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
	AL11969278	A. BUILDING: _____ B. WING _____	01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL SEASONS IN NAPLES	15450 TAMIAMI TRL N NAPLES, FL 34110

(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 #2019018966 & #2019019580 was conducted on through at All Seasons in Naples, an assisted living facility in Fort Myers, Florida. Complaint #2019018966 & 2019019580 were substantiated . The following is description of the deficiency.	A 000		
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;	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 follow physician's orders for the medication , a medication used to treat imbalance, for 7 (Resident #7, #, 12, #13, #15, #16, #17, and #18) out of 7 residents reviewed. The facility failed to follow policies and procedures for medication error. Failure to follow policies and procedures for medication error led to an additional medication error for Resident #15. Resident #15 did not receive medication from to . The findings included: 1. Resident #7 had a physician's order for 75 micrograms (mcg) dated . Resident #7 missed medication the following days: , , , , , , , /2019 and then , up to and including . A total of 21 missed dosages of medications. The regional director of	A 056		

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A 056	Continued From page 3 operations/administrator/practical nurse (RDO/LPN) faxed a note to the physician on . She did not provide the correct missed dosages. The administrator RDO/LPN indicated missed dosages from to . She did not notify next of kin. No follow up labs found on record. 2. Resident #12 had an order for , 50 mcg dated . Resident #12 missed the medication , 50 mcg , , , to and including . The administrator/RDO/LPN notified via fax resident's physician on . The record review found no evidence of notification of next of kin. 3. Resident #13 had an order for 125 mcg of , once daily dated . The administrator/RDO/LPN found Resident #13 missed medication from to . The administrator/RDO/LPN faxed a note on to the resident's physician identifying the medication error and asking for new orders. There was a progress note on record indicating notification of next of kin or legal representative. The administrator/RDO/LPN said on at 11:35 a.m. she had a brief conversation with Resident #13's legal guardian on the phone, but did not document. The administrator/RDO/LPN said the legal guardian took the resident to her physician sometime in . Resident #13's physician ordered labs on . Labs on record dated indicated results elevated -stimulating hormone ( ) of 30.24. The administrator/RDO/LPN said Resident #13's legal guardian called the Department of Children's and Families (DCF) when she saw the results. She said DCF came	A 056		

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A 056	Continued From page 4 to investigate the complaint and as far as she know the case was closed. She did not provide specific days. On at 2:00 p.m., Executive Director (ED) said he did not have a grievance related to Resident #13. He said he was aware Resident #13 missed medications for few days, but the administrator/RDO/LPN was responsible and handled specifics related to DCF investigation. He said he was present at the time of the conversation but did not recall the specifics. 4. Resident #15 had a physician's order dated for , 137 mcg one before breakfast. This medication was prescribed due to resident having a , . Resident #15 was not given medication , , , or . The Resident was not given medication from up to and including . Per the medication observation record (MOR), the resident was given only one dosage on . The medication was not given from to . On at 10:00 a.m., the administrator/RDO/LPN said she changed the time of medication administration from 6:00 a.m. at 7:00 p.m. She did not know why there were no more entries since and she was going to look and find out what happened. She said I think I accidentally missed one of the pages of the MOR. On at 10:26 a.m., the administrator/RDO/LPN said the order was accidentally discontinued in the system the day she changed the time and Resident #15 did not receive additional medications. She said she was the one that accidentally discontinued the medication. She said a resident nurse practitioner (NP) comes in the facility monthly. They give her a current medication list every time she comes. Said she did not understand how the	A 056		

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A 056	Continued From page 5 NP missed it. She said she notified the resident's NP. She said the NP ordered labs as soon as possible. In an interview with Resident #15's NP on at 12:11 p.m., she said she was not made aware until today ( ) Resident #15 was not taking her prescribed medication. She said she ordered labs. The NP said she was not given electronic access by the facility while on premises and had very few resources while she was there. The NP said she was concerned Resident #15 did not receive her medication as prescribed. She ordered labs STAT (as soon as possible) and as soon as she reviewed them she will order changes on the direction of medication. Lab results dated indicated high -stimulating hormone ( ) results of 7.844 and low free thyroxin ( ) of 0.69. The administrator/RDO/LPN was asked if the resident's medication was still on premises. In an interview with the administrator/RDO/LPN at 12:15 p.m., she stated the facility does not have or use reconciliation forms when medications are delivered, she stated the pharmacy delivers the medications around 11:00 a.m., to the nurses station and gives them to the nurse on duty at the time, and leaves. She stated if there are being delivered, there is documentation for accepting the medications, all discontinued medications or medications not being used are returned to the pharmacy for credit to the resident/family representative, and the facility does not keep any documentation to show the medication was returned. 5. Resident #16 had a physician's order for 50 mcg dated for . The MOR review found Resident #16 missed medication on the following dates: , ,	A 056		

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A 056	Continued From page 6 . . . . , ... , ... and from . . . . . to . . . . . The administrator/RDO/LPN notified Resident #16's physician via fax with inaccurate information since she said Resident #16 missed 15 dosages when Resident #16 missed a total of 20 dosages. She did not receive any new orders from the resident's physician. 6. Resident #17 had an order dated . . . . . , for . . . . 50 mcg once daily. Resident #17 had a diagnosis of . . . . Review of the MOR found Resident #17 missed the following dosages: . . . . . , ... , ... , ... , ... , then from . . . . to . . . . . Missed 20 dosages. The administrator/RDO/LPN notified Resident #17's physician with inaccurate information since she said Resident #17 missed only 15 dosages when Resident #17 missed a total of 20 dosages. 7. Resident #18 had a physician's order dated . . . . . for . . . . . 75 mcg. MOR record review for Resident #18 found the resident missed the following dosages: . . . . & . . . . Resident #18 missed medications from . . . . . to and including . . . . . Then she missed again . . . . and . . . . . Resident #18 missed a total of 17 dosages. The administrator/RDO/LPN faxed a note to Resident #18's physician on . . . . . , indicating the resident missed a total of 18 doses from . . . . to . . . . . She did not notify the next of kin. 8. On . . . . . at 9:58 a.m., the administrator/RDO/LPN said she did not notify next of kin for any of the 7 residents. She just notified their corresponding physicians and only one physician responded to her. She said she just changed the time to 7:00 a.m. for all residents. She said the overnight nurse left	A 056		

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A 056	Continued From page 7 without a notice. She said when the overnight nurse was working all residents received their medication at 6:00 a.m. When she quit without notice she notified the previous director of nursing (DON). She said she told the previous DON to modify the time to 7:00 a.m. for all residents receiving . . . , . . . since they did not have another overnight nurse to cover for the one that left. She said the DON left without notice two weeks after that conversation. She said when the DON left administrator/RDO/LPN conducted a medication review and found the error. The administrator/RDO/LPN said she changed the time of administration to 7:00 a.m. The administrator/RDO/LPN said she did not conduct additional audits to ensure medication orders were followed and medications were given to residents. 9. Per facility policy in place, the facility is to conduct an investigation when a medication error occurs. Per policy the facility is to develop a plan of correction after the medication error occurs. Per policy a medication error report is to be completed. After reviewing the medication error, the director is to determine appropriate follow up and document in the resident's record and notify the resident's family or responsible party. The resident will be placed on alert charting. On at 1:30 p.m., the administrator/RDO/LPN confirmed she did not follow the facility's policy and procedure related to medication error. Class III	A 056		