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
	AL11966084	A. BUILDING: _____ B. WING _____	09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TITUSVILLE TOWERS	405 INDIAN RIVER AVENUE TITUSVILLE, FL 32796

(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 A Complaint Investigation 2019014221 was conducted at Titusville Towers on [redacted], 2019. Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.	A 025		

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A 025	Continued From page 1 (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to document the events and notification of family and health care provider when 1 of 3 sampled residents (#3) was sent to the hospital. Findings: On .. . . . at 2 PM staff D said resident #3 was admitted to the hospital on because she was not feeling well. Review of the electronic notes provided by the facility revealed there was no documentation regarding what had transpired resulting in the resident needing to be transported to the hospital. Further review revealed there was no documentation that the health care provider and family were notified. On .. . . . at 3:15 PM, the administrator reviewed the facility's electronic notes and confirmed the findings.	A 025		

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A 025	Continued From page 2 Class III	A 025		
A 052 SS=D	429.256( ); 58A-5.0185 (3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container. (c) Placing an oral dosage in the resident ' s or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (h) Using a to perform -level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the	A 052		

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A 052	Continued From page 3 prescribed [illegible] settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with [illegible] bags. (4) Assistance with self-administration does not include: (a) Mixing, [illegible], converting, or [illegible] 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. (c) Administration of medications by way of a tube inserted in a [illegible] of the body. (d) Administration of [illegible] preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) [illegible], or [illegible] preparations. (g) 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. (h) 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. 58A-5.0185 (3) ASSISTANCE WITH SELF-ADMINISTRATION.	A 052		

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A 052	Continued From page 4 (a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] or older, trained to assist with self administered medication pursuant to the training requirements of rule 58A-5.0191, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) 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 that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's	A 052		

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A 052	Continued From page 5 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. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), 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. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to notify a health care provider when noncompliance with a medication was suspected for 1 of 3 sampled residents (#1). Findings: Resident #1's record revealed a facility admission date of . . . . . His current 1823 health assessment form, dated , indicated that he has a diagnosis of . . . . . and . . . . . type 2. He requires assistance with	A 052		

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A 052	Continued From page 6 self-administered medications. A facility notes, dated . . . . , indicated that his , reading was 54 at 7:30 p.m. The caregiver checked his sugar again at 9 p.m. and it was 84. He said he wanted to take only half of his prescribed . . . dose, so he took 43 units. A facility notes, dated . . . . . , indicated that he tried to hide his , in his while taking his morning medications. The nurses were notified. His record did not contain documented evidence to indicate a health care provider was notified of either occurrence. On at 2 p.m. caregiver B said she believes she told nurse E when the resident took only half of his , but she was not sure. At 2:30 p.m. nurse E said she did not know whether a health care provider was notified when the resident tried to hide his , and when he took only half of his . . . Class III	A 052		
A 078 SS=D	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff	A 078		

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A 078	Continued From page 7 does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative . . . . . examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual . . . . . examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . . . . . . 2. If any staff member has, or is suspected of having, a communicable . . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 58A-5.0191, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to	A 078		

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A 078	Continued From page 8 perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience by allowing an unlicensed staff to give a medication that required judgement and discretion to 1 of 3 sampled residents (#1) and allowed unlicensed staff to dial an . . , . . for 1 of 3 sampled residents (#1). Findings: Resident #1's record revealed a facility admission date of . . . . . A current 1823 health assessment form, dated , indicated that his diagnoses included . . . . . type 2, , , and he requires assistance with self-administration of medications. A health care provider's order, dated . . . . . , indicated to hold his medication for	A 078		

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A 078	Continued From page 9 Review of his [illegible] Medication Observation Record (MOR) revealed an entry for [illegible] ER 60 milligram tablet, give one tablet by [illegible] two times a day for [illegible]. On [illegible] at 8:26 p.m. and [illegible] at 10:51 a.m. "5" was charted, which meant "hold/see progress notes." The progress notes indicated that "resident is [illegible] and drowsy, keeps falling asleep" and "held due to [illegible]." Unlicensed caregivers F and G each authored a note. On [illegible] at 8:11 p.m. and [illegible] at 9:23 a.m. "9" was charted, which meant "other/see progress notes." The progress notes indicated that "held due to [illegible]" and "medicine held due to [illegible]." Unlicensed caregivers C and G each authored a note. Holding the medication due to [illegible] required an assessment and judgement on the part of the person administering the medication, tasks that are not permitted by unlicensed staff. The resident's record did not contain documentation to indicate a nurse made the decision to hold the medication. On [illegible] at 1:30 p.m. nurse E confirmed the findings. The resident's [illegible] MOR contained an entry for [illegible] Solution pen-injector 100 unit/milliliter ([illegible] Lispro) Inject 48 units [illegible] before meals for [illegible]. On [illegible] at 1:39 p.m. nurse E said the unlicensed staff check the resident's [illegible] dials his [illegible] to the prescribed units, then the resident self-administers it.	A 078		

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A 078	Continued From page 10 At 2:13 p.m. unlicensed caregiver A said she assists the resident by setting up his _ _ _ _ _ meter, inserting a test strip, putting a lancet into the lancet device, he sticks himself, she puts on the test strip, she dials the , to the prescribed units, puts a needle onto the pen, then the resident self-injects the . Dialing his , to the prescribed units is a task the unlicensed staff are not permitted to do. Photographic evidence obtained. Class III	A 078		