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
	AL11966016	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL OAKS MANOR	1833 SEMINOLE BLVD LARGO, FL 33778

(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 biennial re-licensure and a COVID-19 focused . . . . control suvey was conducted at Royal Oaks Manor on . Deficiencies were identified at the time of the survey.	A 000		
A 008 SS=D	429.26(.) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner ' s form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident ' s admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner ' s direct observation of the patient at the time of examination and must include the patient ' s medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident ' s admission to or continued residency in the facility. The medical examination form, reflecting the resident ' s condition on the date the examination is performed, becomes a permanent part of the facility ' s record of the resident and must be made available to the agency during inspection or	A 008		

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A 008	Continued From page 1 upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special	A 008		

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A 008	Continued From page 2 needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of , or any other communicable , which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and,	A 008		

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A 008	Continued From page 3 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S. (b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed. 1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider. 2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided. 3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823. (c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission.	A 008		

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A 008	Continued From page 4 (d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule. (f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida . . . . . Form, for residents who do not wish . . . . . to be administered in the case of or . (g) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by:	A 008		

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A 008	Continued From page 5 Based on record review and interview, the facility failed to maintain the signed and completed medical examination report from admission as a permanent part of the residents' record for one (Resident #8) of two sampled. Findings included: A record review conducted on . . . . . for Resident #8 with an admission date of , revealed that the completed medical examination that the facility received upon admission was not in his file. In an interview with the Manager conduct on at 3:30 PM, she confirmed that she did not have the original health assessment for Resident #8. She stated that she did not know you had to keep the original. Class III	A 008		
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.	A 056		

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A 056	Continued From page 6 (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 electronic copy of a signed order is acceptable.	A 056		

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A 056	Continued From page 7 (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 review and interview, the facility failed to ensure that prescriptions for residents who receive assistance with self-administration were filled or refilled in a timely manner for two (Resident #3 and #4) of four sampled. Additionally, the facility failed to provide assistance with self-administration of medication within the 2-hour window for one (Resident #3) of four sampled.	A 056		

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A 056	Continued From page 8 Findings included: In an interview conducted on at 9:47 AM, Resident #4 stated that he did not get his , last weekend on and . He stated he was not sure of the name of the drug but thought it was the . Record review of the , MOR conducted on for Resident #4 revealed the following medication were not available: * , 100 milligrams (MG) take 2 tablets 2 x daily o 12:00 PM and 5:00 PM dose not available * 300 (MG) take 1 capsule 2 x daily; 5:00 PM dose not given reason given is other o1-20-21 8 AM dose not available o1-22-21 8 AM dose not available o1-24-21 8 AM and 5 PM dose not available o1-25-21 8 AM dose not available o1-30-21 8 AM dose not available o1-31-21 8 am dose not available * 0.5 MG take 1 tab at bedtime 8:00 PM o1-23-24 and 8:00 PM dose not available * , 4 MG take 1 tab at bedtime for o1-23-21 and 8:00 PM dose not available *Polyethylene , Powder mix 17 grams with 8 ounces of water and drink daily at 8:00 AM	A 056		

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A 056	Continued From page 9 o1-24-21 not available o1-25-21 not available o1-30-21 not available o1-31-21 not available * 80 MG take 1 tablet at 8:00 PM o1-23-21 and not available * , 400 MG take 1 tab at bedtime 8:00 PM o1-23-21 and not available During a Medication Pass Observation conducted on at 12:05 PM Resident #3 asked for her noon dose of , and was told by the Manager that her medication was not in the drawer. The Manager explained that the prescription was written by the resident's primary care physician and a test needed to be taken before the order could be written. Record review of the Medication Observation Record (MOR) conducted on for Resident #3 revealed that , 5/325 1 tab at 8:00 am, 12:00 PM and 8:00 PM was not available on the following days: * 12:00 PM and 8:00 PM * 8:00 AM 12:00 PM and 8:00 PM * 8:00 AM 12:00 PM and 8:00 PM * 8:00 AM, 12:00 PM and 8:00 PM * 8:00 AM and 12:00 PM In an interview conducted on at 12:55 PM via phone call with the Pharmacist, he stated that the for Resident #3 was delivered on . In an interview with Staff A conducted on	A 056		

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A 056	Continued From page 10 at 1:10 PM, Staff A stated that medications were delivered from the pharmacy on at 6:00 PM. She took the bag of medication and put it in the office on the couch. She stated that the night shift organizes the medications and puts them away. In an interview with the Administrator conducted on at 1:11 PM, while holding the bag of medication delivered from the pharmacy the night before, she stated that she found the bag with Resident #3's medication in her office on the couch. Record review of the , MOR conducted on for Resident #3 revealed that the scheduled 12:00 PM dose of , 5/325 was given at 4:00 PM on , , , , , , , and . Interview with Staff A conducted on at 1:45 pm Staff A stated that Resident #3 does not want her , at noon as scheduled. Resident #3 takes the scheduled noon dose at 4:00 PM. Class III	A 056		