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
	AL11969020	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDERMERE MEMORY CARE INC	7901 KIPLING ST PENSACOLA, FL 32514

(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 On , , through , , an unannounced state biennial survey was conducted at Windermere Assisted Living Facility located in Pensacola, Florida. A generator assessment and Focused Control survey were also conducted. Deficient practice was identified at the time of the survey.	A 000		
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 prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (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	A 052		

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A 052	Continued From page 1 storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a [illegible], including removing the cap of a [illegible], opening the unit dose of [illegible] solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the [illegible]. (h) Using a [illegible] to perform [illegible] level checks. (i) Assisting with putting on and taking off [illegible] stockings. (j) Assisting with applying and removing an [illegible] but not with titrating the prescribed [illegible] settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with [illegible] bags. (4) Assistance with self-administration does not include: (a) Mixing, [illegible], converting, or [illegible] medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a [illegible] of the body. (d) Administration of [illegible] preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with [illegible], or [illegible] preparations. (g) Assisting with medications ordered by the	A 052		

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A 052	Continued From page 2 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 the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (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 [illegible] or older, trained to assist with self administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and	A 052		

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A 052	Continued From page 3	A 052		

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
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

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A 052	Continued From page 4 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 [illegible] control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observations, staff interviews and resident medical record reviews, the facility failed to ensure staff followed self assistance with medications guidelines for 2 of 3 residents observed during assistance with self-administration of medication (Residents #1 and #2). Unlicensed staff were observed to assist with an [illegible] by dialing the dosage of [illegible], and there were no clear instructions regarding [illegible] testing frequency or parameters for physician notification (#2). Resident #1 was experiencing a medication side-effect of itching. There was no evidence of physician notification of the side effect and no medications on the medication observation record were documented to be given for itching (#1). The findings include: On [illegible] beginning at approximately 08:50 AM, observations of Staff Member D, a non-licensed healthcare worker, providing assistance with self-administration of medication was conducted. Staff Member D, assisted Resident #1 without concerns, however, after the resident took her medications she stood up and	A 052		

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A 052	Continued From page 5 began to scratch incessantly at her . Staff Member D stated that the the resident takes makes her itch for several hours. Following the above observation, a medical record review was conducted for Resident #1. According to the 1823, a Resident Health Assessment (RAH), the resident had a diagnosis of and Resident #1 has orders for 25mg one capsule by three times daily as needed (no indication for use); cream 5% (an) with documentation to support it was last administered on ; and two additional prn (as needed) medications, and 25mg for agitation. The Medication Observation Record (MOR) indicated the resident had received 25mg at 4PM for what appears to be at least 16 out of 22 days thus far in . The electronic MOR identified as an ( ). This medication also has properties and is commonly used for itching. There was no documentation in the record or on the MORS to indicate that the resident requested the medication and/or for what reason. On at approximately 11:15 AM, Staff Member D was interviewed and asked about the and cream. Staff member D stated that the resident gets the for , and that the resident will ask for the medication. When asked how she knows to give and not or , she didn't have an answer. She stated that the resident had not had cream in a long time, she has not administered it and it was discontinued on .	A 052		

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A 052	Continued From page 6 On [redacted], at approximately 9:00 AM, Staff Member D stated that Resident #2 requires an Accu-check and gets [redacted]. Staff D called Resident #2 into the medication room to inform her that it was time for her [redacted] check and medications. The Resident was handed a push-button safety lancet. With the assistance of Staff D, the resident was guided to the middle [redacted] of her left [redacted] and was able to depress the lancet. Staff Member D then applied a sample of [redacted] from the [redacted] onto a test strip and inserted the test-strip into the [redacted]. The [redacted] read = 556 (significantly elevated, per the Center for Control a fasting [redacted] level of 80-130 before a meal or below 180, 2 hours after a meal would be normal.) Staff Member D stated she would have to call the doctor. Resident #2, was then handed an [redacted], that had been dialed to the correct dose by the Staff Member, and with staff member assistance guided the resident to her upper left [redacted]. The staff member held the [redacted], in place, and the resident pressed the button to release the [redacted]. Following the observation of above, a medical record review was conducted for Resident #2. Resident #2 has a primary diagnosis of "[redacted]." The resident's most recent "1823," Resident Health Assessment (RHA) form, dated [redacted] was marked that "the individual needs help with taking his or her medications (meds) and 'Needs Assistant with Self Administration'." The RHA also indicated the resident should receive [redacted] monitoring in the am (morning) and pm (evening). A review of the facility's 'order , received from Guardian Pharmacy, indicates "Accu-check once daily (resident does, staff to observe and	A 052		

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A 052	Continued From page 7 document)." The order failed to include a parameter of what is 'too high' or 'too low,' and when the physician should be notified. The order also failed to indicate that the Accu-checks should be performed in the morning and evening. A review of Resident #2's [illegible] reading from to , found only two [illegible] reading under 150. There was no documentation to support that the physician or family had been notified of high [illegible] readings. On at approximately 10:55 AM an interview was conducted with the Administrator, who also is a Licensed Practical Nurse. The Administrator stated that they don't have orders to indicate what staff are to do for high or low [illegible] levels and that they can't make a judgement on that. She stated she tries to educate her staff to look at behaviors. She was asked about a previous note located in the record related to an increase in [illegible] and for the resident to be sent to the Emergency Room, however the note was not dated. The Administrator stated the resident has not had any recent incidents related to her [illegible] levels, and that she was not aware of the significantly elevated [illegible] from the reading obtained at 9:03 AM (556 reading.) The Administrator, though an LPN, was not aware that she could act as a nurse in her current occupational capacity. On [illegible] at approximately 11:05 AM, Staff Member D stated she had been trying to reach the Nurse Practitioner about the resident's [illegible] level and was going to FAX the results. On at approximately 2:00 PM, a FAX	A 052		

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A 052	Continued From page 8 was presented from the physician's office, recommending that a [illegible] be performed 'before lunch' and 'before dinner' and if the [illegible] was still high, over 250, to give an additional 10 units of [illegible]. Staff Member D stated she had faxed this order to pharmacy and was awaiting to receive the order [illegible] from them. On [illegible] at approximately 2:45 PM a telephone interview was conducted with Resident #2's primary physician. The physician stated he was familiar with Resident #2 and that the last time he saw her was in [illegible] of last year (2019). He said he was trying to get someone else to see her, as there was "no way in the world I can take care of her the way she is." He stated that during his visits with the resident; medications are reviewed and that he has been the physician managing her [illegible]. He said he would consider a [illegible] reading of 150 fasting to be high for this resident and a low [illegible] reading would be under 80. He expected to be notified of high or low readings and that they [the facility] have notified him this past week, and that was the first time he could recall they have called him. He stated the resident has [illegible] and would not be able to call him herself. Class III	A 052		