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
	AL11969348	A. BUILDING: _____ B. WING _____	02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TESSERA OF BRANDON	1320 OAKFIELD DR BRANDON, FL 33511

(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 Biennial Re-licensure and a Complaint Investigation (Complaint Numbers: 2019018474, 2019019772, and 2020001257) were conducted at Tessera of Brandon on .... Deficiencies were identified at the time of survey.	A 000		
A 010 SS=D	429.26(&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility. (9) A , ill resident who no longer meets	A 010		

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A 010	Continued From page 1 the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care	A 010		

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A 010	Continued From page 2 provider, the resident must be discharged from the facility. (c) A [redacted], ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C.	A 010		

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A 010	Continued From page 3 This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the Facility failed to obtain a -to- health assessment by a health care provider after a significant change in condition necessitated admission to Hospice services; the Facility failed to obtain an interdisciplinary care plan ( ), which specified the services provided by Hospice and those provided by the Facility and agreed upon by Hospice, the Facility, and the resident (or Responsible Party) for one Hospice Resident (#6) of two sampled Hospice residents. Furthermore, the Facility failed to obtain services necessary for medication administration for one Resident (#15) that required medication administration. Findings Included: During an observation of the medication pass with Staff B (an unlicensed Medication Technician) for Resident #15, conducted on at 09:13am, Staff B assisted Resident #15 with the residents 08:00am medications. A record review for Resident #15, conducted on , revealed that Resident #15 required medication administration according to Resident #15's health assessment form dated . A record review for Resident #6, conducted on , revealed that Resident #6's most recent health assessment form dated did not state that the resident required the nursing services of Hospice. Resident #6 did not have a Hospice admission form or consent form in his record. Resident #6 did not have an order or an authorization for hospice services in his record from a health care provider. Resident #6 did not	A 010		

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A 010	Continued From page 4 have an . that specified the services provided by Hospice and those provided by the Facility and agreed upon by Hospice, the Facility, and the resident (or Responsible Party). It was noted in Resident #6's record that the resident was bedridden on . During an interview with the Administrator, conducted on . at 08:45am, the Administrator identified Resident #6 as one of three residents admitted to Hospice services. The Administrator stated that the Facility employed unlicensed Medication Technicians to assist with medications. At 01:25pm, the Administrator and the Health and Wellness Director agreed that Resident #6 did not have an admission or consent form or and authorization from a health care provider for Hospice services. The Administrator and the Health and Wellness Director agreed that there was no stipulation on Resident #6's health assessment form that the resident required the nursing services of Hospice. The Administrator and the Health and Wellness Director agreed that Resident #15's health assessment form stated that the resident required medication administration. Class III	A 010		
A 052 SS=D	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	A 052		

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A 052	Continued From page 5 prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (h) Using a to perform - level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the prescribed 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 bags. (4) Assistance with self-administration does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid	A 052		

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A 052	Continued From page 6 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 , of the body. (d) Administration of , preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) , , or , preparations. (g) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (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	A 052		

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A 052	Continued From page 7 procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's 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	A 052		

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A 052	Continued From page 8 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the Facility failed to ensure proper assistance with self-administration of medications according to the required steps in 429.256 Florida Statutes as the unlicensed Medication Technician did not pop pills out of medication packs in front of residents or read the medication label to the resident for four Residents (#9, #13, #14, and #14) of four sampled residents that required either assistance with self-administration of medications or medication administration. Findings Included: During an observation of the medication pass with Staff B for Residents #13, #14, and #15 and Staff H for Resident #9, conducted on , Staff B and Staff H did not read	A 052		

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A 052	Continued From page 9 medication labels to the residents or pop pills out of medication packs in front of the residents. At 08:56am, Staff B assisted Resident #13 with , 81milligrams (mg) and 10mg. Resident #13 was in her own room with the door closed. Staff B popped out the pills from the medication packs at the medication cart and placed the medication packs in the medication cart and carried the cup of pills into Resident #13's room. Staff B did not read the medication labels to the resident. At 09:13am, Staff assisted Resident #15 with , 650mg, 25mg, , 25mg, 100mg, , 12.5mg, 1.5mg, and 0.4mg. Staff B popped the pills out of the medication packs in front of the resident. However, Staff B did not read the medication labels to Resident #15 and stated, "here's your medications". At 09:20am, Staff B assisted Resident #14 with 100mg, , 200mg, , 2.5mg, 1000micrograms, 28mg, Olanza/ , 10milliequivaent, and 0.4mg. Resident #14 was in his own room with the door closed. Staff B popped out the pills from the medication packs at the medication cart and placed the medication packs in the medication cart and carried the cup of pills into Resident #14's room. Staff B did not read the medication labels to the resident. At 09:36am, Staff H popped Resident #9's medications into a med cup. Resident #9 was not present at the medication cart and was in the resident's own room with the room door closed. Staff H carried the medication cup of pills into Resident #9's room and did not have the resident's medication packs and was unable to read the medication labels to Resident #9.	A 052		

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A 052	Continued From page 10 During an interview with the Administrator and Health and Wellness Director, conducted on at 01:25pm, both agreed that unlicensed Medication Technicians must follow their training and pop pills out of medication packs in front of the residents and read medication labels out loud to the residents Class III	A 052		
A 054 SS=D	59A-36.008(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 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	A 054		

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A 054	Continued From page 11 medication as prescribed, or medication errors. (c) For medications that serve as chemical [redacted], 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 record review and interview, the Facility failed to ensure that Medication Observation Records (MORs) were accurate and free from errors for two Residents (#14, and #15) of four sampled Residents who required either assistance with self-administration of medication or medication administration. Findings Included: A review of MORs for Resident #14, conducted on [redacted], revealed that there were duplications of medications on Resident #14's MORs related to an overlap of start and end dates with medication order changes, which made it appear as the resident was overdosed on medications, which are as follows: - [redacted] 0.4milligrams (mg) take one capsule by [redacted] every day was documented as given at 08:00am on [redacted] before the order ended; it was also documented, on the same date, as given at 10:00am when the new order started - [redacted], 200mg take one tablet by [redacted] twice every day was documented as given on [redacted] at 08:00am before the order ended; it was also documented, on the same date, as given at 10:00am and 05:00pm when the new order started - [redacted], 2.5mg take one tablet by [redacted] twice every day was documented as given at 08:00am on [redacted] before the order ended; it was also	A 054		

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A 054	Continued From page 12 documented, on the same date, as given at 10:00am and 05:00pm when the new order started - Olanza/ 3-25mg take one capsule by . . . . every day was documented as given at 08:00am on before the order ended; it was also documented, on the same date, as given at 10:00am when the new order started - . . . . . Emilio take one tablet by every day was documented as given at 08:00 am on . . . . . before the order ended; it was also documented, on the same date, as given at 10:00 am when the new order started - Alsatian 100 mg take one tablet by every day was duplicated on the Morse and documented as given both doses on and . . . /202 at 08:00 am and 10:00 am A review of Morse for Resident #15, conducted on , revealed that there was a duplication of a medication on Resident #15's Morse, which made it appear as the resident was overdosed on the medication Reinvestigation 1.5 mg, take one tablet every day. This medication was duplicated and documented as given on at 08:00 am and 05:fpm. During an interview with the Administrator and Health and Wellness Director, conducted on at 01:2, both agree of the errors and duplication of medications on Resident #14 and #15's Morse. Class III	A 054		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS.	A 056		

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A 056	Continued From page 13 (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 the resident's health care provider. The new directions must promptly be recorded in the	A 056		

Agency for Health Care Administration

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	AL11969348	A. BUILDING: _____ B. WING _____	02/13/2020

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A 056	Continued From page 14 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., before dispensing any sample or complimentary prescription drug, the resident's health care	A 056		

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A 056	Continued From page 15 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 provide prescribed medications as ordered from resident's health care providers and failed to notify their health care providers when residents refused their medications and were not receiving their medications due to the unavailability, refusals, or was away from the Facility to receive their medications for four Residents (#7, #12, #14, and #15) of four sampled resident that required either assistance with self-administration of medications or medication administration. Findings Included: During an interview with Resident #12's health care provider, conducted on at 10:49am, the health care provider stated the Facility did not make Resident #12's health care provider aware that the resident was not taking his prescribed medications in which the resident nearly had to have surgery due to a severe impaction as a result of not taking medication to counteract . . . . . A MORs review for Resident #7, conducted on , revealed that Resident #7 had medications not given and the Facility had no evidence that Resident #7's health care provider was notified that the resident was not receiving the prescribed medications. . . . . . / . . . . . Hydrofluoroalkane Inhaler 80/4.5milligram (mg) was documented as not given to the resident on . . . . . , , and at 08:00am due to	A 056		

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A 056	Continued From page 16 the medication was "not available". 100mg was documented as not given on at 05:00pm due to the resident refused and on at 05:00pm due to the medication was "not available". , 2% was documented as not given to the resident from through at 05:00pm due to "not available". , 325mg was documented as not given to the resident on at 11:00pm due to "refused". There was no evidence found that Resident #7's health care provider was notified that the resident was not receiving the medications as prescribed. A MORs review for Resident #12, conducted on , revealed that Resident #12 had a medication and a treatment not given and the Facility had no evidence that Resident #12's health care provider was notified that the resident was not receiving the prescribed medication and treatment as ordered. Resident #12 had , ( ) checks prescribed for twice a day twice per week. The checks were due on , , & at 09:00am and 05:00pm. There was documentation on Resident #12's MORs that the resident did not receive the ordered checks as ordered due the resident's refusals. There was no evidence found that Resident #12's health care provider was notified that the resident was not receiving the checks as ordered. Resident #12 had a prescribed medication , 5mg take one tablet by every day if no movement in three days and to notify PCP (primary care physician) if no movement in one week. This medication was due every day from through at 06:00pm. There was no documentation if the medication was given or not give to the resident during the	A 056		

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A 056	Continued From page 17 specified time that the medication was ordered. There was no evidence of the need or no need to notify the resident's primary care physician, or health care provider. There was no evidence if the resident had a movement or not. During a medication pass observation with Staff B for Resident #14, conducted on at 09:20am, Staff B provided Resident #14's 08:00am medications late, which included 100mg, 200mg, 2.5mg, 1000micrograms, 28mg, Olanz/ 10milliequivalent, and 0.4mg. There were no orders or evidence that Resident #14's health care provider was aware that the resident had received prescribed medications late. A MORs review for Resident #15, conducted on , revealed that Resident #15 had medications not given and the Facility had no evidence that Resident #15's health care provider was notified that the resident was not receiving all of the resident's prescribed medications as ordered. 250mg and 650mg was documented as not given due to out of the Facility at 12:00pm. Powder was documented as not given on and at 08:00am due to unavailability. There was no evidence that the Facility made provisions for the resident to receive their medications when the resident was away from the Facility. There was no evidence that Resident #15's health care provider was notified that the resident did not receive prescribed medications as ordered. During survey on , Resident #15 received 08:00am medication at 09:13am, which was late. There were no orders or evidence that the resident's health care provider was aware that the resident had received	A 056		

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A 056	Continued From page 18 prescribed medications late, which included [illegible] 650mg, [illegible] 25mg, [illegible] 25mg, [illegible] 100mg, [illegible] 12.5mg, [illegible] 1.5mg, and [illegible] 0.4mg. During an interview with the Administrator and Health and Wellness Director, conducted on [illegible] at 01:25pm, both agreed that there was no evidence in Resident #7, #12, #14, and #15's record that the resident's health care providers were notified that they were not receiving prescribed medications as ordered. Class III	A 056		