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 01/08/2021

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

(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 third revisit to complaint investigation (complaint number: 2019019424) and a COVID-19 focused 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 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, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container. (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 storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (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 . (h) Using a to perform -	{A 052}		

AHCA Form 3020-0001

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

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{A 052}	Continued From page 1 level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the prescribed 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 bags. (4) Assistance with self-administration does not include: (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. (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 of the body. (d) Administration of preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) , , or preparations. (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. (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	{A 052}		

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{A 052}	Continued From page 2	{A 052}		

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 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

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{A 052}	Continued From page 3	{A 052}		

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 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 control policy and procedures when assisting with the self-administration of medication.

This Statute or Rule is not met as evidenced by:
Based on observation and interview, the Facility

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{A 052}	Continued From page 4 failed to ensure proper assistance with self-administration of medications according to the required steps in 429.256 Florida Statutes for four Residents (#1, #2, #3, and #4) of four sampled residents that required assistance with self-administration of medication. Findings Included: During an observation of the medication pass with Staff A (unlicensed Medication Technician) for Residents #1, #2, #3, and #4, conducted on . . . . . , beginning at 12:05pm the following was observed: * At 12:05pm, Staff A assisted Resident #1 with the prescribed medication . . . . , 100milligram (mg) and did not tell the Resident #1 the dosage of the medication. * At 12:08pm, Staff A assisted Resident #2 with the prescribed medication , 500mg and did not tell Resident #2 the dosage of the medication. * At 12:10pm, Staff A assisted Resident #3 with the prescribed medication . . . . 5mg and did not tell Resident #3 the dosage of the medication. * At 12:15pm, Staff A assisted Resident #4 with . . . . . Hydrofluoroalkane and . . . . , Inhaler with an Opti chamber. Staff A did not compare the medication labels to the Medication Observation Record and did not read the name or dose of the medications to Resident #4. * Staff A administered the two inhalers and did not wait the required timeframe of five minutes between puffs of two different inhalers.	{A 052}		

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{A 052}	Continued From page 5 During an interview with the Administrator, conducted on [redacted] at 01:00pm, the Administrator stated that the expectation was for unlicensed Medication Technicians to compare medication labels to the Medication Observation Records before giving a prescribed medication and read the medication name and dose to the residents. The Administrator agreed that unlicensed Medication Technicians should wait five minutes between puffs of different inhalers. Class III	{A 052}		
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	A 054		

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A 054	Continued From page 6 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. (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 seven Residents (#4, #5, #6, #8, #10 and #12) of seven sampled residents. Findings Included: A review of Resident #4's MORs, conducted on , revealed that Resident #4's prescribed medication Hydrofluoroalkane and Inhalers did not have the dosages of the medications. A review of Resident #5's MORs, conducted on , revealed that Resident #5's prescribed medication / , 10-325mg take one tablet by every four hours was not documented as given on and at 12am and 4am. Resident #5's prescribed medication 10mg was documented as given even though the medication was not available on and at 08:00am and on at 12:00pm.	A 054		

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A 054	Continued From page 7 A review of Resident #6's MORs, conducted on , revealed that Resident #6's prescribed medication was noted on the MORs three times. One stated for 145mcg take one capsule every day and two were for 72mcg take one capsule every day. All three were signed as given from through . Resident #6's prescribed medication , was noted on the MORs twice and both stated 600mg take one tablet three times every day and both were signed as given every day from through . Resident #6's prescribed medication -S was noted on the MORs twice. One stated 8.6-50mg take two tablets at bedtime and the other take two tablets twice every day. Both were signed as given every day from through . Resident #6's prescribed medication ProAir Hydrofluoroalkane did not have the dosage of the medication. A review of Resident #8's MORs, conducted on , revealed that Resident #8's prescribed Hydrofluoroalkane did not have the dosage of the medication. Resident #8's was noted on his MORs as 6.25mg take one tablet twice every day and his pill bottle stated 12.4mg take two tablets twice every day. Resident #8's , was noted on his MORs as 1mg take one tablet twice every day and his pill bottle stated , 0.5mg take one tablet twice every day. Resident #8's 60mg was documented as given on and even thought the medication was not available to give. Resident #8's prescribed medication , 2.5mg take one tablet every day was ordered on and not noted on the resident's MORs.	A 054		

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A 054	Continued From page 8 A review of Resident #10's MORs, conducted on , revealed that Resident #10's prescribed medication 5mg as needed did not have the reason to provide the medication. A review of Resident #12's MORs, conducted on , revealed that Resident #12's prescribed medication Inhaler did not have the dosage of the medication. Resident #12's prescribed medication 5mg as needed did not have the reason to provide the medication. During an interview with the Administrator, conducted on , while reviewing Residents #4, #5, #6, #8, #10, and #12 MORs, the Administrator agreed that medications were missing dosages, staff signed medications as given when the medications were not available, staff did not immediately update MORs when medications were given, medication labels did not match MORs, and as needed medications did not have the reasons to provide the medications. Additionally, the Administrator agreed that there were duplications of medications on Resident #6'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	A 055		

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A 055	Continued From page 9 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 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	A 055		

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A 055	Continued From page 10 located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such 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	A 055		

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A 055	Continued From page 11 pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the Facility failed to keep centrally stored medications locked and secured at all times. Findings Included: During an observation of the third floor Memory Care Unit's medication cart, conducted on at 12:00pm, the medication cart was not locked, and the medication cart were left in the medication cart lock. There was no staff present. During an observation of the nursing office in , conducted on at 3:20pm, the office door was wide open. There was no staff present in the nursing room office. There were medication lying out on the counter tops in the outer office. See photographic Evidence1, 2, and 5. There was an inner office that the door was closed but not locked. There were many medications in the inner office that were lying on the counters. See photographic Evidence3 and 7. There was no staff present in the inner office. During a telephone interview with the Administrator, conducted on at 03:37pm, the Administrator stated that she would come to the nursing office immediately. The Administrator arrived at 03:42pm and there continued to be no other staff present. The Administrator stated that medications were to be locked and secured at all times when there was no staff present. The Administrator agreed that there was no staff present upon her arrival to the nursing office.	A 055		

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A 055	Continued From page 12 Class III	A 055		
{A 056} SS=D	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 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	{A 056}		

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{A 056}	Continued From page 13 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 kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed,	{A 056}		

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	AL11910842	A. BUILDING: _____ B. WING _____	R 01/08/2021

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{A 056}	Continued From page 14 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 residents' health care providers; failed to notify their health care providers when the residents did not receive their medications as prescribed due to the unavailability of the medications or the refusals of the medications; and, failed to fill or refill prescriptions in a timely manner for eight Residents (#5, #6, #7, #8, #9, #10, #11, and #13) of six sampled residents that required assistance with self-administration of medications. Finding Included: During an interview with Resident #10 and the family of Resident #11, conducted on at 01:50pm, Resident #10 and Resident #11's family member stated that they were having trouble with medications, specifically, their medications were given late and sometime did not come or were the wrong medications. During an interview with Resident #5, conducted on at 01:55pm, Resident #5 stated that he received his 07:00am medications at 10:00am. During an interview with Resident #6, conducted	{A 056}		

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{A 056}	Continued From page 15 on [redacted] at 02:00pm, Resident #6 stated that she received her morning medications at 10:00am. At 03:50pm, Resident #6 stated that she does not receive her prescribed medications on time. During an interview with Resident #8, conducted on at 03:45pm, Resident #8 stated that the Facility does not give medication on time and they kept running out of prescribed medications for residents. During an observation of Resident #8's medications, conducted on at 02:26pm, Resident #8's prescribed medication 325milligram (mg) and 10mg was not in the medication cart. Resident #8 had a pill bottle labeled , 2.5mg take one tablet every day ordered on [redacted]. During an interview with Staff C (an unlicensed Medication Technician), conducted on at 02:30pm, Staff C stated that Resident #8 received his 08:00am medications late today because Staff C was behind in giving medications. A review of Resident #5's Medication Observation Record, conducted on [redacted], revealed that Resident #5 did not receive his prescribed [redacted] 10mg on [redacted] and [redacted] at 12:00pm and 08:00pm and on at 08:00am and 08:00pm and on [redacted] at 08:00am due to the unavailability of the medication. A record review for Resident #5, conducted on , revealed that there were no notifications to Resident #5's health care provider that he was not receiving prescribed medications	{A 056}		

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{A 056}	Continued From page 16 as ordered. A review of Resident #6's Medication Observation Records, conducted on , revealed that Resident #6 received her morning medications at 09:37am. A review of Resident #6's Medication Observation Records, conducted on , revealed that Resident #6's 20mg take one tablet every twelve hours was given less than twelve apart. On , Resident #6 was given 20mg at 10:40am and 07:43pm. On , Resident #6 was given 20mg at 09:00am and 08:00pm. A review of Resident #6's Count Log, conducted on , revealed that Resident #6's 10mg was documented as given on at 08:00am and 11:00am, which was less than the prescribed directions of use for every four hours. See photographic Evidence5. A review of Resident #7's Medication Observation Records, conducted on , revealed that Resident #7 did not receive the prescribed medication 5mg on at 06:00am, 02:00pm, and 10:00pm and on at 02:00pm due to the unavailability of the medication. Resident #7 did not receive the prescribed medication 1000mg on at 08:00am due to the unavailability of the medication. Resident #7 did not receive the prescribed medication 15mg on at 10:00pm, at 02:00pm and 10:00pm, and at 02:00pm due to the unavailability of the medication. A review of Resident #8's Medication Observation Records, conducted on , revealed that	{A 056}		

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{A 056}	Continued From page 17 Resident #8 did not receive his prescribed 325mg on , , , , , , at 08:00am and 04:00pm and at 04:00pm due to the unavailability of the medication. Resident #8 did not receive his prescribed medication 60mg on , , , , and at 08:00am due to the unavailability of the medication. Resident #8 did not receive his prescribed medication 10mg on , , , , and at 08:00pm due to the unavailability of the medication. Resident #8 did not receive his prescribed medication 80mg on , , , , and at 08:00am due to the unavailability of the medication. Resident #8 did not receive his prescribed medication 300mg on at 08:00am and 12:00pm and at 08:00am due to the unavailability of the medication. Resident #8 did not receive his prescribed medication Polymix B/ , , Solution on at 08:00am and 12:00pm, at 04:00pm and 08:00pm, at 12:00pm, 04:00pm, and 08:00pm, and at 04:00pm due to the resident's refusal of the medication. Resident #8's prescribed , 2.5mg take one tablet every day was not on his Medication Observation Records. A record review for Resident #8, conducted on , revealed that there were no notifications to Resident #8's health care provider that he was not receiving prescribed medications as ordered. Resident #8's prescribed , 2.5mg was ordered on .	{A 056}		

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{A 056}	Continued From page 18 A review of Resident #13's Medication Observation Record, conducted on , revealed that on at 09:00am Resident #13 refused the prescribed medications 12% Cream, 25mg, , 5mg, , 125mg, 10GM/15ml Solution, , 0.5mg, 5mg, One Daily , 50mg, and 500mcg. At 02:00pm, the Facility documented that they gave Resident #13 his prescribed , 0.5mg on at 02:00pm and documented the medication as "given late". On , Resident #13 refused the prescribed medications 25mg, , 125mg, , 10mg, and , 7.5mg. A record review for Resident #13, conducted on , revealed that there were no notifications that Resident #13's health care provider was notified that the resident was not taking his medications as prescribed. There was no order to give Resident #13 his prescribed , 0.5mg at 02:00pm instead of the ordered time 08:00am on . A review of the licensed Pharmacist Consultant Visit report dated , conducted on , revealed that there were two unnamed residents did not receive medications due to the unavailability of the medications and continued to have ongoing medication issues. A review of the Facility's Master Medication Pass Times, conducted on , revealed that the seventh floor was scheduled to receive their 08:00am medication as early as 07:00am and not later than 09:00am. See photographic Evidence4.	{A 056}		

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{A 056}	Continued From page 19 A review of the missed, early, or late documentation report with the Administrator, conducted on . . . . . , revealed that Resident #6 received her medications at 09:37am. It appeared that the entire seventh floor received their morning medications after 09:00am, which included Resident #9. During an interview with the Administrator, conducted on at 02:32pm, the Administrator confirmed that Resident #6 and #9 received their 08:00am medications after 09:00am. The Administrator stated that based on the scheduled medication pass times, the entire seventh floor received their morning medications late. The Administrator stated that the Facility's expectation was for residents to receive their medication up to an hour before the scheduled dose or up to an hour after the scheduled dose. At 04:09pm, the Administrator agreed that there was no evidence that the Facility notified residents' health care providers that they were not taking medications as prescribed. The Administrator agreed that medication with specific timeframes should be given at the specified hours. Class III	{A 056}		
{A 058} SS=D	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (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 058}		

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{A 058}	Continued From page 20 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. (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. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 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. 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	{A 058}		

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{A 058}	Continued From page 21 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. 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. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to ensure documented class III deficiencies regarding medicinal drugs were corrected as required. Findings Included: A third revisit to complaint investigation (complaint number: 2019019424), conducted on , revealed that the Facility continued with uncorrected and recited Class III medication deficiencies and had newly cited medication deficiencies. During an interview with the Administrator, conducted on at 04:45pm, the Administrator verbalized understanding that the Facility was required to continue to employ or contract, as previously cited, with the consultative services of a licensed Pharmacist or a licensed Registered Nurse Consultant to provide medication oversite and that the consultant	{A 058}		

Agency for Health Care Administration

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{A 058}	Continued From page 22 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. Class III	{A 058}		