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
	AL11964280	A. BUILDING: _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA MANOR AT DAYTONA BEACH, LLC	252 FOREST LAKE BLVD DAYTONA BEACH, FL 32119

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A 000	Initial Comments A re-licensure survey with complaint survey (complaint numbers 2020015502 and 2020018549) and control visit was conducted at Magnolia Manor at Daytona Beach on and . The provider had deficiencies at the time of the visit.	A 000		
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 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	A 056		

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A 056	Continued From page 1	A 056		

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 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

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A 056	Continued From page 2 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 ensure medications were filled in a timely manner for 2 of 3 sampled residents. (Resident # 1, 7) The findings include: Record review for Resident #1 revealed she was admitted on . . . . . Her diagnoses included: like activity, multiple , 's . . . . . , ... and . . . . . . Facility records showed that on . . . . . , she was observed with like activity and transferred to the hospital. She returned the same day with new orders to increase . , , (medication) to 1500 mg every 12 hours and new order for , 500 mg ( ) 3 times a day for 7 days. Review of the Medication Observation Record (MOR) revealed there was a new order entered on . . . . . for . . . . . 500 mg every 8 hours x 7 days and to increase . , , 1500 mg (3 tabs	A 056		

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A 056	Continued From page 3 500 mg) every 12 hours for . . . . Further review revealed the medications were not available on . . . . . for the 3pm and 11pm dose. Photographic evidence obtained. An interview was conducted with the Wellness Director (WD) on . . . . . at 1:58pm. She was asked what the protocol was for medications that were not received when ordered; she said the pharmacy would be notified. During an interview with Resident #7 conducted on . . . . . at 9:30 am, she said there were times when her medications were out for days, including her . . . . . , ... medication which was out for a week, about 2 weeks ago. Review of the MOR for revealed an order for . . . . . 50 mg (. . . . ,) twice daily. Further review found there were missed doses on . . . . . at 9 am and 5pm and 9 am dose on . The reason documented was that is was not delivered by the pharmacy. There was also an order for D 3 5000 units daily. The medication was not documented as given from /20. The reason given was that it was not delivered by the pharmacy. Photographic evidence obtained. An interview was conducted with the WD on . . . . . at 1:55pm. She was asked to review the MOR for Resident # 7. She was asked if Resident #7 received VitD3 5000 units daily from . . . . -7th. After review she confirmed the medication was not given and reason being that medication was not delivered by pharmacy. She was asked if Resident #7 missed any doses of . . . . . 50 mg twice daily, after review she said there were missed doses on . . . . at 9 am and 5pm and 9 am dose on . The	A 056		

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A 056	Continued From page 4 reason documented not delivered by pharmacy. When asked what the protocol was when medications were not received timely, she said the Medication Technicians (MT) were to report to her or Resident Care Coordinator (RCC) for follow up and call the pharmacy. If it happens over the weekend the MT was to notify the on-call person so the pharmacy can be notified. When asked if she had been notified of the missed medications, she said she was not made aware. Review of the facility policy "Medication management" revealed: medications refills will be obtained in a timely manner to ensure residents have all physician ordered medication available, the designated staff person contacts the dispensing pharmacy to obtain refill at least seven days prior to running out, medications are never allowed to run out unless directed by physician. Class III	A 056		
A 083	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National	A 083		

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A 083	Continued From page 5 Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on employee record review, review of the facility schedule, and staff interview, the facility failed to ensure one staff member working in the facility at all times was trained in ( ) and First Aid for 9 employees (Employee A, B, C, G, H, I J, K and L) therefore putting the health and safety of the 34 residents that reside in the facility at risk. The findings include: A random sample of one employee from each shift at the facility was selected for record review. Record review of the employee file for Employee A working the 7:00 AM to 3:00 PM shift, Employee B working the 3:00 PM to 11:00 PM and the 11:00 PM to 7:00 AM shift and Employee C working the 11:00 PM to 7 AM shift found no evidence the three employees had training in and First Aid. During an interview with the Administrator on at 11:25 AM, he was notified the three employees did not have evidence of and first aid in their employee files. During a follow-up interview with the Administrator	A 083		

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A 083	Continued From page 6 on . . . . . at 11:25 PM, when looking for the and First Aid training for the employee he discovered that not all of the employee at the facility had and First Aid training and so he called yesterday and scheduled someone to do training at the facility today. He stated he could not provide for Employee A, B and C and did not have a way to show there was an employee in the facility at all times with . and First Aid. A review of the facility schedule for the period of time from . . . . . /2020 and /2020 and the documentation provided by the Administrator on . . . . . at 11:25 PM of the staff that had training in and First Aid revealed the facility did not have staff working the 7:00 AM-3:00 PM shift on with First Aid and . training. The employees were Employee G, H, I and J. The facility also did not have staff working the 3:00 PM to 11:00 PM shift on , and scheduled to work that shift on . . . . . and . . . . . . The facility did not have staff working the 11:00 PM to 7:00 AM shift with First Aid and . working on and scheduled to work on . . . . . The employees were B, C J, K, L. Photographic evidence obtained Class III	A 083		
A 084	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed	A 084		

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A 084	Continued From page 7 persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , and dosage forms;	A 084		

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A 084	Continued From page 8 b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , , rate, temperature, and , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have	A 084		

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A 084	Continued From page 9 successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure 2 of 2 sampled employees providing assistance with self-administration of medication completed the required training prior to assisting with self-administration of medication at the facility. (Employee B and C) The findings include:	A 084		

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A 084	Continued From page 10 Record review of the employee file for Employee B (hired) found no evidence of training in providing assistance with self-administered medications. Record review of the employee file for Employee C (hired) found evidence of 2 hour training on assistance with self-administration of medication on . There was not other training in the employee file for assistance with self-administration. During an interview with the Administrator on at 1:35 PM, he was notified of the missing training. He stated would look for the evidence of the training. On at 3:54 PM, the Administrator was asked again for evidence of the training for Employee B and C. He stated he was still trying to locate the training. During further interview with the Administrator on at 1:10 PM, he stated he did not have any evidence of current Assistance in Self-Administration of Medication training for Employee B and C. A review of the facility schedule found Employee B worked as a Med Tech during the 11:00 PM to 7:00 AM shift on . A review of the facility schedule for through found Employee B worked as a Med Tech on the 11:00 PM to 7:00 AM shift on , ,/12/13, and . A review of the medication observation record (MOR) for Resident #7 found Employee B signed she gave Resident #7 her 9:00 PM dose of 80 milligrams (MG) and , 25 MG tablet on although she was on the schedule for a resident	A 084		

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A 084	Continued From page 11 care assistant that shift. A review of the MOR for Resident #17 revealed Employee B signed she gave Resident #17 her 10:00 PM ER 20 milliequivalent (MEQ) medications on , and and her 6:00 AM , 88 microgram(MCG) tablet on , and . A review of the current facility schedule revealed Employee C was on the schedule to work as the only Med Tech on and and scheduled to work on as a Med Tech. A review of the schedule for the period of /2020 found Employee C worked as a Med Tech during the 11:00 PM to 7:00 AM shift on . Further review of the MOR for Resident #17 found Employee C initialed she gave Resident #17 her 6:00 AM , 88 MCG tablet on , , , , , , , , , and and gave Resident #17 all of her 11:00 AM medications on . Photographic evidence obtained Class III	A 084		