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 03/22/2021

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 fourth Revisit to the 02/12/2020 Complaint Investigation (# 2019019424), and a Complaint Investigation (#2021000485), in conjunction with a COVID-19 Focused . . . . . Control and generator monitoring visit were conducted at the Oaks of Clearwater on . . . . . , Deficiencies were identified at the time of the survey.	{A 000}		
{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,	{A 056}		

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{A 056}	Continued From page 1 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. (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	{A 056}		

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{A 056}	Continued From page 2 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 properly label and dispense medication based on provider's orders for two (Resident #2 and #8) of seven sampled residents. Additionally, the facility failed to notify the resident's health care providers when the resident did not receive their medications as prescribed due to the unavailability of the medications for one (Resident #2) of seven sampled residents that required assistance with self-administration of medications. Findings Included: In an observation conducted at 10:11am on . . . . . , an unlabeled . . . HFA (. . . . . 90mcg per actuation-200 Metered inhalation) inhaler was found lying on the table just inside the door to Resident #8's room. The door to Resident #8's room was open and the resident was not present. There was no medication box found for the inhaler and it was not labeled with the resident's name, medication	{A 056}		

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{A 056}	Continued From page 3 name or instructions for use. In an interview conducted on . . . . . at 10:11am with Staff G, she revealed that Resident #8 does not self-administer medications and she was not sure why the inhaler was in his room. During an observation of Resident #8 conducted on . . . . . at 10:14am, he stated to Staff G and the Administrator-Regional Liaison that if they took away the . . . inhaler from his room, he would need another one. In an interview conducted on at 10:11am with the Administrator-Regional Liaison, she stated Resident #8 should not have medications in his room and the inhaler should be locked up in the medication cart with his other medications. A review of Resident #8's medical record conducted on revealed an 1823 assessment dated . . . . . that revealed he requires assistance with self-administration, and no orders in the record for the . . . HFA (. . 90mcg per actuation-200 Metered inhalation) inhaler. In an interview conducted on . . . . . at 1:30pm with the Administrator-Regional Liaison revealed Resident #8 had no prior or current order for a HFA (. . 90mcg per actuation-200 Metered inhalation) inhaler. In an interview conducted on . . . . . at 11:00am with Resident #2 she revealed that she was not receiving her post-surgical . , medications as ordered for both of her , . In a review of Resident #2's medical record	{A 056}		

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{A 056}	Continued From page 4 conducted on , the 1823 Resident assessment dated revealed that the Resident requires assistance with self-administration of medication. A review of the MOR for Resident #2 conducted on at 11:30am revealed there were orders for 0.5% , solution, instill one drop in each twice daily , Prenisolone Acet 1% , suspension to instill one drop in each twice daily for four weeks (effective), then Presdnisolone Acet 1% suspension (effective) to instill one drop in each daily for two weeks and then discontinue. A review of the , 2021 MOR for Resident #2 conducted on revealed that the Resident did not receive the pm dose of 0.5% , solution on , , , , and and the am dose on and . Also, Resident #2 did not receive the Prenisolone Acet 1% suspension morning doses on , , and /021 and did not receive the evening doses on , , and ; Also Resident #2 did not receive the daily dose of Acet 1% on and . A review of Resident #2's medical record conducted on revealed no documentation that the provider was notified that the Resident did not receive the post-surgical as ordered. In an interview with the Administrator-Regional Liaison conducted on at 2:01pm, she	{A 056}		

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{A 056}	Continued From page 5 confirmed there was no documentation in the record that the provider was notified of Resident #2 not receiving the prescribed [illegible] (Photographic evidence obtained) Class III	{A 056}		