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 _____	R 06/24/2020

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 revisit survey was conducted on [redacted] at All Seasons in Naples, an assisted living facility in Naples, Florida. This was a follow-up to the complaint survey completed on [redacted]. The following is description of the deficiencies found at the time of the visit.	{A 000}		
A 054	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 [redacted] 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.	A 054		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 054	Continued From page 1 (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 record review and staff interview, the facility failed to maintain a daily Medication Observation Record (MOR) for 5 (Residents #1, #2, #3, #4, and #18) out of 7 residents sampled who receive assistance with medication self-administration. The facility failed to maintain a chart for recording each time the medication is taken, any missed doses, refusal to take medications or medication errors. The facility failed to follow it's policy for "Medication Refusal and/or Missed Doses." On during survey, a MOR audit for month of through was conducted. The findings included Record Review: Resident #6 - Medication , ( ) was prescribed by a Health Care Provider (HCP) on : , 5 milligrams (mg), take one tablet by twice a day, scheduled at 8:00 a.m. and 9:00 p.m. Facility staff documented on the MOR medication notes: , 5 mg not given/not available on , , missing 2 doses each day and not given/not available and . On the MOR front sheet: facility staff did not sign their initials to document medication was given at 9:00 a.m., 9:00 p.m., and not documented on for the 9:00 p.m. dose. Resident #3 - Medication ( ) prescribed on : 100 units/milliliters (ml) KWIKPE- inject , per	A 054		

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A 054	Continued From page 2 three times a day. There was no documentation by facility staff was given on dates at 8:00 a.m., 1:00 p.m., and 8:00 p.m., and on at 8:00 a.m. Resident #18 - Medication (medication) prescribed by HCP on : 90 mg, one tablet by three times daily. Medication was not documented by facility staff as given on dates and at 7:00 p.m. Resident #1 - Medication prescribed by HCP on : instill one drop in each four times a day, scheduled 8:00 a.m., 1:00 p.m., 5:00 p.m., 8:00 p.m. There was documentation by the facility staff the medication was: "waiting on pharmacy" for dates . Resident #2 - Medication Gel (, medication) prescribed by HCP on : "Apply to areas with hematoma on right orbit, right upper extremity and right lower extremity once a day." There was no documentation medication was given on dates through and through . The medication was documented in the medication notes as "not available/not given" on dates , and . Interview with the Assisted Living (AL) Director on at 1:35 p.m., she reported she started auditing the Medication Observation Records (MORs) on and she became aware of medications not documented as given. She reported she has counseled 7 out of the 7 medication technicians (med techs) at the facility regarding medications. She reported she has been employed at the facility since . She reported the facility med techs were not notifying the nurse or the resident's family or health care	A 054		

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A 054	Continued From page 3 provider of missed medications. She reported the med techs were not following the facility policy on Medication refills and Medication Refusals and or Missed Doses. She reported she aware that part of her job description as the AL Director is, "To supervise a team that provides care services to residents." On [redacted] at 2:30 p.m., Staff D reported she has worked at the facility as needed (prn) and averages 3 - 12 hour shifts per week. She reported she has noted when the med techs give the residents their medications, the med techs do not use identifiers next to their initials on the MOR. Class III	A 054		
{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	{A 056}		

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{A 056}	Continued From page 4 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 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	{A 056}		

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{A 056}	Continued From page 5 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 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 make a reasonable effort to ensure residents' medications are refilled in a timely manner for 5 (Residents #1, #2, #3, #6, and #18) out of 7 residents sampled. The facility failed to follow their policy titled: "Medication Refills." The findings included: On during survey, a Medication Observation Record (MOR) audit for the month of	{A 056}		

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{A 056}	Continued From page 6 through was conducted. The findings included record review. Resident #6 - Medication , ( ) was prescribed by Health Care Provider (HCP) on : 5 milligrams (mg), take one tablet by twice a day, scheduled at 8:00 a.m. and 9:00 p.m. Facility staff documented on the MOR medication notes: , 5 mg not given/not available on , , missing 2 doses each day and not given/not available and . ON MOR front sheet , facility staff did not sign their initials to document medication was given , 9:00 a.m., 9:00 p.m., not documented on for 9:00 p.m. dose. Resident #3 - Medication ( ) prescribed on : 100 units/milliliters (ml) KWIKPE - inject , per three times a day. There was no documentation by facility staff was given on dates: at 8:00 a.m., 1:00 p.m., and 8:00 p.m. and at 8:00 a.m. Resident #18 - Medication (medication) prescribed by HCP on : 90 mg, one tablet by three times daily. Medication was not documented by facility staff as given on dates and at 7:00 p.m. Resident #1 - Medication prescribed by HCP on : instill one drop in each four times a day, scheduled 8:00 a.m., 1:00 p.m., 5:00 p.m., 8:00 p.m. There was documentation by the facility staff the medication was: "waiting on pharmacy" for dates , and . Resident #2 - Medication Gel (medication) prescribed by HCP on :	{A 056}		

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