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
	AL11942866	A. BUILDING: _____ B. WING _____	10/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS ASSISTED LIVING (THE)	26455 RAMPART BLVD. PUNTA GORDA, FL 33983

(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 survey for complaint #2019011364 was conducted [redacted] at the Courtyards Assisted Living, an assisted living facility in Punta Gorda, Florida. Complaint #2019011364 was substantiated with a citation at tag A0056. The following is description of the deficiency.	A 000		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified;	A 056		

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A 056	Continued From page 1	A 056		

for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist.
(d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.
(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.
(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
(g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they

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A 056	Continued From page 2 were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain documentation of reasonable efforts to obtain prescription ordered medications for 2 (Resident #2 and #3) of 3 sampled residents who receive assistance with self-administration of medications. The failure to obtain and administer physician's ordered medications on a timely manner has the potential to cause complications for the residents, including treatment failure and exacerbation of . The findings included: 1. Resident #2 was admitted to the facility on and received assistance with self-administration of medications. Review of the clinical record revealed a physician's order dated at 9:24 a.m. for 300 milligrams 1 tablet by twice a day for 10 days for a .	A 056		

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A 056	Continued From page 3 The Medication observation record (MOR) for [redacted] indicated on [redacted] at 7:33 p.m., and [redacted] at 9:54 a.m., the [redacted] was "on order". The documentation on the MOR indicated the resident received the first dose of the medication on [redacted] at 8:00 p.m., approximately 35 hours after the physician's order. On [redacted] at 10:55 a.m., the assistant administrator said she checks every day on the computer to see which resident is missing medications and she calls the pharmacy right away. She said she did not keep any documentation of the phone calls made to the pharmacy and doesn't know what efforts were made to obtain Resident #2's [redacted] on time. On [redacted] at 12:20 p.m., the Administrator said the facility did not have a policy on ordering medications or a policy to ensure the medications are received on a timely manner. He said "it's just standard operating procedures." He said he relies on the supervisors to monitor and ensure all medications are ordered and received on a timely manner. 2. Resident #3 was admitted to the facility on [redacted] and received assistance with self-administration of medications. The physician's orders included but were not limited to [redacted] diskus 250-50 1 puff 2 times a day for [redacted], [redacted] 0.5 mg (milligram) 1 tablet by [redacted] 3 times daily and [redacted] ER (extended release) 10 meq (milliequivalent) 1 tablet by [redacted] 1 time daily. The MOR contained the following entry for the [redacted] diskus on [redacted] at 8:29 a.m., and	A 056		

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A 056	Continued From page 4 . . . . . at 7:52 a.m., " Medication on order". The medication was documented as administered on . . . . . at 8:00 a.m. and 8:00 p.m., ... at 8:00 p.m., and at 8;00 a.m. and 8:00 p.m. The MOR for . . . . failed to have documentation the Resident received the , ... 0.5 mg as per the physician's order from . . through . On (8:29 a.m., 1:04 p.m., and 9:14 p.m.), ... (7:52 a.m., and 7:55 p.m.), (7:23 a.m., 11:16 a.m., and 8:02 p.m.), ... (7:30 a.m., 11:21 a.m. and 8:11 p.m.), an entry was made indicating "Medication on order." On . . . . . (9:53 a.m., 2:33 p.m., and 8:22 p.m.), and at 8:13 a.m., the MOR indicated Resident #3 refused the , ... Further review of the MOR for . . . revealed Resident #3 was not assisted with the self administration of the . . . . . ER 10 meq form . through . . . . On Each time an entry was made that the medication was "on order." On at 10:35 a.m. the Resident Assistant Supervisor said she didn't know why the staff documented Resident #3 received the Diskus or that she refused the , ... since she has not received these medications since her admission on . . . . . She said she spoke to the daughter who said the medications were discontinued. The Resident Assistant Supervisor said she placed a call to the primary care provider who called . . . last Friday (. . . .) but she missed the call. She said she would try to call again today. She said the facility did not contact the pharmacy to try and obtain the resident's	A 056		

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A 056	Continued From page 5 medications. 3. On [redacted] at 1:00 p.m., the administrator said he relied on his supervisors to make sure the medications are received in a timely manner. He said he knew about the situation with Resident #2 but was not informed about Resident #3. He said the staff needed to understand that because the Resident's daughter said she wasn't taking the medication that it was not ok. He said they needed to understand to escalate the problem to him until it's resolved and document every effort made to obtain the medications. Class III	A 056		