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
	AL11968636	A. BUILDING: _____ B. WING _____	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS SENIOR LIVING AT NEW TAMPA, LLC	14712 N 42ND ST TAMPA, FL 33613

(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 re-licensure survey was conducted at Angels Senior Living at New Tampa on [redacted]. The provider had deficiencies at the time of the survey.	A 000		
AL243 SS=D	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and	AL243		

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AL243	Continued From page 1 must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy	AL243		

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AL243	Continued From page 2 of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide 6 hours of limited mental health (LMH) training to 2 (Staff B & C) of 3 direct care staff plus the administrator, who were reviewed for LMH training within six (6) months of hire. The administrator and staff who have direct contact with mental health residents in a licensed limited mental health facility must receive the LMH training. Findings included: Record review on of Direct Care Staff B's personnel file revealed there was no certificate in the file regarding 6 hours of completed LMH training within six (6) months of hire. Staff B was hired on . The LMH training should have been done by . Record review on of Direct Care Staff C's personnel file revealed there was no certificate in the file regarding 6 hours of completed LMH training within six (6) months of hire. Staff C was hired on . The LMH training should have been done by Record review on of the Administrator's personnel file revealed there was no certificate in the file regarding 6 hours of completed LMH training within six (6) months of hire. The administrator was hired on . The LMH	AL243		

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AL243	Continued From page 3 training should have been done by [redacted]. The administrator on [redacted] at 2:00 pm verified Staff B and Staff C and herself did not have the completed 6 hours LMH training certificates which were required within 6 months of hire in their files. Class III	AL243		
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 [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		

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A 054	Continued From page 4 (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 interview, the Facility failed to maintain Medication Observation Records (MORs) free of omissions and errors and failed to update the MORs immediately each a medication was offered for four Residents (#7, #16, #17, and #18) of four sampled residents that required assistance with self-administration of medications. Findings Included: A record review for Resident #7, conducted on , revealed that Resident #7's prescribed , 2.5milligrams (mg) was not documented as given to the resident on at 05:00pm (See Photographic Evidence2). A record review for Resident #16, conducted on , revealed that Resident #16's prescribed Cream was incorrectly transcribed onto the resident's MORs. The 0.1% Cream was ordered twice per day from through and on the ordered medication was prescribed for once per day. Resident #16's MORs continued with the twice per day order and was documented as given twice per day on through , through , through , and (See Photographic Evidence2).	A 054		

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A 054	Continued From page 5 A record review for Resident #17, conducted on , revealed that Resident #17's prescribed 50mg was not documented as given to the resident on at 08:00pm (See Photographic Evidence2). A record review for Resident #18, conducted on , revealed that Resident #18's prescribed , 25mg was not documented as give to the residents on at 08:00pm (See Photographic Evidence2). During an interview with the Administrator, conducted on at 02:25pm, the Administrator after reviewing Resident #7, #16, #17, and #18 MORs agreed that Residents #7, #17, and #18 had medications not documented as given to the residents. The Administrator agreed that Resident #16's prescribed was incorrectly transcribed onto the resident's MORs. Class III	A 054		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the	A 055		

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A 055	Continued From page 6 medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such	A 055		

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A 055	Continued From page 7 staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the Facility failed to keep centrally	A 055		

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A 055	Continued From page 8 stored medications in a locked cart and secured at all times in the memory Care unit. Findings Included: During observations of the memory care unit, conducted on . . . . . at 10:26am, the medication cart was parked in the hallway adjacent to the dining room. The medication cart was unlocked and there was no staff present (See Photographic Evidence1). There were thirteen memory care residents sitting at the dining table nearby. At 10:46am, Staff D approached the medication cart to assist one resident with cigarettes and locked the medication cart at that time. At 12:20pm, Staff D walked away from the unlocked medication cart to wash her . Staff D left the medication cart keys on top of the medication cart. Staff D was away from the unsecured medication cart for four minutes. A review of the medication storage policy and procedures, conducted on , revealed that the medication storage policy and procedures stated that medications were to be locked/secured at all times. During an interview with the Administrator, conducted on at 11:12am, the Administrator stated that medication carts were to be locked and secured at all times when staff were not present. Class III	A 055		