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
	AL11965589	A. BUILDING: _____ B. WING _____	03/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF ST CLOUD	3791 OLD CANOE CREEK RD SAINT CLOUD, FL 34769

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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 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	A 056		

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A 056	Continued From page 1 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, 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.,	A 056		

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A 056	Continued From page 2 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 resident record review and interview, the facility failed to ensure medications were refilled in a timely manner for 2 of 5 sampled residents (#3 & #5). Findings: 1) Review of the record for resident #3 revealed an admission date of . The health assessment was date and noted diagnoses including , , , ( ) and , . She required assistance with self-administration of medications. The health assessment listed 4 prescribed medications. 2.5mg, once daily (used for ,); DR 50mg, twice daily (for ,); 5mg, once daily (for ,); and , 40mg, once daily (for). Continued review of the record revealed a pharmacy prescription record dated listing the same 4 medications that were listed on the health assessment. Also found in the record was a medication reconciliation report dated from a hospital emergency room visit which listed the same 4 medications as on the admission health assessment. Review of the medication observation record (MOR) for , and listed 3 medications: , and , which were marked as refused all but 4 days in , and 3 days in . The MOR also listed , 325mg, twice daily, noted as being refused more	A 056		

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A 056	Continued From page 3 than half the time. . . . . and , . . . , ... were not listed on the MOR. There were no discontinue orders found for either medication. There was no order found for , . Observation of the medication cart at 1:50PM on found there was no , in the cart for resident #3, and no . . . . . or , , in the cart. There were no notes that the medications were requested, or that they contacted the physician to clarify the medication orders. (photographic evidence obtained) On at 2:00PM staff A and B (both unlicensed caregivers) stated they call for prescription refills when there are 5 days of medication remaining. They stated if there are no refills left, they call the physician. Staff A said she calls the pharmacy or the doctor. Staff B stated they never had or , , for resident #3. They said they do not have a place to document repeated attempts to obtain medications when they are out of stock. 2) Review of the closed record for resident #5 revealed an admission date of . The health assessment was dated . . . . . and included diagnoses of , , , , , , and . . . . . He required assistance with self-administration of medications. Review of the MOR for . . . . , revealed and "I" for all medications from . . . . evening doses through . . . . . The MOR showed (, reliever)50 mg, take 2 tablets every 8 hours, was circled on . . . . at 4:00PM, and all doses on and and noted on the . . . of the MOR as "out of stock, not given." , 400mg, take one tablet at 8PM for , , was circled on and and marked on the of the MOR as "out of	A 056		

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A 056	Continued From page 4 stock, not given." Continued review did not find any documentation that the facility had attempted to reorder the medications or contact the physician for a new prescription. (photographic evidence obtained) On . . . . at 2:00PM Staff A said the "I" notation indicated the resident was in the hospital. She said resident #5 did not return to the facility after he went to the hospital and that he on . . . . . She said their policy is to call for prescription refills when there are 5 days of medication remaining. She confirmed she did not have any documentation to show they had attempted to get his medication before they ran out. Class III	A 056		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with	A 152		

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A 152	Continued From page 5 the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a clean and safe living environment due to 1) carpet stains in a resident room, 2) sliding closet doors not installed properly, 3) dirty mattress stored in the staff break room. Findings: Observations during a tour of the facility with the activity director on between 9:00 and 10:00 AM found the following: 1) Carpeting in resident was stained throughout the room. 2) A dirty mattress was stored in the staff break room. It was observed standing on end directly behind the staff table and chairs.	A 152		

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A 152	Continued From page 6 3) Closet doors in multiple resident rooms in the 100 and 200 hallways were installed without a track on the lower edge of the sliding doors, allowing them to swing freely in and out of the closet, creating a safety hazard. On [redacted] at 10:00AM, the activity director confirmed the findings. She stated the facility had recently had a flood which required new flooring in most of the 200 hallway and perhaps the door tracks were not reinstalled after the new flooring was installed. She confirmed that some of the closets in the unaffected 100 hallway with carpeting also did not have tracks installed on the floor. She said she could not explain why the bed was stored in the break room. Class III	A 152		
A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's:	A 160		

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A 160	Continued From page 7 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [redacted]; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with [redacted]'s [redacted] or related [redacted], a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule	A 160		

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A 160	Continued From page 8 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a current and updated admission-discharge log. Findings:	A 160		

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A 160	Continued From page 9 Review of the census provided on . . . found the facility had 26 residents. The census listed each resident's admission date. Review of the admission/discharge log found the log was last updated on . The census showed 11 residents who have moved in since and who were not listed on the admission log. The log also listed former residents #4 and #5 as current residents. On at 11:05AM, the activity director confirmed the finding. Class III	A 160		
A 181 SS=D	59A-36.019(2) FAC Emergency Plan Approval (2) EMERGENCY PLAN APPROVAL. The plan must be submitted for review and approval to the local emergency management agency. (a) If the local emergency management agency requires revisions to the emergency management plan, such revisions must be made and the plan resubmitted to the local office within 30 days of receiving notification that the plan must be revised. (b) A new facility as described in Rule 59A-36.014, F.A.C., and facilities whose ownership has been transferred, must submit an emergency management plan within 30 days after obtaining a license. (c) The facility must review its emergency management plan on an annual basis. Any substantive changes must be submitted to the local emergency agency for review and approval. 1. Changes in the name, address, telephone number, or position of staff listed in the plan are not considered substantive revisions for the	A 181		

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A 181	Continued From page 10 purposes of this rule. 2. Changes in the identification of specific staff must be submitted to the local emergency management agency annually as a signed and dated addendum that is not subject to review and approval. (d) The local emergency management agency is the final administrative authority for emergency management plans prepared by assisted living facilities. (e) Any plan approved by the local emergency management agency is considered to have met all the criteria and conditions established in this rule. This Statute or Rule is not met as evidenced by: Based on facility record review and interview, the facility failed to obtain approval by the county Office of Emergency Management (OEM) for their comprehensive emergency management plan (CEMP) as required by 59A-36.019(2) FAC. Findings: Request to review the approval letter for the facility combined CEMP and EPP (Emergency Power Plan), found an approval letter from the county OEM dated . . . . , which documented the plan was approved through and was to be submitted annually. (photographic evidence obtained) On at 3:20PM, the activity director and the regional operations director confirmed they did not have any more recent approval documentation. Class III	A 181		

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A 000	Continued From page 11	A 000		
A 000	Initial Comments A Complaint investigation #2021004063 was conducted at Savannah Court of St. Cloud on . Deficiencies were identified at the time of the visit.	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	A 008		

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A 008	Continued From page 12	A 008		

facility ' s record of the resident and must be made available to the agency during inspection or 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,

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A 008	Continued From page 13 Department of Children and Families personnel shall explain to the facility operator any special 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 [illegible] 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 [illegible] 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 , [illegible] 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	A 008		

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A 008	Continued From page 14	A 008		

provider, the individual's needs can be met in an assisted living facility; and,
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

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A 008	Continued From page 15 administrator using AHCA Form 1823 within 30 days after admission. (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 [illegible] Form, for residents who do not wish [illegible] to be administered in the case of [illegible] or [illegible]. (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.	A 008		

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A 008	Continued From page 16 This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to ensure a complete and accurate health assessment was obtained for 2 of 5 sampled residents (#2 and #3). Findings: 1. Review of the record for resident #2 revealed an admission date of . The most recent health assessment was dated . . . . . She was noted to be receiving hospice services. The sections for diagnosis, physical or sensory limitations, and special precautions were left blank. Page 5 of the assessment to document what services the facility will provide, how often, and by whom was blank, but signed by the resident and a facility nurse. (photographic evidence obtained) 2. Review of the record for resident #3 revealed an admission date of . The health assessment was date . . . . and noted diagnoses including , , , and , , ... The sections for physical or sensory limitations, and special precautions were left blank. Page 5 of the assessment to document what services the facility will provide, how often, and by whom was blank. (photographic evidence obtained) On at 12:30PM, the activity director confirmed the findings. Class III	A 008		

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A 025	Continued From page 17	A 025		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.	A 025		

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A 025	Continued From page 18 (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, resident record review, facility observation notes, and incident reports, the facility failed to maintain documentation of significant changes or illnesses that resulted in medical attention, or documentation of notification to the resident's provider or responsible party following significant changes for 3 of 5 sampled residents (#3, #4 & #5). Findings: 1) On at 9:15AM, during a tour of the facility, resident #3 was observed to be sleeping. A strong odor was noticed in the room. Review of the record for resident #3 revealed an admission date of . The health assessment was date and noted diagnoses including , ( ) and , . She did not require any assistance with activities of daily living	A 025		

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A 025	Continued From page 19 but did receive assistance with self-administration of medications. The health assessment listed 4 prescribed medications. , 2.5mg, once daily (for ,); DR 50mg, twice daily (for ,); , 5mg, once daily (for ,); and , 40mg, once daily (for). Continued review of the record revealed a prescription record from the pharmacy dated listing the same 4 medications that were listed on the health assessment. Also found in the record was a medication reconciliation report dated from a hospital emergency room visit which listed the same 4 medications as on the admission health assessment. Review of the medication observation record (MOR) for , and listed 3 medications: , and , which were marked as refused all but 4 days in , and 3 days in . The MOR also listed , 325mg, twice daily, noted as being refused more than half the time. and , were not listed on the MOR. There were no discontinue orders found for either medication. There were no notes that the medications were requested, or that they contacted the physician to clarify the medication orders. There was no documentation to indicate the physician or responsible party had been notified of the resident's refusal to take her medications. Continued review of the record found a note in the communication log on which noted the resident went to the emergency room at 8:30PM and returned at 12:52AM. There were no notes found to indicate why the resident went to the hospital or if the facility notified the resident's physician or responsible party of the need for medical attention. There were no notes after her return to the facility indicating if she had a change in medications or level of care.	A 025		

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A 025	Continued From page 20 On . . . . . at 2:35PM, resident #3 stated she does not like her roommate because she is always bothering her and telling her to leave. She stated she has spoken to the administrator about it. On . . . . . at 10:15AM, staff A stated that resident #3 refused to shower and the odor in the room was a result of no showers. She stated they had discussed this with the resident. Staff A confirmed she did not have any notes about shower refusals or any documentation of contact with the resident's responsible party or physician. At 2:20PM in a phone interview with the administrator, she stated she had been in contact with the resident's case manager about the issue of refusing to shower or take medications. The administrator confirmed there were no notes documenting the conversations with the resident or case manager. 2) Review of the closed record for resident #4 revealed an admission date of and a discharge date of . . . . . The health assessment was dated and documented diagnoses including . . . . . , and . She did not require any assistance with activities of daily living but did receive assistance with self-administration of medications. An incident report dated . . . . . revealed resident #4 pushed another resident causing her to . The incident report was blank in the sections to indicate that her physician or responsible party was notified. There were no observation notes in the record regarding the altercation with resident #2. There were no notes in the record regarding discharge from the facility. On at 11:30AM, staff A stated resident #4	A 025		

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A 025	Continued From page 21 was removed from the room with resident #2. She confirmed they did not have any notes about who was notified or any follow-up observations. On [redacted] at 12:45PM staff B stated the staff does not write notes in the resident record, they have a communication log. Review of the communication log (24-hour log) found it listed each resident and had columns for morning and afternoon temperatures, bathing and laundry, and a column for comments or special instructions. No notes were found related to resident #4's altercation with resident #2. 3) Review of the closed record for resident #5 revealed an admission date of [redacted]. The health assessment was dated [redacted] and included diagnoses of [redacted], and [redacted]. He required assistance with self-administration of medications. He was receiving hospice services. Review of the MOR for [redacted] revealed and "I" for all medications from [redacted] evening doses through [redacted]. The MOR showed [redacted] (pain reliever) 50 mg, take 2 tablets every 8 hours, was circled on [redacted] at 4:00PM, and all doses on [redacted] and [redacted] and noted on the [redacted] of the MOR as "out of stock, not given." [redacted] 400mg, take one tablet at 8PM for [redacted], was circled on [redacted] and [redacted] and marked on the [redacted] of the MOR as "out of stock, not given." Continued review did not find any documentation that the facility had attempted to reorder the medications or contact the physician for a new prescription. There were no notes found documenting why the resident was sent to the hospital. On [redacted] at 2:00PM Staff A said the "I" notation indicated the resident was in the hospital. She	A 025		

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A 025	Continued From page 22 said resident #5 did not return to the facility after he went to the hospital and that he on . . . . . . She said their policy is to call for prescription refills when there are 5 days of medication remaining. She confirmed she did not have any documentation to show they had contacted the physician in an attempt to get his medication before they ran out. Staff A confirmed there were no notes to explain why he went to the hospital and if hospice, his physician, or responsible parties were notified. Class III	A 025		
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 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	A 055		

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A 055	Continued From page 23 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 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	A 055		

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A 055	Continued From page 24 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 and interview the facility failed to ensure centrally stored medications were locked and secured at all times. Findings: Upon entry into the facility on . . . . . at 9:15AM, staff A (unlicensed caregiver) was seen standing at the medication cart in the 200 hallway. She stated she was not passing medications at that time but was reviewing some paperwork. During a tour of the facility with the activity director between 9:20AM and 10:00AM, the unattended medication cart in the 200 hallway	A 055		

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A 055	Continued From page 25 was observed to be unlocked. Residents were present and walking in the hallway. On at 10:00AM, the activity director confirmed the cart was unlocked and unattended and locked it in the presence of the agency representative. Class III	A 055		