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
	AL11968334	A. BUILDING: _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMTER PLACE IN THE VILLAGES	1550 KILLINGSWORTH WAY THE VILLAGES, FL 32162

(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 (complaint numbers 2019015332, 2019016223 and 2019016463) and Emergency Power Plan (EPP) monitoring survey was conducted at Sumter Place in the Villages Assisted Living Facility on , through . Deficiencies were identified at the time of the survey.	A 000		
A 052	429.256( ); 59A-36.008(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 .	A 052		

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A 052	Continued From page 1 (h) Using a [illegible] to perform [illegible] level checks. (i) Assisting with putting on and taking off [illegible] stockings. (j) Assisting with applying and removing an [illegible] but not with titrating the 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	A 052		

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A 052	Continued From page 2 reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of rule 59A-36.011, 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.	A 052		

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A 052	Continued From page 3 (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 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:	A 052		

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A 052	Continued From page 4 Based on observation, interview and record review, the facility failed to provide assistance with self-administration of medications for 2 of 3 observed residents (Resident #2 and Resident #3). Findings: On ... ... at 8:20 AM, Staff E, LPN (Licensed Practical Nurse) was observed in Memory Care Level One (MC1) getting prepared to assist Resident #2 and Resident #3 with their medications. Staff E was observed unlocking the medication cart and retrieving two unlabeled cups of pills (unknown medications) for Resident #2 and Resident # 3. Resident #2 and Resident #3 were not present when Staff E pre-poured the medication or when she was about to administer the medication. On ... ... at 8:22 AM, during an interview, Staff E confirmed that she pre-poured the medications and Resident #2 and Resident #3 were not available for medication pass. Staff E stopped her medication pass and reported the medication pass to the Assistant Director of Wellness and Health. The Assistant Director of Health and Wellness confirmed that Staff E should not have pre poured medications for Resident #2 and Resident #3 and that Resident #2 and Resident #3 should have been present when medication was poured. A record review of the facility Medication Pass Policy revealed: " ... Assisting with self-administration of medication includes: * Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. * In the presence of the resident, reading the label,	A 052		

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A 052	Continued From page 5 opening the container, removing prescribed a prescribed amount of medication from the container and closing the container ...". Class III	A 052		
A 056	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; 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	A 056		

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A 056	Continued From page 6 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 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	A 056		

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A 056	Continued From page 7 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 interview, the facility failed to 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 for 3 of 3 (Resident #2, Resident #7, and Resident #10) residents reviewed for medication. Findings: A review of the Medication Observation Records (MORs) for Resident #2 revealed missed doses of medications on the following dates: , at 1:00 AM, a dose of TAB [Tablet] 500 MG was not provided. A note entered in the MOR at 12:34 AM stated, "meds not on the cart." , at 5:00 AM, a dose of TAB [Tablet] 50 MCG was not provided. A note entered in the MOR at 5:01 AM stated, "meds not on the cart." A review of the Medication Observation Records (MORs) for Resident #7 revealed missed doses	A 056		

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A 056	Continued From page 8 of medications on the following dates: , at 8:00 PM, a dose of Dorzolam/ OPTH [,] Solution was not provided. A note entered in the MOR at 8:53 PM stated, "not given waiting on med to come in." , at 8:00 PM, a dose of Rhopressa OPTH [,] Solution 0.02% was not provided. An entry in the MOR at 9:37 PM listed the reason as "Physically unable to take." No note was provided to explain why the resident was physically unable to take the medication. , at 8:00 AM, doses of the following medications were not provided: Acidophilus CAP [Capsule] 500 MG, , TAB [Tablet] 5 MG, Fish Oil CAP [Capsule] 1000 MG (Omega-3), , CAP [Capsule] 12.5 MG, and , TAB [Tablet] 20 MG. A note entered in the MOR at 11:51 AM stated, "pharmacy did not send to facility awaiting arrival." , at 8:00 PM, a dose of Rhopressa OPTH [,] Solution 0.02% was not provided. An entry in the MOR at 9:02 PM listed the reason as "Physically unable to take." No note was provided to explain why the resident was physically unable to take the medication. , at 8:00 PM, a dose of Rhopressa OPTH [,] Solution 0.02% was not provided. A note entered in the MOR at 7:24 PM stated, "Not in cart." A review of the Medication Observation Records (MORs) for Resident #10 revealed missed doses of medications on the following dates: , at 7:00 AM, a dose of CAP [Capsule] 300 MG was not provided. A note entered in the MOR at 8:30 AM stated, "Not available from pharmacy." 10/32019, at 2:00 PM, a dose of , TAB	A 056		

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A 056	Continued From page 9 [Tablet] 25 MG was not provided. A note entered in the MOR at 5:24 PM stated, "Awaiting pharmacy delivery." , at 2:00 PM, a dose of , TAB [Tablet] 25 MG was not provided. An entry made in the MOR at 3:19 PM listed the reason as "Physically unable to take." No note was provided to explain why the resident was physically unable to take the medication. , at 8:00 PM, a dose of , , , TAB [Tablet] was not provided. A note entered in the MOR at 6:33 PM stated, "Awaiting pharmacy delivery." , at 8:00 PM, a dose of , , , TAB [Tablet] was not provided. A note entered in the MOR at 6:44 PM stated, "Not available awaiting pharmacy delivery." , at 8:00 PM, a dose of , , , TAB [Tablet] was not provided. An entry in the MOR made at 8:16 PM listed the reason as "Physically unable to take." No note was provided to explain why the resident was physically unable to take the medication. , at 8:00 PM, a dose of , , , TAB [Tablet] was not provided. A note entered in the MOR at 6:34 PM stated, "Awaiting pharmacy delivery." , at 8:00 PM, a dose of , , , TAB [Tablet] 2.5 MG was not provided. A note entered in the MOR at 7:06 PM stated, "not available awaiting pharmacy delivery new order was sent yesterday at 4pm for this medication." , at 4:00 PM, a dose of Boost LIQ [Liquid] (Vanilla) was not provided. A note entered in the MOR at 4:04 PM stated, "No here." , at 7:00 AM, a dose of Boost LIQ [Liquid] (Vanilla) was not provided. A note entered in the MOR at 7:51 AM stated, "Awaiting order from pharmacy." , at 7:00 AM, a dose of Boost LIQ	A 056		

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A 056	Continued From page 10 [Liquid] (Vanilla) was not provided. A note entered in the MOR at 8:42 AM stated, "Awaiting order from pharmacy." A review of the facility policy and procedure titled, "Medication Standards" revealed that it stated, " ... The administrator shall assure that all prescriptions are filled and refilled in a timely manner. It is Discovery Senior Living communities' responsibility to assure residents' medications are available per the health care providers' orders. This assurance shall be confirmed for those residents that self-administer, residents requiring assistance with self-administration of medication and for those residents that require administration of medication ..." On [redacted] at 12:55 PM, during an interview, the Assistant Director of Health and Wellness confirmed that Resident #2, Resident #7, and Resident #10 did not receive their medications at the scheduled times because they had run out and were waiting for the pharmacy to deliver more. The Assistant Director of Health and Wellness stated that the facility had a secondary pharmacy that they could use if they ran out of a medication, but he did not know he had to get a prescription refilled unless the Med Techs told him that a resident had run out. Class III	A 056		