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
	AL11910384	A. BUILDING: _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE 5081 LLC	5081 DUNN ROAD FORT PIERCE, FL 34981

(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 An unannounced licensure Complaint (#2021010400 & #2021011244) and Generator Monitoring survey was conducted on at Cambridge 5081, LLC. The facility had deficiencies identifed for Complaint #2021010400 at the time of the survey.	A 000		
A 053	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including [illegible] testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and chapter 483, part I, F.S. A valid copy of the State Clinical Laboratory License, if required, and the federal CLIA Certificate must be maintained in the facility. A state license or federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The	A 053		

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A 053	Continued From page 1 facility is not required to maintain a State Clinical Laboratory License or a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the State Clinical Laboratory License and federal CLIA Certificate is available from the Laboratory Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on staff interview and record review, Staff A, an unlicensed staff member, administered prescribed medication to 1 of 5 residents (Resident #4) without the resident's knowledge and consent. The findings included: Resident #4 is an alert and oriented resident who is mostly independent with his activities of daily living (ADLs). His prescribed medications are as follows: 1) [illegible] ER 500 mg to be taken daily; 2) [illegible] 750 mg to be taken every 12 hours; 3) [illegible] 300 mg, [illegible] tablet to be taken every 12 hours. On [illegible] at 11:22 AM, Staff A confirmed that she assists residents with their medications and had received the 6 hours of specialized training related to providing assistance to residents with self-administered medications. Staff A stated in the presence of the facility Manager that Resident #4 was often non-compliant with taking his medications. She said, "I would crush them [the medications] and put them in his chocolate milk that he likes and mix it up so then he would take them. He didn't know the medication was in	A 053		

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A 053	Continued From page 2 there." The facility Manager immediately told Staff A that she could not do this, and that the resident had the right to refuse his medications. The Manager notified Resident #5's physician that this Resident was often refusing his medications. Class III	A 053		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical	A 054		

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A 054	Continued From page 3 , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interviews, Staff A failed to maintain accurate daily medication observation records (MOR) for 1 of 5 residents (Resident #4). The findings included: On at 10:00 AM, Resident #4 stated, "I am supposed to be getting , and Iron. I haven't been getting these medications." A Review of the and , MOR for Resident #4 showed no staff initials signifying the provision of the medication for the following: 1) , ER 500 mg on and at 8:00 AM ; nor on through ; 2) , 750 mg on at 8:00 PM and at 8:00 AM and 8:00 PM; nor on at 8:00 AM, or on through at 8:00 AM and 8:00 PM 3) , 300 mg, ½ tablet, on at 8:00 PM and at 8:00 AM and 8:00 PM; nor on at 8:00 AM, or through at 8:00 AM and 8:00 PM. 4) 20 mg on and at 8:00 AM. 5) There was no physician order provided for Iron for Resident #4. During interview with Staff A on at 11:13 AM, she stated that the resident was in the hospital the evening of through	A 054		

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A 054	Continued From page 4 . . . . . . She confirmed there was no documentation on the MOR that Resident #4 had not been given his medication at this time due to his hospitalization. As for the remaining dates, Staff A stated Resident #4 had run out of medications, which was why he had missing doses on - . . . . . and . . . . . and . . . . . She stated she had notified the Manager that the resident was low on medications a few days before. There was no documentation on the MOR as to why the medications had not been given on these days. On at 11:22 AM, Staff A stated in the presence of the facility Manager that Resident #4 was often non-compliant with taking his medications. The Manager notified Resident #5's physician that this Resident was often refusing his medications. A review of the Medication Observation Record for and revealed no documentation that Resident #5 had refused his medications on any date. Class III	A 054		
A 055	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.	A 055		

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A 055	Continued From page 5 Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked;	A 055		

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A 055	Continued From page 6 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C.	A 055		

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A 055	Continued From page 7 This Statute or Rule is not met as evidenced by: Based on observation and interviews, Staff A failed to keep resident medications secured at all times for Residents #2 and #4(photographic evidence obtained). The findings included: On at 10:15 AM, an open cardboard box of medication bubble-packs was observed on the floor in the kitchen sitting next to the medication cart. At this time, there were no Staff present in the area, but residents were sitting in the next room. Most of the bubble packs were empty, but several of them still had a few days worth of medications left in them. The bubble-packed medication cards observed with medication still inside were: 1) Resident #2's Morning medications a) , 300 mg and 25 mg (pill in pocket for the 31st) b) , , 10 mg, 20 mg, and 2 other pills not identified due to the labels for these medications being located on the of the medication card and a photo of the of the medication card was not obtained (pills in pocket for the 31st) 2) Resident #2's Afternoon medication a) , 300 mg (pill in pocket for the 31st) 3) Resident #4's Morning medications a) 20 mg (pills in pocket for the 27th, 28th, 29th, and 30th) On at 10:18 AM, Staff A stated that the medications were either discontinued, left over	A 055		

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A 055	Continued From page 8 from previous residents, or extras. She had pulled these medication cards out of the cart this morning to show the Manager. It was discussed with Staff A at this time that all medications are required to be secured at all times. Class III	A 055		
A 056	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 9 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 10 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 staff interview and record review, Staff A, an unlicensed staff member, 1) crushed prescribed medication for 1 of 5 residents (Resident #4) without a written order from the physician allowing these medications to be crushed; and 2) did not provide daily medications as prescribed for 1 of 5 sampled residents (Resident #4). The findings included: Resident #4 is an alert and oriented resident who was prescribed the following medications: 1) [redacted] ER 500 mg to be taken daily; 2) [redacted] 750 mg to be taken every 12 hours; 3) [redacted] 300 mg, [redacted] tablet to be taken every 12 hours. 4) [redacted] 20 mg to be taken daily 1) On [redacted] at 11:22 AM, Staff A confirmed that she assists residents with their medications and had received the 6 hours of specialized training related to providing assistance to	A 056		

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A 056	Continued From page 11 residents with self-administered medications. Staff A stated in the presence of the facility Manager that Resident #4 was often non-compliant with taking his medications. She said, "I would crush them [the medications] and put them in his chocolate milk that he likes and mix it up so then he would take them. He didn't know the medication was in there." The facility Manager immediately told Staff A that she could not do this, and she informed Staff A that she was not allowed to crush medications without a doctor's order stating that these medications could be crushed. A review of the Medication Observation Record for ... and ..., and Physician Orders revealed no documentation allowing any of Resident #5's medications to be crushed. 2) On ... at 10:00 AM, Resident #4 stated, "I am supposed to be getting ... ..., ... and Iron. I haven't been getting these medications." A Review of the ... and ..., MOR for Resident #4 showed no staff initials signifying the provision of the medication for the following: 1) ..., ... ER 500 mg on ... and ... ... at 8:00 AM ; nor on ... ... through ... ; 2) ..., ... 750 mg on ... ... at 8:00 PM and ... at 8:00 AM and 8:00 PM; nor on ... ... at 8:00 AM, or on ... ... through ... at 8:00 AM and 8:00 PM 3) ... ..., ... 300 mg, ½ tablet, on ... ... at 8:00 PM and ... at 8:00 AM and 8:00 PM; nor on ... ... at 8:00 AM, or ... ... through ... at 8:00 AM and 8:00 PM. 4) ... ... 20 mg on ... ... and ... ... at 8:00 AM.	A 056		

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A 056	Continued From page 12 5) There was no physician order provided for Iron for Resident #4. During interview with Staff A on at 11:13 AM, she stated that the resident was in the hospital the evening of through . She confirmed there was no documentation on the MOR that Resident #4 had not been given his medication at this time due to his hospitalization. As for the remaining dates, Staff A stated Resident #4 had run out of medications, which was why he had missing doses on - and and . She stated she had notified the Manager that the resident was low on medications a few days before. There was no documentation on the MOR as to why the medicaitons were not given on these days. On at 11:18 AM, the Manager showed Staff A that there was Overflow medications in the medication cart for Resident #4 which would have covered the 3 days until Resident #4 received his meds for . It was also discovered that there was a medication bubble-pack card in a box set aside for disposable that included 4 doses of 20 mg labeled for days 27, 28, 29, and 30 of the month. No explanation was provided by Staff A or the Manager as to why these pills were not given to the resident on or . Class III	A 056		
A 160	59A-36.015(1) FAC Records - Facility	A 160		

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A 160	Continued From page 13 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: 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 , ; 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	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910384	A. BUILDING: _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE 5081 LLC	5081 DUNN ROAD FORT PIERCE, FL 34981

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A 160	Continued From page 14 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 's or related , 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 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.	A 160		

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A 160	Continued From page 15 (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 staff interview, the facility failed to maintain an accurate and up-to-date admission and discharge log. The findings included: On at 9:30 AM, the Live-in Caregiver on duty at the time of the survey stated that there were 5 residents currently residing in the facility. She identified the residents as being Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5. On during review of the facility's Admission and Discharge Log, it was noted that current residents, Resident #4 and Resident #5, and former resident, Resident #6, were not listed anywhere on the Admission/Discharge Log. It was also noted that 6 residents listed on the log and showing that they were still residing at the facility, had been previously discharged, per Staff A during interview on at 9:45 AM. Staff A also confirmed that Resident #6 had been a resident at the facility and had been discharged in During interview with the Manager on at	A 160		

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A 160	Continued From page 16 10:34 AM, she stated she had discussed the need to update the Admission/Discharge Log with the Administrator a prior to my visit when she had noticed that it was out of date. Class	A 160		