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 |
|---|---|---|---|
| | AL11910842 | A. BUILDING: _____ B. WING _____ | R 11/04/2020 |

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| OAKS OF CLEARWATER, THE | 420 BAY AVENUE CLEARWATER, FL 33756 |

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| {A 000} | Initial Comments<br><br>A second Revisit to 02/12/2020 Complaint Investigation (Complaint Number: 2019019424), a Complaint Investigation (Complaint Number: 2020016861), and an Control Visit were conducted at the Oaks of Clearwater on . Deficiencies were identified at the time of survey. | {A 000} | | |
| {A 052} SS=D | 429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin<br><br>429.256<br>(3) Assistance with self-administration of medication includes:<br>(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.<br>(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.<br>(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 .<br>(d) Applying , medications.<br>(e) Returning the medication container to proper storage.<br>(f) Keeping a record of when a resident receives assistance with self-administration under this section.<br>(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 . | {A 052} | | |

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| {A 052} | Continued From page 1<br><br>(h) Using a ... to perform ...<br>level checks.<br>(i) Assisting with putting on and taking off<br>stockings.<br>(j) Assisting with applying and removing an<br>but not with titrating the<br>prescribed settings.<br>(k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device.<br>(l) Assisting with measuring vital signs.<br>(m) Assisting with bags.<br><br>(4) Assistance with self-administration does not include:<br>(a) Mixing, converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.<br>(b) The preparation of syringes for injection or the administration of medications by any injectable route.<br>(c) Administration of medications by way of a tube inserted in a of the body.<br>(d) Administration of preparations.<br>(e) Irrigations or debriding agents used in the treatment of a skin condition.<br>(f) , , or preparations.<br>(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.<br>(h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the | {A 052} | | |

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| {A 052} | Continued From page 2<br><br>reason for administration requires judgment or discretion on the part of the unlicensed person.<br><br>(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.<br><br>59A-36.008<br>(3) ASSISTANCE WITH SELF-ADMINISTRATION.<br>(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 procedures described in section 429.256, F.S. and this rule.<br>(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.<br>(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.<br>(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. | {A 052} | | |

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| {A 052} | Continued From page 3<br>(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:<br>1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,<br>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,<br>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<br>4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.<br>(f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S.<br>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.<br>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.<br>(g) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.<br><br>This Statute or Rule is not met as evidenced by: | {A 052} | | |

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| {A 052} | Continued From page 4<br><br>Based on observation, record review, and interview, the facility failed to ensure proper assistance with self-administration of medications according to the required steps in 429.256 Florida Statutes for three Residents (#9, #10, and #11) of three sampled residents that required assistance with self-administration of medications.<br><br>Findings Included:<br><br>During an observation of the medication pass with Staff D (unlicensed Medication Technician) for Residents #9, #10, and #11, conducted on , Staff D did not follow proper assistance with self-administration of medications according to the required steps in 429.256 Florida Statutes. At 12:05pm, Staff D assisted Resident #10 with the prescribed medication 5mg. Staff D did not compare the medication label to the Medication Observation Record. Staff D did not read the name or dose of the medication from the medication label to Resident #10. Staff D walked away before Resident #10 took the medication. At 12:09pm, Staff D assisted Resident #11 with the prescribed medication , 100mg. Staff D did not compare the medication label to the Medication Observation Record. Staff D did not read the name or dose of the medication from the medication label to Resident #11. Staff D walked away before Resident #11 took the medication. At 12:12pm, Staff D assisted Resident #9 with the prescribed medication HFA Inhaler and Inhaler with an Opti-chamber. There was no dose noted on Resident #9's Medication Observation Record and Staff D did not compare the medication label to the Medication Observation Record. Staff D did not read the name or dose of the medication from the medication label to Resident #9. Staff D did not wait the required five | {A 052} | | |

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| {A 052} | Continued From page 5<br>minutes between puffs of two different inhalers.<br><br>During an interview with the Assisted Living Manager and Assisted Living Charge Nurse, conducted on [redacted] at 04:24pm, both stated that is was their expectation the unlicensed Medication Technicians and licensed Nurse to compare medication labels to Medication Observation Records before giving a prescribed medication, to read the medication name and dose to the resident, and to observe residents take their medications. Both agreed that unlicensed Medication Technicians and licensed Nurses wait one minute between puffs of the same inhaler and five minutes between puffs of different inhalers and stated that the Facility should put this information onto the Medication Observation Records. Both stated that they would check Resident #9's Medication Observation Records to ensure the dosage was documented.<br><br>Class III | {A 052} | | |
| {A 056} SS=D | 59A-36.008(7) FAC Medication - Labeling and Orders<br><br>(7) MEDICATION LABELING AND ORDERS.<br>(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:<br>1. The resident's name; and,<br>2. The identification of each medicinal drug in the | {A 056} | | |

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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 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

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| {A 056} | Continued From page 7 | {A 056} | | |

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 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 reviews and interviews, 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 meds and were not receiving their meds due to the unavailability of the meds for five Residents (#3, #6, #8, #13, and #15) of six sampled

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| {A 056} | Continued From page 8<br><br>residents that required assistance with self-administration of medications.<br><br>Findings Included:<br><br>During an interview with Resident #5, conducted on [redacted] at 11:34am, Resident #5 stated that she had run out of her medications twice while residing in the Facility.<br><br>During an interview with Resident #6, conducted on [redacted] at 11:50am, Resident #6 stated that the Facility did not give his medications on time.<br><br>During an interview with Resident #8, conducted on [redacted] at 02:26pm, Resident #8 stated that the staff wake him up during the night to give him medications at 12:00am and 05:00am and he has not medications ordered at that time and thinks they give him his roommates medications. Resident #8 stated that he does not take the medications and that the Staff do not watch him take the medications. Resident #8 reached in his pocket and pulled out a handful of medications from his pocket - see photographic evidence.<br><br>A Medication Observation Record review for Resident #3, conducted on [redacted], revealed that Resident #3 had medications not given as ordered. Resident #3's prescribed [redacted] 5/325mg take one tablet by [redacted] every four hours on [redacted] was given at 12:55pm and 04:32pm and on [redacted] it was given at 12:09pm and 03:28pm, which was less than every four hours order. Resident #3 refused the prescribed [redacted] 20 MeQ at 12:00pm on [redacted], and [redacted]. There was no evidence found that Resident #3's health care | {A 056} | | |

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| {A 056} | Continued From page 9<br><br>provider was notified that the resident was not receiving prescribed medications as ordered.<br><br>A Medication Observation Record review for Resident #6, conducted on . . . . . , revealed that Resident #6 had medications not given as ordered. Resident #6's prescribed . . . . . 10mg was documented as not given due to "waiting on delivery" at 08:00pm on . . . . . , , , , , . . . . . , . . . . . , . . . . . , and and was documented as given at 08:00pm on . . . . . and . . . . . when the medication was not available to give. Resident #3's prescribed . . . . 1000mcg was documented as not given due to "waiting on delivery" at 08:00am and 04:00pm on . . . . and . . . There was no evidence found that Resident #6's health care provider was notified that the resident was not receiving prescribed medications as ordered.<br><br>A Medication Observation Record review for Resident #8, conducted on , revealed that Resident #8 had medications not given as ordered. Resident #8's prescribed 24mcg was documented as not given due to "waiting on delivery" on at 08:00am, at 08:00am, . . . . . at 08:00am and 08:00pm, and at 08:00am and was documented as given on . . . . . at 08:00pm and at 08:00pm when the medication was not available to give. Resident #8's prescribed 20mg was documented as not given due to "waiting on delivery" at 08:00am and 04;00pm on , , . . . . . , and . . . . . There was no evidence found that Resident #8's health care provider was notified that the resident was not receiving prescribed medications as ordered. | {A 056} | | |

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| {A 056} | Continued From page 10<br><br>A Medication Observation Record review for Resident #13, conducted on . . . . . , revealed that Resident #13 had medications not given as ordered. Resident #13's prescribed 12% Cream was documented as not given due to "resident refused" from . . . . . through at 08:00am and 04:00pm. There was no evidence found that Resident #13's health care provider was notified that the resident was not receiving prescribed medications as ordered.<br><br>A Medication Observation Record review for Resident #15, conducted on . . . . . , revealed that Resident #15 had medications not given as ordered. Resident #15's prescribed , 600mg was documented as not given due to "waiting on delivery" at 08:00am and 12;00pm on , , and . There was no evidence found that Resident #15's health care provider was notified that the resident was not receiving prescribed medications as ordered.<br><br>A review of the Pharmacist Consultant report dated , conducted on , revealed that the Facility continued to have issues with re-ordering medications on time so that resident did not have to go without their prescribed medications.<br><br>During an interview with the Assisted Living Manager and Assisted Living Charge Nurse, conducted on at 04:24pm, both agreed that there continued to be ongoing issues with medication re-ordering and that it was hopeful that the issues would be rectified when the Facility began automatic medication refills with the pharmacy on . . . . . . The Assisted Living Manager stated that it was doubtful that | {A 056} | | |

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| {A 056} | Continued From page 11<br><br>Resident #3, #6, #8, #13, and #15's health care providers were notified that they did not receive their medications as prescribed. No documented evidence of notifications provided.<br><br>Class III | {A 056} | | |
| A 058 SS=D | 429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies<br><br>429.42 Pharmacy and dietary services.-<br>(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.<br>(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.<br><br>58A-5.033(3)<br>(3) EMPLOYMENT OF A CONSULTANT.<br>(a) Medication Deficiencies. | A 058 | | |

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| (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 058 | Continued From page 12<br><br>1. If a class I, class II, or uncorrected class III 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.<br>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.<br>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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the Facility failed to ensure documented class III deficiencies regarding medicinal drugs were corrected as required. | A 058 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11910842 | A. BUILDING: _____ B. WING _____ | R 11/04/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OAKS OF CLEARWATER, THE | 420 BAY AVENUE CLEARWATER, FL 33756 |

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|---|---|---|---|---|
| A 058 | Continued From page 13<br><br>Findings Included:<br><br>A second Revisit to 02/12/2020 Complaint Investigation (Complaint Number: 2019019424), conducted on 11/04/2020, revealed that the Facility continued with uncorrected and recited Class III medication deficiencies.<br><br>During an interview with the Assisted Living Manager and the Assisted Living Charge Nurse, conducted on at 04:24pm, both verbalized understanding that the Facility was required to continue to employ or contract, as previously cited on and Complaint Investigations, with the consultative services of a licensed Pharmacist or a licensed Registered Nurse Consultant to provide medication oversite and that the consultant services at a minimum must provide onsite quarterly consultation until the Inspection Team from the Agency determines that such consultative services are no longer required.<br><br>Class III | A 058 | | |