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
	AL11966321	A. BUILDING: _____ B. WING _____	R 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN WELL CARE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 056} SS=D	58A-5.0185(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 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	{A 056}		

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{A 056}	Continued From page 1	{A 056}		

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 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.,

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{A 056}	Continued From page 2	{A 056}		

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 observation, record review, and interview, the facility failed to dispense medications and follow medication orders by Health Care Providers for five residents (#1, #5, #9, #13 and #19) of five residents that required assistance with self-administration of medications.

Findings Included:

During a medication cart audit, conducted on , revealed that there were medications for residents that were not noted on the residents MORs and the residents were not receiving their prescribed medications. In a medication cart (not used for the Facility's specific medication pass) there was found a box of , 250mg and 4mg that was filled for Resident #1 on . These medications were not listed as medications to give on the resident's MORs. There were two tablets left in the box and eleven tablets remained in the box, which indicated that the resident did not receive all doses of both, of the medications. There was found a box of 4mg for Resident #5 ordered on with all, of the doses remaining in the pack, which indicated that the resident did not receive any of the doses ordered. There was found a box of 4mg for Resident #9 ordered on with eleven doses remaining in the pack, which indicated that the resident did not receive doses of the

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{A 056}	Continued From page 3 medication. There was found a box of , 250mg for Resident #13 ordered on with six doses remaining in the pack, which indicated that the resident did not receive all of the doses ordered. There was found a box of 600mg for Resident #13 ordered on with all, of the doses remaining in the pack, which indicated that the resident did not receive any of the doses ordered. During a record review for Resident #19, conducted on , revealed that Resident #19 had went to the hospital on and returned to the Facility with new orders for medications and the Facility failed to attempt to obtain the new orders from the Pharmacy or follow the directions of the new orders. The new orders for 2mg as needed for smoking cessation; 150mg take one capsule three times every day; and 75mg take two tablets every day were not noted on Resident #19's MORs. Resident #19 had been sent to the hospital for exacerbation in , signs and symptoms and returned for the new orders. There was no evidence found that the orders were sent to Pharmacy or that the Facility had attempted to obtain the new orders for Resident #19. There was no evidence provided that the Facility had notified Resident #19's Health Care Provider for further instructions. During an interview with the Administrator, conducted on , the Administrator agreed that the medications appeared not have been given to Residents #1, #5. #9, and #13 and could not provide evidence that the residents were receiving their prescribed medications for . The Administrator was unable to provide evidence that Resident #1,	{A 056}		

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{A 056}	Continued From page 4 #5, #9, #13, and #19s' Health Care Providers were notified that the residents were not receiving their prescribed medications. Class III	{A 056}		
{A 058} SS=D	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III	{A 058}		

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{A 058}	Continued From page 5 deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to correct class III deficiencies related to medications as required.	{A 058}		

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{A 058}	Continued From page 6 Findings Included: During a third Revisit to 08/20/19 Complaint Investigation, conducted on 01/03/2020, revealed that the Facility failed to correct Class III medication deficiencies and failed to follow the recommendations of their licensed Pharmacist Consultant. Due to the uncorrected Class III deficiencies concerning the facility's medication practices, the facility will be required to employ the consultation services of a licensed Pharmacist or a Registered Nurse. The consultant shall at a minimum, provide onsite quarterly consultation until the inspection team from the Agency determines that such consultation services are no longer required. This written statement and serves as notification of the above stated requirement. Class III	{A 058}		
{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 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	{A 078}		

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{A 078}	Continued From page 7 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 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.	{A 078}		

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{A 078}	Continued From page 8 (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 review and interview, the facility failed to ensure that a communicable statement was completed for 2 out 6 (Staff A and C) employees sampled. Findings included: An employee record review was conducted on , Staff A (hired) and Staff C (hired) did not have evidence of a completed communicable statement by a health care provider in their files. An interview was conducted with the Administrator on at 2:47 PM. The Administrator confirmed the missing information. Class III	{A 078}		
{A 093} SS=D	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and	{A 093}		

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{A 093}	Continued From page 9 available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.	{A 093}		

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{A 093}	Continued From page 10	{A 093}		

2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.
(d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.
(e) Therapeutic diets must be prepared and served as ordered by the health care provider.
1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.
2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.
(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the

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{A 093}	Continued From page 11 purposes of [redacted], the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on [redacted]. (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on [redacted] at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to substitute menu items with foods of comparable nutritional value and failed to maintain a six-month log of substitutions noted before or when meals were served (Substitution Log). Findings included: A dining and food service review was conducted on [redacted]. A review of the menu for this date showed that the meal included baked French fries, zucchini/tomato, lemon pudding, and cornbread. The meal was observed at 11:30 AM on [redacted] and the food items served were ham and cheese sandwiches, turkey and cheese sandwiches, potato salad, and chicken noodle soup. There was no observation of a substitution	{A 093}		

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{A 093}	Continued From page 12 for the registered dietitian approved zucchini/tomato vegetable side dish. Staff E was interviewed on at 3:49 PM concerning the lunch meal. Staff E acknowledged that there was no substitution provided for the zucchini/tomato approved for the lunch meal. Staff E also provided a copy of the Substitution Log with the first entry only dating . . . to . Staff E stated that the facility did special meal substitutions every month.	{A 093}		
{A 123} SS=D	429.27( ) FS; 58A-5.021(2) FAC Fiscal - Resident Trust Funds 429.27 (3) A facility, upon mutual consent with the resident, shall provide for the safekeeping in the facility of personal effects not in excess of $500 and funds of the resident not in excess of $500 cash, and shall keep complete and accurate records of all such funds and personal effects received. If a resident is absent from a facility for 24 hours or more, the facility may provide for the safekeeping of the resident's personal effects in excess of $500. (4) Any funds or other property belonging to or due to a resident, or expendable for his or her account, which is received by a facility shall be trust funds which shall be kept separate from the funds and property of the facility and other residents or shall be specifically credited to such resident. Such trust funds shall be used or otherwise expended only for the account of the resident. At least once every 3 months, unless upon order of a court of competent jurisdiction, the facility shall furnish the resident and his or her guardian, trustee, or conservator, if any, a complete and verified statement of all funds and	{A 123}		

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{A 123}	Continued From page 13	{A 123}		

other property to which this subsection applies, detailing the amount and items received, together with their sources and disposition. In any event, the facility shall furnish such statement annually and upon the discharge or transfer of a resident. Any governmental agency or private charitable agency contributing funds or other property to the account of a resident shall also be entitled to receive such statement annually and upon the discharge or transfer of the resident.
(5) Any personal funds available to facility residents may be used by residents as they choose to obtain clothing, personal items, leisure activities, and other supplies and services for their personal use. A facility may not demand, require, or contract for payment of all or any part of the personal funds in satisfaction of the facility rate for supplies and services beyond that amount agreed to in writing and may not levy an additional charge to the individual or the account for any supplies or services that the facility has agreed by contract to provide as part of the standard monthly rate. Any service or supplies provided by the facility which are charged separately to the individual or the account may be provided only with the specific written consent of the individual, who shall be furnished in advance of the provision of the services or supplies with an itemized written statement to be attached to the contract setting forth the charges for the services or supplies.

58A-5.021
(2) RESIDENT TRUST FUNDS. Funds or other property received by the facility belonging to or due a resident, including personal funds, must be held as trust funds and expended only for the resident's account. Resident funds or property may be held in one bank account if a separate

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{A 123}	Continued From page 14	{A 123}		

written accounting for each resident is maintained. A separate bank account is required for facility funds; co-mingling resident funds with facility funds is prohibited. Written accounting procedures for resident trust funds must include income and expense records of the trust fund, including the source and disposition of the funds.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to maintain accurate records for personal funds held in trust for one (Resident #15) of eleven resident records reviewed.

Findings included:

An interview was conducted with the Administrator at 11:37 AM on . . . . . concerning resident trust funds. The Administrator stated that funds were disbursed twice a month to residents. The Administrator stated that some residents ask the facility to provide them with cigarettes and 7 dollars is taken out of their personal funds twice a month to cover the cost. He stated that residents that were provided with cigarettes received a $20.00 twice monthly and those residents that did not get cigarettes received $27.00 twice monthly.

An interview was conducted with Resident #15 at 12:32 PM on . . . . . and she stated that she only received $20.00 twice monthly. She stated that she did not smoke and did not know why she did not receive $27.00 twice monthly. A review of the resident trust fund log dated . . . . . showed that Resident #15 was only given $20.00 (photographic evidence obtained).

An interview was conducted with the Administrator at 4:14 PM on . . . concerning

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{A 123}	Continued From page 15 resident trust fund disbursements to Resident #15, who was not provided with cigarettes by the facility. The Administrator could not explain why Resident #15 did not receive the full $27.00 due twice monthly. There was no evidence presented concerning written consent from Resident #15 to justify not providing her with the required $27.00 twice monthly. Class III	{A 123}		
{A 152} SS=D	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [illegible] to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, or other furniture designed for storage of clothing or personal effects; 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and	{A 152}		

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{A 152}	Continued From page 16 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, clean, and decent living environment with mechanical and structural systems in good working order. Findings included: A tour of the facility was conducted on beginning at 9:15 AM. The pool in the rear of the property was observed containing dark green water (photographic evidence obtained). According to the website www.plumbingnerds.com, water of this nature promotes growth, insect breeding, and provides watering sources for vermin that carry and spread waste. Three resident bathrooms with showers were observed and all three contained shower mats that were covered in black dirt marks (photographic evidence obtained). The Administrator stated shortly entering the facility at 9:00 AM that he had not yet corrected the issue with the water in the pool. The	{A 152}		

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{A 152}	Continued From page 17 Administrator was interviewed at 9:37 AM on concerning the facility's physical environment and mechanical systems. The Administrator stated that the employee time clock was still not working and a washing machine was not operational as it required a new solenoid. The observations concerning the dirty shower mats was also discussed with the Administrator and he stated that he would replace them. The same shower mats were present prior to exiting the facility at 5:35 PM. Class III	{A 152}		
{A 200} SS=D	58A-5.036 FAC Emergency Environmental Control (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less	{A 200}		

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than twenty (20) net square [illegible] per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the [illegible] to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S., and subsection 58A-5.026(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained.
2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code.
3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve [illegible] temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment.
a. An assisted living facility in an evacuation zone

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pursuant to Chapter 252, F.S., must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary.
b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan.
c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage.
(b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage.
1. Facilities must store minimum amounts of fuel onsite as follows:
a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite.
b. A facility with a licensed capacity of 17 or more

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beds must store 72 hours of fuel onsite.
2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S., that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency.
3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule.
4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel.
(c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility.
(d) The acquisition and maintenance of a monoxide alarm.
(2) SUBMISSION OF THE PLAN.
(a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously submitted and approved pursuant to Emergency Rule 58AER17-1, F.A.C., will require resubmission only if changes are made to the plan.
(b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining

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{A 200}	Continued From page 21 a license. (c) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than	{A 200}		

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{A 200}	Continued From page 22 . . . , ..., have implemented the plan required under this rule. (b) The Agency shall allow an extension up to . , . . to providers in compliance with subsection (c), below, and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to Section 120.542, F.S. (c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of paragraph (1)(a), for a minimum of ninety-six (96) hours. 1. An assisted living facility not located in an evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the assisted living facility, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite. 2. An assisted living facility located in an evacuation zone pursuant to Chapter 252, F.S., must either:	{A 200}		

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{A 200}	Continued From page 23 a. Fully and safely evacuate its residents prior to the arrival of the event, or b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted living facility. (d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including:	{A 200}		

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{A 200}	Continued From page 24 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and, 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, F.S., or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN.	{A 200}		

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{A 200}	Continued From page 25 (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a), above, in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain enough fuel onsite to operate its emergency power source for the required amount of time, acquire an operating monoxide detector, and notify residents and resident representatives in writing of implementation of its emergency environmental control plan (EECP).	{A 200}		

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{A 200}	Continued From page 26 Findings included: A review of the facility's EECP was conducted on . The Administrator was interviewed at 1:45 PM and he stated that there was only enough fuel maintained onsite to fuel the emergency power source for 20 hours. The Administrator was asked if the facility had a monoxide detector and he stated that he was not aware of having one. The Administrator was asked to provide proof that residents and resident representatives were notified in writing of implementation of its EECP. The Administrator was unable to provide proof of this written notification. Class III	{A 200}		
{A 000}	Initial Comments A second revisit to complaint investigation (Complaint Numbers 2019008264 and 2019012291), a biennial survey with Limited Mental Health, a fifth revisit to complaint investigation (Complaint Number 2019002873), and a revisit to complaint investigation (Complaint Number 2019013833) was conducted at American Well Care Assisted Living Facility on . Deficiencies were identified at the time of survey.	{A 000}		
{A 054} SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the	{A 054}		

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	AL11966321	A. BUILDING: _____ B. WING _____	R 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN WELL CARE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 054}	Continued From page 27 resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to immediately update Medication Observation Records (MORs) when medications were offered or given to a resident and failed to maintain MORs with all required data, including but not limited to resident's Health Care Provider's name and telephone number for seven residents (#5, #7, #12, #13, #16, #17, and #19) of seven sampled residents that required assistance with self-administration of medications. Findings Included:	{A 054}		

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{A 054}	Continued From page 28 A MORs review for Resident #5, conducted on , revealed that Resident #5 had a prescribed order on for 4mg that was not noted on the resident's MORs. A MORs review for Resident #7, conducted on , revealed that Resident #7's MORs did not contain Resident #7's Health Care Provider's name and telephone number as required. A MORs review for Resident #12, conducted on , revealed that Resident #12's MORs did not contain Resident #12's Health Care Provider's name or telephone number as required. Resident #12's MORs did not have documentation that the resident received her prescribed 0.5mg/3ml on at 12:00pm, at 06:00pm, and at 06:00am. Resident #12's prescribed 100units/ml inject 5 units every day for twelve days was written on and continued, on the resident's MORs. Resident #12's prescribed medication 4mg for the resident to take as needed, did not have a reason noted for the resident to take the medication. A MORs review for Resident #13, conducted on , revealed that Resident #13's MORs did not have documentation that the resident received the prescribed medication 20mg on at 08:00am. Resident #13's prescribed medication 50mcg/inhaler aerosol for the resident to to take as needed, did not have a reason noted for the resident to take the medication. Resident #13 had prescribed medications 250mg and 600mg for an	{A 054}		

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{A 054}	Continued From page 29 and these medications were not noted as to give to Resident #13 on the resident's MORs. A MORs review for Resident #16, conducted on , revealed that Resident #16's MORs did not contain Resident #16's Health Care Provider's name or telephone number as required. A MORs review for Resident #17, conducted on , revealed that Resident #17's MORs did not contain Resident #17's Health Care Provider's name or telephone number as required. Resident #17's prescribed medication , 0.0005% was not documented as given to the resident on , and at 08:00am. Resident #17's prescribed medication , ended on and continued on Resident #17's MORs as a current and active order. A MORs review for Resident #19, conducted , revealed that Resident #19's MORs did not contain Resident #19's Health Care Provider's name or telephone number as required. Resident #19's prescribed medication , for the resident to take as needed, did not have a reason noted for the resident to take the medication. Resident #19's prescribed medication , , was not documented as given to the resident on at 08:00am. Resident #19's prescribed medication 2mg , as needed was not noted on the resident MORs. Resident #19's , , was not documented as given to the resident on at 08:00am. During an interview with the Administrator, conducted on at 03:30pm, the Administrator agreed that Residents #5, #7, #12,	{A 054}		

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{A 054}	Continued From page 30 #13, #16, #17, and #19 had medications not noted on their MORs and their MORs did not contain all required data, including but not limited to the residents' Health Care Provider's name and telephone numbers. Class III	{A 054}		
{A 055} SS=D	58A-5.0185(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of	{A 055}		

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{A 055}	Continued From page 31 medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 58A-5.0181, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family,	{A 055}		

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{A 055}	Continued From page 32 or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to dispose of centrally stored expired medications within thirty days as required for two Residents (#7 and #21) of two sampled resident that had expired medications. Findings Included: During a medication reconciliation audit, conducted on , revealed that the Facility did not dispose of expired medications appropriately for Residents #7 and #21 appropriately and within thirty days as required. The Facility had Resident #7's expired prescribed medication on and in use and the medication had expired on . The facility had Resident #21's expired and discontinued medication in the medication room refrigerator and the medication had expired on .	{A 055}		

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{A 055}	Continued From page 33 During an interview with Staff E, conducted on [redacted], Staff E stated that there was no other available for use for Resident #7. During an interview with the Administrator, conducted on [redacted], the Administrator observed and agreed that the for Resident #7 and the for Resident #21 had expired and that it was greater that thirty days since expiration of both medications. Class III	{A 055}		