisting with medications for Resident #1. Employee #3 administered 1 tablet of generic Extra Strength and gave it to resident # 1.

A review of the resident record and Medication Observation Record revealed that Resident #1 was supposed to receive 2 tablets of the Extra Strength 4 times a day.

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An interview with Employee #3 on at 1:25pm confirmed that she incorrectly gave 1 tablet of Extra Strength to Resident #1.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation, record review and staff interview, the facility failed to ensure that medications which had expired were disposed of within 30 days of expiration for 3 of 10 sampled residents. (Residents #3, #4 and #5)

The findings include:

Observation of medications in the medication cart for building #1 on at approximately 9:45 AM revealed a tube of ointment with an expiration date of 2012. The label indicated that the medication was for Resident #4.

A review of the clinical record for Resident #4 revealed no current order for ointment, and a review of Resident #4 ' s 2013 MOR (in building #2) revealed that Bactroban ointment was not listed on the MOR.

Observation of the medications in the medication cart for building #2 on at approximately 12:15 PM revealed Bayer 81 mg tablets plus labeled for Resident #3 and expired in 2003. A partial bottle of Equate brand Adult was also observed in the building #2 medication cart. It was labeled for Resident #5, and the expiration date was 2013. Lastly, a bottle of Colace 100 mg capsules was observed in the medication cart for building #2. It was labeled for Resident #4 and had an expiration date of 2013.

A review of the clinical record for Resident #3 on revealed a current order for 81 mg tablets plus and a review of Resident #3 ' s 2013 MOR on revealed that Resident #3 had received 81 mg tablets plus on and

A review of the clinical record for Resident #5 on revealed that Adult was ordered as needed, however, a review of Resident #5 ' s MOR for 2013 revealed that Resident #5 was not receiving this medication.

A review of the clinical record for Resident #4 on revealed that 100 mg was ordered as needed, however, a review of Resident #4 ' s MOR for 2013 revealed that Resident #4 was not receiving this medication.

An interview with Employee #3 on at approximately 10:00 AM revealed that Employee #3 was unaware that the expired was in the medication cart. When asked how the facility checked for expired medications, Employee #3 said that the consultant nurse was supposed to check the cart weekly when she was in the facility.

An interview with Employee #4 on at approximately 12:30 PM revealed that Employee #4 was unaware that expired medications were in the medication cart for building #2. When asked how the facility checked for expired medications, Employee #4 said that the consultant nurse was supposed to check weekly when she was in the facility.

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An interview with the administrator on [redacted] at approximately 2:30 PM revealed that she was unaware that there were expired medications on the medication carts. The administrator said that the consultant nurse was supposed to check for expired medications; however, she may not have been aware that she should also be checking for over-the-counter medications. The administr [redacted] that she would review the facility ' s expectations with the consultant nurse.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation, record review and staff interview, the facility failed to ensure that no prescription drug was kept or administered by the facility, was properly labeled and dispensed in accordance with Chapters 465 and 499, F.S. and Rule 64B16-28.108, F.A.C. for 1 of 1 sampled residents. (Resident #1)

The findings include:

Observation of medications in the medication cart for building #1 on [redacted] at approximately 9:45 AM revealed a prescription bottle for [redacted] 50 mg tablets, labeled for a resident who no longer lived at the facility. The prescription bottle had been marked out in several places with a black permanent marker. The discharged resident ' s name had been marked out, and Resident #1 ' s name was written on the bottle. The original directions for use were marked out, and new directions for use were written on the bottle. (Twice daily) The name and address of the pharmacy who prescribed the original medication was marked out as well as the original prescription number and the number of refills. The pharmacist ' s name, the date the medication was filled and the expiration date were all marked out. The bottle cap was marked [redacted] and in red marker was written, "AM". (Photos obtained of bottle and bottle cap) There were 14 pills and 3 half pills in the bottle. The pills had [redacted] 50" stamped on them; they were not scored. Some pill halves were larger than others. (photo obtained)

A second bottle of [redacted] was in Resident #1 ' s medication drawer and was labeled as follows: [redacted] 25 mg tablets, take two tablets by mouth every morning and 1 tablet every evening as directed. The prescription bottle was laebeled for Resident #1 and was filled on [redacted] (photos)

A review of Resident #1 ' s MOR on [redacted] revealed that this resident was receiving [redacted] 25 mg tablets, 25 mg every evening at 9:00 PM and [redacted] 25 mg tablets, 50 mg (2 tablets) every morning at 8:00 AM.

An interview with the assistant administrator at 11:15 AM revealed that Resident #1 ' s brother received samples of [redacted] from the resident's doctor because the brother was "frugal". The assistant administrator stated that the medication samples that the brother obtained did not come in a bottle, so the facility used a discharged resident's medication bottle to hold the pills. The assistant administrator said that the facility changed the label to reflect what the medication in the bottle was and who it was for.

An interview with the administrator at 11:22 AM revealed that Resident #1 ' s brother obtained samples which did not come in a bottle, so the discharged resident ' s empty bottle was marked over with marker, and Resident #1 ' s " sample " pills were placed in the bottle. The administrator said that her consultant nurse had tried to obtain a new label for the bottle twice, but nothing had come in yet.

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An interview with the assistant administrator at 11:28 AM revealed that a new label had just been received from the pharmacy. The assistant administrator said, "I didn't want you to think that I was lying about the label. Here it is. It literally just came in." (photo obtained) The label was identical to the one on the that Resident #1 was currently taking. The label read "Seroquel 25 mg tablets, take two tablets by mouth every morning and take one tablet every evening as directed. " The pills in the bottle in question were 50 mg pills, so the new label was still inaccurate.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on personnel record review and staff interview, the facility failed to ensure that one of the four sampled employees (#1) obtained documentation that they were free of communicable including

The findings include:

Personnel record review revealed that Employee #1, the administrator did not have evidence of a freedom from communicable statement or screening result in the her personnel file from a physician other than herself. A form located in the administrator's file noted that a self examination was not acceptable.

An interview with the Assistant Administrator (AA) was conducted on at approximately 2:45 PM. The AA confirmed the finding.

Class III

E210-ECC - Training 58A-5.0191(7) FAC
Based on record review and staff interview, the facility failed to ensure that direct-care staff providing care to residents in an extended congregate care (ECC) program completed at least 2 hours of in-service training, provided by the facility administrator or the ECC supervisor within 6 months of beginning employment in the facility for 3 of 3 sampled employees. (Employees #2, #3, and #4)

The findings include:

A review of the employee personnel records for Employees #2, #3 and #4 revealed no documentation of in-service training related to extended congregate care (ECC) standards.

An interview with the administrator on at approximately 2:00 PM confirmed that ECC in-service training was not provided to Employees #2, #3, or #4. When asked about direct-care staff ECC training, the administrator said that she was unaware that she was required to provide this training to her staff.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
The Jane Adams House
1550 Nectarine Street
Fernandina Beach, FL 32034

Dear Administrator:

This letter reports the findings of a state biennial licensure survey that was conducted on 2013 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. Staff from this office will conduct a review after 2013 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 surveyors. Should you have any questions please call this office at

Sincerely,

Keisha Woods, MPH
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

CB/KW/sm
Enclosure

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