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
	AL11963790	A. BUILDING: _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF DEERFIELD BEACH	1050 SOUTHWEST 24TH AVENUE DEERFIELD BEACH, FL 33442

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A 000	Initial Comments An unannounced licensure Complaint survey (#2021009148) and Generator Assesment survey was conducted on through at Grand Villa of Deerfield Beach. The facility had deficiencies related to the Complaint (#2021009148) at the time of the survey.	A 000		
A 052	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, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident ' s medications or dosages change. (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.	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 (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 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) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations.	A 052		

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A 052	Continued From page 2 (g) Assisting with 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 the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (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 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 , 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,	A 052		

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A 052	Continued From page 3 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 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.	A 052		

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A 052	Continued From page 4 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, interview and record review, the facility failed to ensure staff accurately assisted with prescribed medication administration for 1 of 6 sampled residents, Resident #1. As evidenced by Staff A, an unlicensed Medication Technician (MT), administered an overdose of benzodiazepine medication to Resident #1, resulting in the hospitalization and subsequent of Resident #1. The findings included: Review of the facility's medication management policies and procedures, created , revised , revealed the following: Policy: It is the policy of the community to provide medication management to residents as indicated on the Agency for Health Care Administration Health Assessment (AHCA 1823) or per written physician order. Residents who are deemed capable of self-administering their medications without assistance by their physician shall be encouraged and allowed to do so. Medication management must be provided by trained unlicensed or licensed staff per state regulations. Staff providing medication management shall be	A 052		

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A 052	Continued From page 5 at least [illegible] and able to read and speak English. Definitions: Assistance with self-administration of medications: Resident requires assistance with taking medications. Assistance includes reminders, cueing, assisting with containers, storing and re-ordering medications. The resident's physician must select this option on the AHCA 1823 or provide a written order indicating the resident may receive assistance with self-administration of medications. Procedure: The resident care supervisor, memory care supervisor and/or designee is responsible for ensuring medication management is provided as required or requested. Assistance with self-administration of medications: 1. All assisted living residents with assistance with self-administration of medication indicated on the AHCA 1823 must be provided assistance with self-administration of medications. 2. Assistance with self-administration of medications shall be provide as outlined in the Department of Elder Affairs assistance with medication study guide for ALF staff (PER-DOEA assistance with medication study guide) 3. All medications for residents receiving assistance with self-administration of medication must be ordered through the community preferred pharmacy unless the resident requests a pharmacy of their choice. a. The resident's choice pharmacy must provide unit dose packaging. 4. All medications for residents requiring assistance with self-administration of medication are required to be unit dose packaged prior to distribution.	A 052		

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A 052	Continued From page 6 a. Any medications that are not unit dose packed must be sent to the pharmacy for re-packaging at the resident's expense. b. Medications requiring repackaging must be delivered to the pharmacy unopened. 5. Unless prescribed by the physician, the community must assist with all medications for residents receiving assistance with self-administration of medication. 6. Active medications must be centrally stored in medication carts and/or medication refrigerator for all residents receiving assistance with self-administration of medication. 7. Residents with medical conditions that require immediate availability of emergency medication (eg, epi pen, inhaler, ,) for life saving purposes may maintain the medication in the resident's possession with the following limitations. a. The resident's physician has provided the community with an order stating that the resident is capable of self-administering the medication. b. The medication must be secured in the residents' possession or stored in the residents' room in a lockable cabinet, drawer or container in the residents' room. Review of the facility's medication pass policies and procedures, created . . ., revealed the following: Policy: It is the policy of the community to ensure residents receive their medications as prescribed by their physician in a timely manner. Procedure: The resident care supervisor, memory care supervisor and/or designee is responsible for ensuring residents who are receiving assistance with self-administration of medication or medication administration receive their medication timely. Perform all steps in the order outlined below:	A 052		

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A 052	Continued From page 7 1. Bring the resident to the cart: a. If the resident is not already in the medication area, locate the resident. b. Confirm you have the correct resident by verifying against the photo on the MOR. c. If delivery is required, medications must be brought to the resident in their original packaging and all steps below must also be followed. 2. Verify medication: a. Review the MOR to determine medications required. b. Individually select the medication from the cart and perform the following steps: i. Verify the instructions to confirm the scheduled delivery time. ii. Verify the label against the MOR to ensure it matches. 1. If there is an order change sticker on the label, follow the instructions on the MOR. 2. Hold medications that have discrepancies until a supervisor or nurse can be notified. iii. After each medication has been verified, set it aside. . If the medication is not required to be passed at this time, return the medication to its proper location in the cart. v. If a medication is not available, reference the no pass policy. 3. Read aloud: a. All medication technicians are required to complete this step i. Nurses are encouraged to follow this step, however it is not required. b. Take all scheduled medications in its original package to the resident. c. Read the following aloud to the resident for each medication prior to dispensing: i. Name ii. Dosage iii. Directions	A 052		

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A 052	Continued From page 8 d. If the resident is hearing , ; and/or e. The resident does not want their medications read aloud i. Show the resident the label of each medication. 4. Dispense medication: a. Dispense each medication as indicated. i. Medication technicians must dispense medications in the presence of the resident or it is considered administration of medications. ii. Only nurses are permitted to administer medications. b. If the medication must be crushed, follow the crush orders policy. 5. Observe: a. the resident the dispensed medications and a drink, if necessary. b. Stop all other tasks. c. Ensure you are observing the resident take each medication. i. It is easy for residents to drop or pocket medications. 6. Document medication pass: a. After you have observed the resident take all scheduled medications. b. Document the medication observation in the MOR. 7. No pass: a. If the resident does not receive the medication, reference the "no pass policy". b. Examples include: i. Medication refusal. ii. Out of the building. iii. Medication not available. . Doesn't receive a medication for any other reason. Review of the facility's policies and procedures, created , revealed the following:	A 052		

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A 052	Continued From page 9 Policy: It is the policy of the community to maintain and other controlled substances double locked. All these medications will be counted as they enter the community and a count must be kept. Those medications that are centrally stored in the medication cart or refrigerator must be counted at each shift change. Procedure: The resident care supervisor, memory care supervisor and/or designee is responsible for ensuring and other controlled substances are kept double locked. and controlled substance delivery: 1. Upon receipt of a or controlled substance, the Staff Are required to verify the quantity of the medication. 2. Notify the supervisor, resident administrative coordinator or nurse on call. 3. The supervisor, resident administrative coordinator or nurse on call must add the quantity of the medication to the eMOR and place in the box of the medication cart. a. If the medication is not immediately placed in the box of the medication cart. The supervisor, resident administrative coordinator or nurse on call must complete a count form (RES-29) and attach the form to the b. Then place the or controlled substance in an appropriate secured storage area as defined above with the count form (RES-29) attached. Review of Resident #1's facility record revealed that the resident was admitted to the facility's Memory Care Unit (MCU) on . Review of Resident #1's Health Assessment (AHCA form 1823) dated revealed the resident with a	A 052		

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A 052	Continued From page 10 inches and was diagnosed with , , generalized , and unsteady gait. Review of this assessment documented the resident required assistance with her activities of daily living (ADLs) including bathing, , and grooming, and required supervision with ambulation, toileting and transfers. Review of this Health Assessment documented the resident required medication management and assistance with self-administration of medications. Further review of this Health Assessment documented Resident #1 was prescribed medications to include the , medication 0.25 milligrams (mg) every 12 hours. Review of Resident #1's record revealed a Physician Order dated , which was signed by the resident's Nurse Practitioner (NP), documenting the resident's current 0.25 mg dose be discontinued and to increase the dose to 0.5 mg oral medication, one tablet three times daily. Review of the resident's Progress Notes revealed on at approximately 8:05 PM, Licensed Practical Nurse (LPN) Staff B received Resident #1's 0.5 mg medication from the pharmacy, which included 18 tablets, in a pack format. Review of these Progress Notes documented LPN Staff B handed this medication to the resident care assistant/medication technician (MT) Staff A in the facility's MCU, where Resident #1 resided, and instructed MT Staff A to give Resident #1 her 8:00 PM dose of medication. Review of these Progress Notes documented LPN Staff B received a call from MT Staff A around 8:44 PM and MT Staff A informed her that she got the resident to take "all of them", and LPN Staff B questioned MT Staff A about this, and MT Staff A did not respond. These	A 052		

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A 052	Continued From page 11 Progress Notes documented LPN Staff B went to the MCU at approximately 8:49 PM and found Resident #1 to be very . . . . . and 911 was called at approximately 8:51 PM. Review of these Progress Notes documented Emergency Medical Personnel arrived at approximately 9:00 PM and Resident #1 was transported to the hospital at approximately 9:05 PM. Further review of these Progress Notes dated . . . . . at 2:14 PM documented Resident #1 had , , in the hospital. Review of Resident #1's . , ... Medication Observation Record (MOR) revealed that the resident received one . . . . 0.25 mg tablet every 12 hours from to at 9:00 AM, and the resident refused the 9:00 PM dose on . Review of the MOR documented MT Staff A assisted the resident with the . . . 0.25 mg medication on at 9:00 PM. Further review of the MOR revealed the Director of Nursing documented the resident's 0.5 mg medication dose on . . . . . at 8:00 PM was not given due to "other problems". Review of the facility's Controlled Substance Log showed Resident #1's 0.25 mg medication was discontinued on . . . . . ; the . . . 0.5 mg medication was ordered on and 18 tablets of this medication were removed from the resident's medication count on (4 days after the incident) . Further review of the Controlled Substance Log revealed the deduction of the 18 tablets of the . . . 0.5 mg medication was currently being reviewed by the facility. Review of the facility's Adverse Incident Report dated . . . . . reported the facility LPN Staff B received Resident #1's 0.5 mg medication from the pharmacy, and she handed this medication to MT Staff A in the facility's MCU.	A 052		

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A 052	Continued From page 12 This report revealed that the LPN Staff B received a call from MT Staff A at approximately 8:44 PM and MT Staff A informed her that she got the resident to take "all of them", and LPN Staff B questioned MT Staff A about this, and MT Staff A did not respond. This report documented LPN Staff B went to the MCU and found Resident #1 to be very ˇ and she called 911 at approximately 8:51 PM, and Resident #1 was transported to the hospital at approximately 9:05 PM. This report stated MT Staff A gave Resident #1 eighteen (18) tablets of 0.5 mg medication and the reason for MT Staff A's action was unknown at that time. Review of the facility's Incident Investigation dated . . . . . reported that MT Staff A gave all 18 tablets of 0.5 mg medication to Resident #1 on . . . . . sometime between 8:00 PM and 8:44 PM which led to Resident #1's hospitalization on this same date. Review of this document stated this medication error may have been . . . . . had MT Staff A conducted the proper process of assistance with self-administration of medications with Resident #1. Further review of this document stated the specific process MT Staff A failed to do was not identified, and in order to prevent future occurrences of medication errors, the facility will provide medication education training to its staff members who assist residents with self-administration of medications. Further review of this investigation stated that the facility did not determine the root cause of Staff A's overmedicating Resident #1 on . . . . . In an interview conducted with Resident #1's Representative on at 10:15 AM, he stated Resident #1 was hospitalized on due to being overdosed with . . medication by	A 052		

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A 052	Continued From page 13 MT Staff A while residing in the facility's Memory Care Unit. In a further interview conducted with Resident #1's Representative on at 11:35 AM, he stated Resident #1 was admitted to the facility on and was prescribed 0.25mg of medications at that time for . He stated that on or about , the facility reported that the resident became more agitated and combative, and requested the medication dose be increased. He stated he received the resident's pharmacy's billing statement, and it stated the facility received 18 tablets of 0.25 mg on and 18 tablets of 0.5 mg of on . He stated Resident #1 , in the hospital on . Review of the www.webmd.com website states is used to treat , and , and it is classified as a benzodiazepine, which acts on the , to produce a calming effect. This website stated that must be taken as directed by your doctor and its dosage is based on your medical condition, age and response to treatment, and one must follow your doctor's instructions closely to reduce the risk of side effects. This website described the side effects of this medication to include drowsiness and , and if any of the side effects persisted or worsened, tell your doctor promptly. This website stated that is prescribed by your doctor because he or she has judged that the benefit to you is greater than the risk of side effects, but serious side effects like mental/ changes (such as , thoughts of), trouble speaking, loss of coordination, trouble walking, and memory problems may occur. This website stated that must be taken exactly as prescribed to lower the risk of addiction and if someone has	A 052		

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A 052	Continued From page 14 overdosed on this medication and developed serious symptoms such as passing out or trouble breathing, call 911 or a poison control center right away. In an interview conducted with the Administrator on at 11:00 AM, he stated Resident #1 was overdosed by MT Staff A on , and this led to the resident to be hospitalized on this same date. He stated Resident #1 , in the hospital a couple of weeks after she was hospitalized. He stated that since MT Staff A did not cooperate with the facility's questioning about the events relating to Resident #1's hospitalization, the staff member was immediately dismissed from employment in the facility after this event on . He stated the facility did not contact the police to further investigate MT Staff A's actions that led to the resident being hospitalized. In an observation conducted on at 11:15 AM of Resident #1's unit dose package for the 0.5 mg medication, the prescribed directions were for the resident to take one tablet by three times a day. Observation of the medication package at this time, revealed 18 out of the 31 clear plastic , labeled from 1 to 18, were broken and empty. Further observation of this medication package revealed that this order was filled and originated by the pharmacy on . (Photographic evidence was obtained.) In a telephone interview conducted with MT Staff A on at 12:35 PM, she stated she worked at the facility for almost 2 years, further stating on at 12:40PM, she was not able to speak about her work in the facility at this time and she disconnected from the call.	A 052		

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A 052	Continued From page 15 In an interview with Resident #1's Nurse Practitioner (NP) conducted on at 10:55 AM, he stated that he initially examined Resident #1 on at his office and determined the resident had memory issues, unsteady gait and prescribed 0.25 mg for the resident. He stated that it was appropriate for the resident to move into the facility's MCU at that time. He stated he increased the resident's dose to 0.5 mg due to a report from the facility on that Resident #1 had increased agitation. He stated he received a call from the facility on or about to inform him that the resident was hospitalized due to an overdose of on . He stated he did not understand the reason why MT Staff A gave the resident so many medications all at once, and that milligrams of benzodiazepine ( ) was likely to place anyone in a comatose state, regardless of their body composition or . In an interview conducted with the facility LPN Staff B on at 11:30 AM, she stated that on at around 7:30 PM, she received Resident #1's 0.5 mg medication from the pharmacy, and she entered the medication into the MOR system and handed this medication to MT Staff A in the facility's MCU, around 8:00 PM. She stated that the 0.5 mg medication came in unit dose packaging that contained 18 tablets inside the clear plastic , labeled from 1 to 18. She stated she told MT Staff A to give the resident her prescribed 8:00 PM dosage and that she commented to MT Staff A the resident could have used this higher dose of medication earlier that day when the resident was more agitated. She stated since Resident #1 was more agitated earlier on , this led to the resident being ordered	A 052		

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A 052	Continued From page 16 an increased dosage of by the NP. She stated she received a call from MT Staff A sometime after 8:00 PM and MT Staff A informed her that she had given Resident #1 all the tablets of the 0.5 mg medication in the unit dose packaging. She stated she rushed over to the MCU area of the facility to see the resident and MT Staff A did not say anything else to her. She stated she immediately called 911 to respond to the resident's potential overdose from the medication and she was aware that the resident may go through severe adverse effects from this increased dosage. She stated she examined Resident #1 before the emergency response personnel arrived at around 8:30 PM, and Resident #1 presented to be , was slumped over on the chair and was minimally responsive. She stated she did not see MT Staff A ever again and she believed MT Staff A departed the facility shortly after this event happened. She stated Resident #1 was hospitalized on due to this overdosing and she was aware Resident #1 , a couple weeks after this in the hospital. In an interview conducted with the Administrator on at 1:50 PM, he stated in order to prevent a reoccurrence like the medication error involving Resident #1 on , the facility provided a medication pass in-service on to its medication technician staff and planned to re-train all of the medication technician staff with the most current assistance with self-administration of medication course. He stated that LPN Staff B or any other of the facility nurses did not receive this training. He stated the facility presently had only in-serviced 5 medication technician staff members (Staff C, D, E, F and G) on the proper medication pass	A 052		

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A 052	Continued From page 17 techniques, and he could not provide a reason why the remaining 10 medication technician staff members did not yet receive this in-service training. He stated the facility employee roster confirmed that there were presently a total of 15 unlicensed staff members who performed medication assistance tasks for residents and the remaining staff members who did not participate in the in-service were identified as Staff H, I, J, K, L, M, N, O, P and Q. He stated that any one of the medication technician staff members may be scheduled to work in the facility's MCU depending on the resident load and staff availability. He also stated at this time, he presently did not have documentation that any of the current 15 medication technician staff members had completed an updated assistance with self-administration of medication course since the event on . . . . . He also stated that the facility did not hire and/or contract any pharmacy consultant to audit the facility's medication practices or to train its staff members. Review of MT Staff A's personnel record revealed she was hired at the facility on . . . as a resident care assistant, whose duties included providing direct care to residents, to assist residents with self-administration of medications and that she must receive and stay current with medication certification training. Review of this personnel record revealed MT Staff A received an initial 4-hour medication training on which was followed up with 2-hour continuing medication trainings on , and . . . . . Review of the personnel record revealed none of the medication training certificates were validated by the facility to ensure MT Staff A was able to perform the procedures and techniques for assisting residents with self-administration of medication. Further review	A 052		

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A 052	Continued From page 18 of the personnel record revealed MT Staff A did not have proof to have completed an "annual" 2-hour continuing education medication training before the expiration of the initial medication training on and there was also no proof in the personnel record that MT Staff A completed an initial 4 or 6-hour medication training during the periods between the expired "annual" 2-hour medication trainings from to . In an interview conducted with the Administrator on at 2:55 PM, he stated the purpose of the facility's and Controlled Substances Policy and Procedure that required the facility's Licensed nurses to place every resident's controlled substance medication into the medication cart after entering the medication data into the MOR was to ensure the safety and security of said medication. He confirmed he became aware that this was not done by LPN Staff B when she directly handed Resident #1's medication to MT Staff A on . In an interview conducted with the Administrator on at 3:20 PM, he stated he was not aware if MT Staff A stayed current with her medication training, which involved staying current from her initial 4-hour medication training on to having all subsequent 2-hour continuing medication trainings, which must be completed on an annual basis. Review of Resident #1's hospital record documented Resident #1 arrived at the Emergency Department via 911 ambulance on at 9:28 PM, had an estimated and presented with and accidental overdose. Review of the Emergency Department record dated at 12:25 AM, documented Resident #1 was	A 052		

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A 052	Continued From page 19 somnolent and moaning; a referral was made to an Intensivist Physician; and she would be admitted to the hospital's [illegible]. Review of the Critical Care consulting Physician report on [illegible] at 1:40 AM, documented the chief complaint for Resident #1's consult was for " [illegible] post possible overdose on [illegible]." Review of this report documented Resident #1 was assessed as a "critically ill patient with accidental benzodiazepine overdose". Review of the [illegible] consulting Physician report on [illegible] at 11:55 AM, documented the chief complaint for Resident #1's consult was for " [illegible] " and "patient is [illegible]." Review of this report documented Resident #1's assessment to include 'Benzodiazepine overdose, [illegible]'; further documenting 'Patient was inadvertently administered higher doses of benzodiazepines at the assisted living where her meds are being distributed' and 'Patient is not responsible for self-administration of medications and therefore is unlikely to have intentionally overdosed'. Review of Resident #1's hospital Discharge Summary dated [illegible] at 2:30 PM, documented Resident #1's final diagnoses included [illegible] due to inhalation of food and [illegible] and benzodiazepine overdose. Resident #1 was administered 18 tablets of [illegible] on [illegible] by MT Staff A. Resident #1 required hospitalization as a result; developed [illegible] after being administered the [illegible] overdose and subsequently [illegible], in the hospital on [illegible]. During a telephone interview with the Administrator and the Regional Executive	A 052		

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A 052	Continued From page 20 Director on [redacted] at 3:05PM, they both acknowledged that this was not normal for an individual to give 18 [redacted] pills to a resident. At this time, they were questioned if they had contacted the local police authories to report this matter. They stated that the facility didn't contact the police to investigate the reason why Staff A overmedicated Resident #1 on [redacted] and the facility also didn't contact the Department of Health to report this event against Staff A's Certified Nursing Assistant license. They also stated that the facility does not validate any of the MT's medication training certificates upon hire. Therefore, they could not confirm the qualifications of MT Staff A to be able to perform assistance with the self-administration of medications in a safe manner for their residents. The facility was unable to provide any further documentation indicating how they had throughly investigated this matter and implemented a system-wide corrective action plan to prevent the reoccurrence of medication overdose of a resident. Class I	A 052		
A 084	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must	A 084		

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A 084	Continued From page 21 meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires	A 084		

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A 084	Continued From page 22 judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of , bags, excluding the removal of the , or manipulation of the site; and, n. Measurement of rate, temperature, and , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education	A 084		

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A 084	Continued From page 23 training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 4 out of 15 current unlicensed staff members (Staff A, D, G and H) whose job descriptions included to assist residents with their medications, were current with their medication management training. As evidence of Staff A, who laked appropriate medication training and provided 18 pills (0.5mg) to Resident #1, resulting in a medication overdose in which the resident developed , and subsequently , in the hospital. The findings are: Review of the facility's Adverse Incident Report	A 084		

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A 084	Continued From page 24 dated . . . . . reported the facility LPN Staff B received Resident #1's 0.5 mg medication from the pharmacy, and she handed this medication to MT (Medication Tech) Staff A in the facility's MCU. This report revealed that the LPN Staff B received a call from MT Staff A at approximately 8:44 PM and MT Staff A informed her that she got the resident to take "all of them", and LPN Staff B questioned MT Staff A about this, and MT Staff A did not respond. This report documented LPN Staff B went to the MCU and found Resident #1 to be very . ˇ and she called 911 at approximately 8:51 PM, and Resident #1 was transported to the hospital at approximately 9:05 PM. This report stated MT Staff A gave Resident #1 eighteen (18) tablets of 0.5 mg medication and the reason for MT Staff A's action was unknown at that time. Review of the facility's Incident Investigation dated . . . . . reported that MT Staff A gave all 18 tablets of . 0.5 mg medication to Resident #1 on . . . . . sometime between 8:00 PM and 8:44 PM which led to Resident #1's hospitalization on this same date. Review of this document stated this medication error may have been . . . . . had MT Staff A conducted the proper process of assistance with self-administration of medications with Resident #1. Further review of this document stated the specific process MT Staff A failed to do was not identified, and in order to prevent future occurrences of medication errors, the facility will provide medication education training to its staff members who assist residents with self-administration of medications. Further review of this investigation stated that the facility did not determine the root cause of Staff A's overmedicating Resident #1 on	A 084		

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A 084	Continued From page 25 Review of Resident #1's record revealed a Physician Order dated , which was signed by the resident's Nurse Practitioner (NP), documenting the resident's current 0.25 mg dose be discontinued and to increase the dose to 0.5 mg oral medication, one tablet three times daily. Review of Resident #1's Progress Notes revealed on at approximately 8:05 PM, Licensed Practical Nurse (LPN) Staff B received Resident #1's 0.5 mg medication from the pharmacy, which included 18 tablets, in a pack format. Review of these Progress Notes documented LPN Staff B handed this medication to the resident care assistant/medication technician (MT) Staff A in the facility's MCU, where Resident #1 resided, and instructed MT Staff A to give Resident #1 her 8:00 PM dose of medication. Review of these Progress Notes documented LPN Staff B received a call from MT Staff A around 8:44 PM and MT Staff A informed her that she got the resident to take "all of them", and LPN Staff B questioned MT Staff A about this, and MT Staff A did not respond. These Progress Notes documented LPN Staff B went to the MCU at approximately 8:49 PM and found Resident #1 to be very and 911 was called at approximately 8:51 PM. Review of these Progress Notes documented Emergency Medical Personnel arrived at approximately 9:00 PM and Resident #1 was transported to the hospital at approximately 9:05 PM. Further review of these Progress Notes dated at 2:14 PM documented Resident #1 had , in the hospital. Review of Resident #1's hospital record documented Resident #1 arrived at the	A 084		

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A 084	Continued From page 26 Emergency Department via 911 ambulance on at 9:28 PM, had an estimated and presented with and accidental overdose. Review of the Emergency Department record dated at 12:25 AM, documented Resident #1 was somnolent and moaning; a referral was made to an Intensivist Physician; and she would be admitted to the hospital's . Further review of Resident #1's hospital records revealed the resident was diagnosed with , due to inhalation of food and and benzodiazepine overdose. Resident subsequently , in the hospital on . Review of MT Staff A's personnel record revealed she was hired at the facility on , as a resident care assistant, whose duties included providing direct care to residents, to assist residents with self-administration of medications and that she must receive and stay current with medication certification training. Review of this personnel record revealed MT Staff A received an initial 4-hour medication training on which was followed up with 2-hour continuing medication trainings on , and . Review of the personnel record revealed none of the medication training certificates were validated by the facility to ensure MT Staff A was able to perform the procedures and techniques for assisting residents with self-administration of medication. Further review of the personnel record revealed MT Staff A did not have proof to have completed an "annual" 2-hour continuing education medication training before the expiration of the initial medication training on and there was also no proof in the personnel record that MT Staff A completed an initial 6-hour medication training during the	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963790	A. BUILDING: _____ B. WING _____	07/09/2021

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A 084	Continued From page 27 periods between the expired "annual" 2-hour medication trainings from to . Further review of the facility's MT/Resident Care Assistants, revealed 3 additional staff members (Staff D, G, H) who were not current with their medication training. These staff members worked in the Memory Care unit and the ALF unit (non-secured unit). Review of MT Staff D's employee record revealed that she was hired at the facility on as a resident care assistant, whose duties included to provide direct care to residents, to assist residents with self-administration of medications and she must receive and stay current with medication certification training. Review of this record revealed that the staff member received an initial 6-hour medication training on . . . (from a registered pharmacist) which was followed up with 2-hour continuing medication trainings on (from education provider), on . . . (at the facility by a registered nurse), on , on . . (from education provider), on . . . . . (from a pharmacy) and on (from education provider.) Further review of this record revealed that the staff member did not have proof to have completed an initial 6-hour medication training at least one year prior to the "annual" 2-hour medication training dated on . . . . . . Review of MT Staff G's employee record revealed that she was hired at the facility on as a resident care assistant, whose duties included to provide direct care to residents, to assist residents with self-administration of medications and she must receive and stay current with medication certification training. Review of this record revealed that the staff member didn't have	A 084		

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A 084	Continued From page 28 a certificate to represent that she received an initial 6-hour medication training. Review of this record indicated that the staff member received the following 2-hour continuing medication trainings on , on (from education provider), on (from a pharmacy), on (from education provider) and on (from a registered nurse.) Further review of this record revealed that the staff member did not have proof to have completed an initial 6-hour medication training at least one year prior to her most recent "annual" 2-hour medication training dated on . Review of MT Staff H's employee record revealed that she was hired at the facility on as a resident care assistant, whose duties included to provide direct care to residents, to assist residents with self-administration of medications and she must receive and stay current with medication certification training. Review of this record revealed that the staff member received an initial 4-hour medication training on (from education provider) and a 6-hour medication training on (from a pharmacy), which was not followed up with any 2-hour continuing medication trainings. Further review of this record revealed that the staff member did not have proof to have completed any "annual" 2-hour continuing medication trainings after her most recent 6-hour medication training dated on . In an interview with the Administrator on at 3:20 PM, he stated that he was not aware if Staff D, G and H stayed current with their medication training, which involved completing subsequent 2-hour continuing medication trainings annually or completing an initial 6-hour medication training before their annual	A 084		

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A 084	Continued From page 29 medication training became expired. It was also confirmed that aforementioned MT Staff work in the Memory Care Unit and the Assisted Living Unit (non-memory care). Class I	A 084		