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
	AL11963919	A. BUILDING: _____ B. WING _____	R 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE	2960 TAMPA ROAD PALM HARBOR, FL 34684

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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	A 056		

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.,

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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 observations, record reviews, and interviews, the facility failed to notify health care providers when medications were not taken as prescribed. Furthermore, the facility failed to provide medications according to the standards of nursing practice and according to packaging labels. Additionally, the facility failed to have as needed prescriptions with the circumstances under which the medication would be appropriate and any limitations specified on medication observation records (MORs) for four Residents (#1, #2, #3, and #4) of four sampled residents that required assistance with self-administration of medications or medication administration. Findings Included: A review of Resident #1's MORs, conducted on , revealed that Resident #1 had as needed medications with no circumstances under which the medication would be appropriate, or any limitations specified for the medications which included: - Liquid 12.5/5ml as needed had no reason for the resident to take this medication or any limitations of taking this medication noted. - Suspension 160/5ml as needed had no reason for the resident to take this medication or any limitations of taking this medication noted. - capsule 135mg as needed had no reason for the resident to take this medication or	A 056		

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A 056	Continued From page 3 any limitations of taking this medication noted. - , Gel 4% as needed had no reason for the resident to take this medication or any limitations of taking this medication noted. According to Resident #1's health assessment form dated , Resident #1 required medication administration. A review of Resident #2's MORs, conducted on , revealed that Resident #2 had medication circled as not given to the resident which included - 5mg was circled as not given on at 05:00pm and there was nothing documented on the MORs as to the reason Resident #2 did not take this medication. There was no evidence that Resident #2's health care provider was notified that the resident did not take the medication as prescribed. - 500mg was circled not given on at 10:00pm and there was nothing documented on the MORs as to the reason Resident #2 did not take this medication. There was no evidence that Resident #2's health care provider was notified that the resident did not take the medication as prescribed. According to Resident #2's undated health assessment form, Resident #2 required assistance with self-administration of medications. An observation of the medication pass with Staff B, and unlicensed Medication Technician, for Resident #3, conducted on at 08:11am, Staff B did not assist Resident #3 with her prescribed , Thera Tears liquid solution ordered for 08:00am. Staff B signed that she had performed the task of assisting Resident #3 with her prescribed on her MORs.	A 056		

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A 056	Continued From page 4 During an interview with Staff B, conducted on , Staff B stated that she does not give Resident #3 her prescribed Thera Tears liquid solution , , and that the resident kept this in her room. A record review for Resident #3, conducted on , revealed that according to Resident #3's health assessment form dated Resident #3 required assistance with self-administration of medications. During a medication pass observation with Staff A for Resident #4, conducted on at 06:13am, Staff A, a licensed Practical Nurse did not follow the standards of nursing practice and administered Resident #4's Refresh Tears prior to administering her Ocusoft , scrub. Staff A did not follow the packaging instructions to use one scrub for each , and Staff A used one scrub for Resident #4's right and left , . Staff A did not rinse either of Resident #4's , after performing the Ocusoft , scrub as the packing instructions stated. A review of the Ocusoft , , packaging instructions, conducted on , revealed that the directions for use were to obtain one scrub and use to cleanse one , with side-to-side while , touching the , and rinse the , thoroughly after application and repeat for the second , . During an interview with the Director of Nursing (DON), conducted on at 10:45am, the DON agreed that Resident #1's as needed medication did not have to circumstances in which the resident may take the medications or any limitations of taking the medications noted on his MORs. The DON agreed that Resident #2's	A 056		

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A 056	Continued From page 5 MORs had medications there were circled as not given. The DON was unable to provide evidence that Resident #2's health care provider was notified that the resident was not taking the medications as prescribed. The DON agreed that resident who required assistance with medications or medication administration should have central storage of medication and the unlicensed Medication Technicians or Nurses must help them with their medications. The DON agreed that the directions of use and the standards of nursing practice should be used when administering [illegible] and [illegible] scrubs. Class III	A 056		
{A 058} SS=D	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration	{A 056}		

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{A 058}	Continued From page 6 of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The	{A 058}		

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{A 058}	Continued From page 7 agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that all medication concerns were corrected as required (Cross Reference: A0054 and A0055). Findings Included: Due to the uncorrected Class III deficiencies and new Class III deficiencies concerning the facility's medication practices, the facility shall be required to employ or contract with a licensed Pharmacist Consultant or Registered Nurse Consultant. The Consultant shall at a minimum, provide onsite quarterly consultation until the inspection team from the Agency determines that such consultation services are no longer required. This written statement serves as notification of the above stated requirement. During an interview with the Director of Nursing (DON), conducted on at 10:24am, the DON was unable to provide evidence that that the facility employed or with a licensed Pharmacist Consultant or Registered Nurse Consultant as previously required on for uncorrected medication deficiencies. Class III	{A 058}		
AE206 SS=D	59A-36.021(6) FAC ECC - Service Plans (6) SERVICE PLANS.	AE206		

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AE206	Continued From page 8 (a) Before receiving services, the extended congregate care administrator or manager must develop a preliminary service plan that includes an assessment of whether the resident meets the facility's residency criteria, an appraisal of the resident's unique physical, , , , and social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs. (b) Within 14 days of receiving services, the extended congregate care administrator or manager must coordinate the development of a written service plan that takes into account the resident's health assessment obtained pursuant to subsection (6); the resident's unique physical, , , , and social needs and preferences; and how the facility will meet the resident's needs including the following if required: 1. Health monitoring, 2. Assistance with personal care services, 3. Nursing services, 4. Supervision, 5. Special diets, 6. Ancillary services, 7. The provision of other services such as transportation and supportive services; and, 8. The manner of service provision, and identification of service providers, including family and friends, in keeping with resident preferences. (c) Pursuant to the definitions of "shared responsibility" and "managed risk" as provided in section 429.02, F.S., the service plan must be developed and agreed upon by the resident or the resident's representative or designee, surrogate, guardian, or attorney-in-fact, and must reflect the responsibility and right of the resident to consider options and assume risks when making choices pertaining to the resident's service needs and preferences.	AE206		

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AE206	Continued From page 9 (d) The service plan must be reviewed and updated quarterly to reflect any changes in the manner of service provision, accommodate any changes in the resident's physical or mental status, or pursuant to recommendations for modifications in the resident's care as documented in the nursing assessment. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to admit a resident and develop a preliminary service plan prior to receiving extended congregate care (ECC) services for one Resident (#5) of one sampled resident that required ECC services for , ( ) maintenance and management. Findings Included: During a medication pass observation with Staff A for Resident #5, conducted on at 07:00am, Staff A administered Resident #5's prescribed medication and bolus feeding inappropriately to Resident #5 via (Reference: E207). Staff A changed Resident #5's site inappropriately as well. A review of the ECC services admission and discharge log, conducted on , revealed that Resident #5 was not admitted to the facility's ECC services. A record review for Resident #5, conducted on , revealed that Resident #5's record did not include an authorization or order from his health care provider to admit him to ECC services. Resident #5's record did not include a preliminary service plan that included an	AE206		

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AE206	Continued From page 10 assessment of whether the resident's needs could be met with the facility's residency criteria, an appraisal of the resident's unique physical, , and social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs and agreed upon by the resident or the resident's responsible party. Resident #5's record did not include and initial assessment prior to him receiving ECC services. Resident #5 was admitted to the facility on with a in place and required ECC nursing services. Resident #5's health assessment form dated did not state the resident's required nursing services of ECC and that the resident required medication administration. Resident #5's medication observation records stated that all medications were to be given via and none of the medication were ordered to be given by . During an interview with the Director of Nursing (DON), conducted on at 10:15am, the DON agreed that Resident #5 did not have evidence that he was admitted to the facility's ECC services. The DON agreed that there was no authorization in Resident #5's record to admit him to ECC services. The DON agreed that staff were providing ECC services to Resident #5 without the development of a preliminary service plan and initial assessment. The DON agreed that Staff A inappropriately administered Resident #5 his medication and bolus feeding and inappropriately changed his . Class III	AE206		
{AE207} SS=D	59A-36.021(7) FAC ECC - Services (7) EXTENDED CONGREGATE CARE	{AE207}		

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{AE207}	Continued From page 11 SERVICES. All services must be provided in the least restrictive environment, and in a manner that respects the resident's independence, privacy, and dignity. (a) A facility providing extended congregate care services may provide supportive services including social service needs, counseling, emotional support, networking, assistance with securing social and leisure services, shopping service, escort service, companionship, family support, information and referral, assistance in developing and implementing self-directed activities, and volunteer services. Family or friends must be encouraged to provide supportive services for residents. The facility must provide training for family or friends to enable them to provide supportive services in accordance with the resident's service plan. (b) A facility providing extended congregate care services must make available the following additional services if required by the resident's service plan: 1. Total help with bathing, [illegible], grooming and toileting, 2. Nursing assessments conducted more frequently than monthly, 3. Measurement and recording of basic vital functions and [illegible], 4. Dietary management including provision of special diets, monitoring nutrition, and observing the resident's food and fluid intake and output, 5. Assistance with self-administered medications, or the administration of medications and treatments pursuant to a health care provider's order. If the individual needs assistance with self-administration the facility must inform the resident of the qualifications of staff who will be providing this assistance, and if unlicensed persons will be providing such assistance, obtain	{AE207}		

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{AE207}	Continued From page 12 the resident's or the resident's surrogate, guardian, or attorney-in-fact's informed written consent to provide such assistance as required in section 429.256, F.S., 6. Supervision of residents with [illegible] and [illegible], 7. Health education and counseling and the implementation of health-promoting programs and preventive regimes, 8. Provision or arrangement for rehabilitative services; and, 9. Provision of escort services to health-related [illegible]. (c) Nursing staff providing extended congregate care services may provide any nursing service permitted within the scope of their license consistent with the residency requirements of this rule and the facility's written policies and procedures, provided the nursing services are: 1. Authorized by a health care provider's order and pursuant to a plan of care, 2. Medically necessary and appropriate for treatment of the resident's condition, 3. In accordance with the prevailing standard of practice in the nursing community, 4. A service that can be safely, effectively, and efficiently provided in the facility, 5. Recorded in nursing progress notes; and, 6. In accordance with the resident's service plan. (d) At least monthly, or more frequently if required by the resident's service plan, a nursing assessment of the resident must be conducted. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide nursing services in accordance with the prevailing standard of practice for medication and bolus feeding administration in the nursing community. Furthermore, the facility failed to	{AE207}		

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{AE207}	Continued From page 13 follow control standards during medication administration. Findings Included: During an observation of ECC services with Staff A for Resident #1 and #5, conducted on , Staff A, a licensed Practical Nurse did not properly provide ECC services for medication administration and bolus feeding via , ( ) tube or follow standards in control and the following was observed: At 06:07am, Staff A gathered medication and equipment for Residents #1 and #4 into one tote that she carried to Resident #4's room first and then to Resident #4's room. Staff A was unable to wash her after administering , , and an , scrub to Resident #4 and had to walk down the hall to the Parlor to wash her where she place the tote holding medication on the countertop without a barrier. At 06:21am, Staff A placed the medication tote onto a chair at Resident #1's bedside that in which it was lying on top of a cushion and , without a barrier. Staff A proceeded to administer Resident #1's , 125mcg first and then his bolus feeding of one carton of Jevity via the tub. Staff A did not check to see if Resident #1 had any residual prior to administering his medication and bolus feeding and after checking for placement, Staff A took her stethoscope off and laid it on Resident #1's bed without a barrier. After completing the medication administration and bolus feeding, Staff A left the room and walked down the hall without washing her	{AE207}		

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{AE207}	Continued From page 14 At 06:42am, returned to med room and obtained Residents #5 and #7's medication and placed the medications together in the medication tote and the stethoscope around her without cleaning it. Staff A went to Resident #7's room first and after providing Resident #7 her medications Staff A proceed to Resident #5's room without washing her . Staff A set up Resident #5's equipment for his 10mcg medication administration and bolus feeding without washing her . Staff A did not check if the resident had residual in his after checking for placement. Staff A removed the stethoscope from around her and place it on the floor at 07:06am. During the bolus feeding administration, Staff A received a call on her walkie talkie and answered the call with her gloved left . Staff A continued to administer the bolus feeding via during and after the call. Staff A did not change her gloves or wash her and place the walkie talkie in her pocket. At 07:15am, Staff A picked the stethoscope off the floor and placed it on the coffee table without a barrier. Staff A removed the to the tube site with the same gloves on and then removed the gloves. Staff A did not wash her or put on new gloves and place a clean to the site barehanded. At 07:25am, Staff A pick the stethoscope off the coffee table and placed it in the medication tote and took the full trash bag out to the trash receptacle without gloves on. Staff A carried the full trash bag in the same as the medication tote to the medication room through the dining room without washing her . The full trash bag was in contact with the medication tote. Staff A placed the medication tote onto the	{AE207}		

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{AE207}	Continued From page 15 medication cart without a barrier and took the stethoscope out of the medication tote and laid it on top of the medication cart without a barrier. Staff A continued without washing her by 07:34am. A record review for Resident #5, conducted on , revealed that Resident #5 did not have an authorization from his health care provider that he may be admitted to extended congregate care (ECC) services. Resident #5 did not have a service plan to follow for ECC services. During an interview with the Director of Nursing (DON), conducted on at 10:30am, the DON agreed that the nurses must give medication according to the standards of nursing practice and follow control precautions which included washing their and changing their gloves before, during and after medication administration, bolus feedings, and changes. The DON agreed that placing the medication tote and the stethoscope on various surfaces in multiple resident rooms posed an control risk to both residents and Staff A and that the medication tote and the stethoscope should have been sanitized between rooms. Class III	{AE207}		
{A 000}	Initial Comments A third revisit to re-licensure biennial survey and a revisit to complaint investigation (complaint number: 2021014481) were conducted at Harborchase on . Deficiencies were identified at the time of survey.	{A 000}		

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A 053	Continued From page 16	A 053		
A 053 SS=D	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 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	A 053		

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A 053	Continued From page 17 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 observation and interview, the facility failed to administer medications per nursing standards of medication administration, packaging instruction, and standards of control for five Residents (#1, #4, # #6, and #7) of five sampled residents. Findings Included: During an observation of the medication pass with Staff A, a licensed Practical Nurse, conducted on , at 05:56am, Staff A obtained a plastic medication cup with the number 103 written on it. The medication cup had opened medications in it with no medication labels. The Surveyor was unable to observe Staff A compare the medication labels to Resident #6's medication observation records or observed the number of pills in the medication cup. Staff A carried the medication cup of pills to Resident #6's room. Staff A did not identify the medications that she was giving Resident #6. Staff A did not wash or sanitize her after providing Resident #6 her medications. During an observation conducted on at 06:07am, Staff A pre-prepped Residents #1 and #4's medications in the same medication tote which included Resident #1's prescribed 125mcg and Resident #4's prescribed Refresh Tears and Ocusoft lid scrub. Staff A carried the tote with both Residents #1 and #4's medications to Resident #4's room and then to Resident #1's room. There were no medication labels or pill packs present. At	A 053		

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A 053	Continued From page 18 06:13am, Staff A placed the medication tote onto Resident #4's dresser without a barrier. Staff A administered Resident #4's Refresh Tears to both and without waiting five minutes. Staff A washed Resident #4's with the prescribed Ocusoft lid scrub. Staff A used one scrub for both Resident #4's right and left . Staff A did not change gloves or wash her between the and the scrub. Staff A did not administer the scrub first to cleanse the resident's before administering the . Staff A did not rinse Resident #4's after administering the scrub. Staff A did not wash her or change her gloves prior to checking on the resident's and removing her socks when she complained that her were hurting. After leaving Resident #4's rooms, Staff A carried the medication tote down the hall to the Parlor and placed the tote on the countertop without a barrier and washed her . During an observation conducted on at Staff A returned to the medication room and pre-prepped medications for Residents #5 and #7 in the same medication tote which included Resident #5's prescribed 10mcg and Resident #7's prescribed 9.5mg/24-hours patch, 25mcg, and 50mg. Staff A carried the tote with both Residents #5 and #7's medication to Resident #7's room first and then to Resident #5's room. There were no medication labels or pill packs present. At 06:56am, Staff A placed the medication tote on a countertop without a barrier in Resident #7's room. Staff A removed the old patch from Resident #7's right with her bare and place it in the resident's trash receptacle by her chair. Staff A did not wash her or put on gloves and placed the new patch on Resident #7's left . Staff A picked	A 053		

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A 053	Continued From page 19 up the medication tote and left the room without washing her and went to Resident #5's room to administer medications via . A review of the Ocusoft , packaging instructions, conducted on , revealed that the directions for use were to obtain one scrub and use to cleanse one , with side-to-side while , touching the , and rinse the , thoroughly after application and repeat for the second , . During an interview with the Director of Nursing (DON), conducted on at 10:30am, the DON agreed that the nurses must give medication according to the standards of nursing practice and follow control precautions which included washing their and changing their gloves before, during and after medication administration. The DON agreed that Nurses should prepare and carry one resident's medications at a time and pre-prepping and carrying multiple residents' medication at a time places the residents at risk for medication errors. The DON agreed that placing the medication tote and the stethoscope on various surfaces in multiple resident rooms posed an control risk to both residents and Staff A and that the medication tote and the stethoscope should have been sanitized between rooms. The DON agreed that the directions of use and the standards of nursing practice should be used when administering , , and , scrubs. Class III	A 053		

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{A 054}	Continued From page 20	{A 054}		
{A 054} SS=D	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 [illegible] 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 [illegible], 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 interview, the facility failed to have all Medication Observation Records (MORs) free from errors, with all required data, and immediately updated each time medications	{A 054}		

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{A 054}	Continued From page 21 were offered for three Residents (#1, #2, and #3) of three sampled residents that required assistance with medications or medication administration (photographic evidence obtained). Findings Included: A record review for Resident #1, conducted on , revealed that Resident #1's MORs contained errors. Resident #1's 5-325mg, Liquid 12.5/5ml, 135mg, Acidophilus tablets, 300mg/5ml, and 2mg stated for the resident to take by . Resident #1 had an order for nothing by and was admitted to the facility's extended congregate care services for management. Resident #1's health assessment dated stated that the resident required medication administration. A record review for Resident #2, conducted on , revealed that Resident #2's MORs had medication that were not documented as given or offered to the resident which included: - 500mg was not documented as given on and at 6am. - 1% cream was not documented as given on at 08:00am. - 2.5mg was not documented as given on at 08:00am. - 40mg was not documented as given on at 08:00am. - C 250mg was not documented as given on and at 08:00am. - 81mg was not documented as given on and at 08:00am. - 1mg was not documented as given on at 08:00am.	{A 054}		

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{A 054}	Continued From page 22 - [illegible] 5mg was not documented as given on [illegible] at 08:00am and 12:00pm. - [illegible] was not documented as given on [illegible] at 08:00am. - [illegible] 2.5mg was not documented as given on [illegible] and [illegible] at 08:00am. - [illegible] was not documented as given on [illegible] at 08:00am. - [illegible] D-3 was not documented as given on [illegible] at 08:00am. Resident #2's [illegible] health assessment form that was not dated and a [illegible] health assessment form dated [illegible] stated that the resident required assistance with medications. A MORs review for Resident #3, conducted on [illegible], revealed that Resident #3's [illegible], MORs did not contain Resident #3's health care provider's name or phone number. Resident #3's health assessment form dated [illegible] stated that the resident required assistance with medications. During an interview with the Director of Nursing, conducted on [illegible] at 10:30am, the Director of Nursing agreed that Resident #1 MORs stated to give the resident medications by [illegible] when he was nothing by [illegible] status. The Director of Nursing agreed that Resident #2's MORs had meds that were not documented as given to the resident. The Director of Nursing agreed that Resident #3's MORs did not list her health care provider's name or telephone number. Class III	{A 054}		

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{A 055}	Continued From page 23	{A 055}		
{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 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	{A 055}		

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{A 055}	Continued From page 24 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 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	{A 055}		

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{A 055}	Continued From page 25 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 keep centrally stored medications locked and secured at all times. Findings Included: Observations, conducted on , revealed that the facility did not keep centrally stored medications locked and secured at all times. At 06:10am, Staff A, a licensed practical nurse, left the medication room and medication cart #4 was unlocked. There was no other staff present in or around the medication room. The medication room double entry doors were both wide open when Staff A left the room to go to the memory care unit. At 10:00am, the medication room double entry doors were wide open and there was no staff present in or around the medication room. Medication cart #2 was unlocked with the keys left in the keyhole. Staff D entered the medication room at 10:05am. During an interview with Staff D, conducted on at 10:05am, Staff D stated that Staff C was in charge of medication cart #2 and had left on her break. During an interview with the Director of Nursing	{A 055}		

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{A 055}	Continued From page 26 (DON), conducted on [redacted] at 10:15am, the DON agreed that all medications were supposed to be locked and secured at all times. Class III	{A 055}		