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
	AL11953279	A. BUILDING: _____ B. WING _____	12/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMS OF PUNTA GORDA (THE)	2295 SHREVE STREET PUNTA GORDA, FL 33950

(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 complaint survey for #2021016796 and #2021014426 was conducted on through at The Palms of Punta Gorda, an assisted living facility in Punta Gorda, Florida. Complaint #2021016796 was substantiated at A0053 and A0054 Complaint #2021014426 was substantiated at A0052, A0054 and A0055 The following is description of the deficiencies.	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	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 or placing the dosage in another container and helping the resident by lifting the container to his or her ..... (d) Applying , medications. (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.	A 052		

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A 052	Continued From page 2 (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. (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	A 052		

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A 052	Continued From page 3 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication 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, 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.	A 052		

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A 052	Continued From page 4 (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) 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. (h) 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, record review, and interviews, the facility failed to ensure 6 (Resident #6, #3, #4, #5, #7, and #8) of 10 residents reviewed received appropriate assistance with self-administration of medications to ensure each resident received prescribed medications as per the physician's orders. The findings included: 1. On , review of Resident #6's record revealed a hospital "Patient Discharge Instruction" form dated noting the resident was diagnosed with a , . The record contained a prescription dated for DS ( ) 800 milligrams (mg)-160 mg, one tablet by daily for five days. Review of the Medication Observation Record (MOR) for showed Resident #6 received Sufamethoxazole (DS) 800 mg-160 mg for three days, , and .	A 052		

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A 052	Continued From page 5 On ... ... at 10:31 a.m., in an interview Med Tech Staff B said she found the bottle of ... in the medication cart, wrote it on the MOR and gave it to Resident #6 on ... , ... and ... . She said on ... she could not locate any of Resident #6's medications in the cart, including the ... . Staff B said she did not know what happened to the resident's medications therefore entered a "0" each day for each prescribed medication and reported the missing medications to the Resident Care Manager Staff A. Further review of the MOR for ... showed Resident #6 did not receive the following medications from ... : ... , ... (...) Extra Strength 500 mg, two tablets twice daily; ... , (for high ... , ...) 40 mg daily; ... , ... (for ...) 125 micrograms (mcg) daily, ... , ... 20 mg (to decrease amount of ... in the ...) daily, ... 25 mg daily (eliminates unneeded water), ... 1000 mcg daily. Resident #6 also had an order for DOK 100 mg (softener) daily. The MOR lacked documentation Resident #6 received the medication from through and ... through ... . On ... ... at 2:43 p.m., in an interview Resident Care Coordinator Staff A said Resident #6 went to the hospital and came ... with an order for an . She said the hospital discharge note and the order should have been in the resident record. She did not know why the ... was not given for five days as ordered. 2. Record review of Resident #3 revealed a Health Assessment AHCA Form 1823 dated	A 052		

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A 052	Continued From page 6 which documented the resident needed assistance with self-administration of medications. Resident #3's physician's orders included to inject Aimovig 140 milligrams (mg) once a month for a diagnosis of . Review of the MOR for and failed to show documentation Resident #3 received the Aimovig on and . The MOR were not in the record making it impossible to determine if Resident #3 received the prescribed Aimovig injection in . The MOR were requested and not provided on , , and . On at 11:41 a.m., in an interview the Advanced Practice Registered Nurse (APRN) said she did not know if Resident #3 self-injected the Aimovig for her and would have to ask the facility staff. Review of Resident #3's most recent Health Assessment AHCA Form 1823 signed and dated by a physician, showed Resident #3 was able to self-administer medications and did not need staff assistance. On at 11:15 a.m., in an interview Resident #3 said she gets the Aimovig from a local pharmacy and self-injects it. On at 2:55 p.m., in an interview Resident Care Coordinator/Med Tech Staff A said a home health agency then the APRN used to do administer the monthly Aimovig to Resident #3.	A 052		

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A 052	Continued From page 7 She said she was not aware Resident #3 was self-injecting the Aimovig. 3. Record review showed Resident #4 was admitted from a local hospital to the facility on . The hospital discharge orders dated included seven different medications including , 5 milligrams (mg) daily at bedtime and 10 mg two times a day for , , 2 mg twice a day, 40 mg once a day for , , and , 0.5 mg three times a day as needed for agitation or . The , , and were not transcribed on the MOR for . There was no documentation Resident #4 received the medications as ordered. The , was transcribed as " 0.5 mg take 1 tab [tablet] as needed" and did not specify the frequency of administration of three times a day as per the discharge orders. The MOR had documentation Resident #4 was assisted with self-administration of medications on , even though had 30 days. The MOR for showed documentation Resident #4 was assisted with , 0.5 mg daily at 5:00 p.m., instead of three times a day as needed without the benefit of a physician's order. There was no documentation Resident #4 received 40 mg from through . On through the Med-Tech entered "0" on the MOR for the	A 052		

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A 052	Continued From page 8 There was no documentation Resident #4 received , 2 mg as ordered from through . The , was not transcribed on the MOR. Resident #4's record did not contain a physician's order for the daily dose of , or to discontinue the , . On at 2:14 p.m., in an interview the Resident Care Coordinator/Med Tech Staff A verified the , , and were missing on the MOR. She also verified the MOR was inaccurate and reflected 31 days for instead of 30 days. Resident Care Coordinator/Med Tech Staff A said she learned to transcribe the medications on the MOR by watching previous Resident Care Coordinators and nurses. They would write the medications they physically had on a MOR while waiting for the pharmacy to send a MOR. She said she looked through the Health Assessment AHCA Form 1823, wrote the MORs for the last 3 months but had no time to study each new MOR as it came in. She said she knew it was dangerous. Staff A said the Executive Director (ED) noticed Resident #4 was acting different the next day but could not describe what "different" was. The ED saw the MOR did not contain all the medications specified on the physician's order. She informed the ED she wrote the medications Resident #4's son provided on the MOR. The next day the Advanced Practice Nurse Practitioner (APRN) was contacted to get orders for the missing medications. The APRN	A 052		

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A 052	Continued From page 9 sent the orders to the pharmacy and not to the facility. On at 2:15 p.m., Resident #4 was observed in the memory care unit. He was not able to hold a conversation or answer questions about his medications. 4. Review of Resident #7's record revealed the most current Health Assessment AHCA form 1823 was completed and signed by a health care practitioner on . The form noted Resident #7's diagnoses included and specified Resident #7 required help with taking medications. The practitioner placed a check mark in the box indicating the resident needed assistance with self-administration of medications. The form indicated Resident #7 had , was , and had a history of aggressive behavior. The physician's orders for included an order with a start date of to inject 30 units , twice a day. Review of the Medication Observation Record (MOR) for , and showed documentation the Medication Technicians (Med techs) were assisting Resident #7 with self-administration of the twice a day at 9:00 a.m., and 5:00 p.m. No MOR was available for review from through , making it impossible to determine if Resident #7 received assistance with self-administration of medications. The MOR showed	A 052		

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A 052	Continued From page 10 documentation the Med Techs assisted Resident #7 with self-administration of oral medications from ... ... through ... ... The MOR lacked documentation the resident received assistance with self-administration of the ... ... An entry that read "self" was entered on the MOR in the box for assistance with the ... administration. There was no physician's order authorizing Resident #7 to self-administer the ... . The record lacked documentation of an assessment of Resident #7's ability to independently self-inject the ... . On ... at 11:41 a.m., in an interview the Advanced Practice Registered Nurse (APRN) said she did not know if Resident #7 self-administered her ... . She said she would think home health nurses would be responsible to administer the ... . On ... ... at 2:55 p.m., in an interview Resident #7 said she has been a ... since she was about ... ... and took her ... when she needed it. She said she was aware when her ... ... was too high or too low and did not take the ... every day. Resident #7 said she did not use ... ... but a vial of ... which she did not refrigerate and kept the needles in her room. On ... ... at 4:15 p.m., observation of Resident #7's room with the business office manager, including refrigerator, dresser drawers, nightstand, table drawers, and closet found no ... , ... or needles. No red biohazard box was found for used needles/pens. Review of Contract Pharmacy Packing slip for medication delivery dated ... showed a 25	A 052		

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A 052	Continued From page 11 days' supply of injection was delivered for Resident #7. A Pharmacy Packing Slip dated showed the facility received and signed for 100 needles for checks for Resident #7. No other shipment of needles, or vials were delivered through from the facility Contract Pharmacy. On at 9:24 a.m., a telephone interview was conducted with the Director of the pharmacy who provided medications to the residents until . The Director said on the pharmacy filled and delivered a shipment of for Resident #7. She said that was the last time and only time they sent for the resident. On at 10:31 a.m., regular Caregiver/Med Tech Staff B said The Resident Care Coordinator/Med Tech Staff A and another Med Tech told her Resident #7 could and did take her own . She said she never knew any different and that's why she wrote "self" on the MOR for the injection. She said she had never seen Resident #7 self-administering her and did not know if she had an . On at 2:47 p.m., in an interview Resident Care Coordinator/Med Tech Staff A said Resident #7's family had said to put the in the resident's refrigerator, and she could do her own injections. Staff A said the facility never assessed Resident #7 to see if she could self-administer her medications. She said she did not know if the resident was injecting her daily. 5. Review of Resident #5's record revealed an admission date of .	A 052		

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A 052	Continued From page 12 The medication list attached to the Health Assessment AHCA Form 1823 included the following medications: , 30 mg 1 tablet at bedtime for , Polyethylene , 17 grams at bedtime ( ), , 0.25% daily to area until healed, / , 5-325 mg one time daily for extreme , as needed. The orders also included to clean the right great with normal , apply a small amount of (barrier) , to the right great, and cover with a dry every two days. The Polyethylene was changed to , another , on . The , Polyethylene , , / , and the treatment to the right great with were not transcribed on the MOR. The Resident record also contained a prescription dated for , 500 mg orally twice a day. The MOR did not include , 500 mg 1 tablet twice a day. The MOR was marked as "Does not have" for the - , 5-325 mg, 1 tablet as needed, 1 time a day for severe . Resident #5's record did not contain a physician's order to discontinue the , Polyethylene , / , or .	A 052		

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A 052	Continued From page 13 On at 2:26 p.m., in an interview Resident Care Coordinator/Med Tech Staff A verified the , Polyethylene , / and the care order with for the Resident's right great were not transcribed on the MOR and the resident was not assisted with these medications from through . She said she was not given the medications to add to the MOR. Staff A She said she handwrote Resident #5's MOR from the medications on . She said the Admission Director did not give her the move-in packet and would not let the Resident Care Coordinator handle the medication portion of the admission. The Admission Director told her it was admission's job and things were missed until the packet was shared. Staff A said the pharmacy usually sends medications and their MOR in days but sometimes when she calls, they do not even have the resident in their system yet. Staff A reported Resident #5 had and can't pass feces like a "normal person" and had no idea what was going on with the resident's right great . Staff A said the admission packet was also sent to the APRN, so she assumes the APRN will follow up on the . She said she had not heard any complaints about the , so she assumed the APRN has addressed it. 6. Review of the MOR for for Resident #8 revealed a handwritten entry for "... drops, 5 drops in each ". The medication was scheduled for 9:00 a.m., and 5:00 p.m., and did not include a stop date. On at 10:31 a.m., Med Tech Staff B said she found a bottle of drops for Resident #8 in the medication cart, so she wrote it on the MOR	A 052		

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A 052	Continued From page 14 to be given. She said she believed the drops were for wax and were sold over the counter at a pharmacy. She said she asked the resident if she needed it and wrote it on the MOR for 9:00 a.m., and 5:00 p.m. On at 2:30 p.m., Resident Care Coordinator Staff A provided a physician's order signed and dated on by an Advanced Practice Registered Nurse for " 6.5% drop, instill 5 drops in each [twice a day] for 7 days". On at 2:43 p.m., Staff A said the APRN ordered the drops for Resident #8 due to wax and hearing issues and it was an old order. Class II	A 052		
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.	A 053		

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A 053	Continued From page 15 (d) A facility that performs clinical laboratory tests for residents, including 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 federal CLIA Certificate must be maintained in the facility. A 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 federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services 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 record review, and interview, the facility failed to provide or arrange for medication administration as ordered by the Health Care Provider for 1 (Resident #1) of 3 resident reviewed for administration of injectable medications. The findings included: Record review revealed Resident #1 was admitted to the facility on . The Resident Health Assessment, Agency for Healthcare Administration (AHCA) form 1823 signed and dated by a physician noted diagnoses including , and related to . The assessment specified Resident #1 needed assistance with activities of daily living and needed medication administration. The prescribed medications listed on the AHCA	A 053		

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A 053	Continued From page 16 form 1823 included Kesimpta 20 milligrams (mg) , every four weeks. Kesimpta is a medication approved to treat relapsing forms of , (RMS) in adults. Kesimpta reduces and helps slow down damage. , ( ) is a inflammatory of the characterized by myelin destruction and axonal damage in the , , , and , cord. The various forms of can be distinguished based on whether a patient experiences relapses (clearly defined acute inflammatory of worsening function), and/or whether they experience progression of damage and from the onset of the . Record review of Resident #1's Medication Observation Record (MOR) for failed to reveal documentation Resident #1 received the Kesimpta injection as ordered. The MOR for bore initials indicating Medication Technicians injected Resident #1 with Kesimpta 20 mg daily on through and through . A line was drawn through the initials with an entry that read, "Med error" with Resident Coordinator Staff A's initials. No other entry was found on the MOR for indicating Resident #1 received the Kesimpta injection as ordered. Review of the Incident/Accident Report completed by Resident Coordinator/Med Tech Staff A and dated , documented on	A 053		

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A 053	Continued From page 17 at 12:45 p.m., Resident #1 was found unresponsive in her bed with her turned to her left, were rolled , and left sided . Resident #1 was transported via Emergency Medical Services ( ) to a local emergency room. On at 9:12 a.m., in an interview Resident #1's Power of Attorney (POA) said he made it clear on Resident #1's admission to the facility the Kesimpta was very important to the remission of her , ( ). He had asked to see her medication observation record (MOR) because he had noticed a change in her behavior and her care. He said he noted she had not received her monthly injection of Kesimpta. He said she was not getting other medications he knew she had been prescribed by her urologist which were needed to prevent , stones. He said he felt the facility was to blame for the condition she was in and the reason she was sent to the hospital. On at 1:10 p.m., in an interview Resident Care Coordinator Staff A said she completed the admission for Resident #1 on . She said when Resident #1 was admitted, she just took the list of medication from the family, looked at medications the family brought in, and wrote them on the MOR to be given by the Med Techs. She said she did not see any injection for the Kesimpta so she did not write it on the MOR. Staff A said she was not aware she should write the medication ordered on the 1823 on the admission MOR. She said she was never taught; she just did what she saw others do in the past. On at 2:51 p.m., in an interview the Pharmacist from the Pharmacy	A 053		

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A 053	Continued From page 18 providing medications until , said they filled the prescription for Kesimpta for Resident #1 and sent it to the facility on and it was signed as delivered. Review of the Pharmacy's packing slip for medication shipment to the facility dated showed Resident Care Coordinator Staff A signed she received one Kesimpta injection 20mg/.4 ml for Resident #1. On at 10:14 a.m., in an interview Resident Care Coordinator Staff A reviewed the packing slip from the contract pharmacy indicating she had signed off receiving the Kesimpta injection for Resident #1 on . She said she did not recall seeing the injectable medication. On at 12:05 p.m., in a telephone interview, Resident #1's said he had been seeing Resident #1 for the past several years for her ( ). He said the Kesimpta injection was essential to her well-being and without the medication she would go into relapse of her and would decline physically and mentally. He said he felt the decline and subsequent admission to the hospital could be directly related to not getting her injectable medication for the last two months. Class II	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;	A 054		

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A 054	Continued From page 19 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 reviewed, observation, and staff interviews, the facility failed to ensure Medication Observation Records (MOR) were accurate for 3 (Residents #3, #4, and #7) of 8 sampled residents. The findings included: 1. Record review of Resident #3 revealed a Health Assessment AHCA Form 1823 dated	A 054		

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A 054	Continued From page 20 which documented the resident needed assistance with self-administration of medications. Resident #3's physician's orders included to inject Aimovig 140 milligrams (mg) , once a month for a diagnosis of . The medication was scheduled for the 22nd of each month. Review of the MOR for and failed to show documentation Resident #3 received the Aimovig on and . The MOR were not in the record and requested on , , and but not provided making it impossible to determine if Resident #3 received the prescribed medications, including the Aimovig injection in . On at 11:41 a.m., in an interview the Advanced Practice Registered Nurse (APRN) said she did not know if Resident #3 self-injected the Aimovig for her and would have to ask the facility staff. Review of Resident #3's most recent Health Assessment AHCA Form 1823 signed and dated by a physician, showed Resident #3 was able to self-administer medications and did not need staff assistance. On at 11:15 a.m., in an interview Resident #3 said she gets the Aimovig from a local pharmacy and self-injects it. On at 2:55 p.m., in an interview Resident Care Coordinator/Med Tech Staff A said a home health agency then the APRN used to do administer the monthly Aimovig to Resident #3. She said she was not aware Resident #3 was self-injecting the Aimovig. 2. Record review showed Resident #4 was admitted from a local hospital to the facility on	A 054		

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A 054	Continued From page 21 .	A 054		

The hospital discharge orders dated included seven different medications including , 0.5 mg three times a day as needed for agitation or , for three days.
The , was transcribed as " , 0.5 mg take 1 tab [tablet] as needed" on the MOR and did not specify the the duration or frequency of administration as specified in the discharge orders.
The MOR had documentation Resident #4 was assisted with self-administration of medications on , even though had 30 days.
The MOR for showed documentation Resident #4 was assisted with , 0.5 mg daily at 5:00 p.m., instead of three times a day as needed without the benefit of a physician's order.
On at 2:14 p.m., in an interview the Resident Care Coordinator/Med Tech Staff A verified the MOR was inaccurate and reflected 31 days for instead of 30 days.

3. Review of Resident #7's record revealed the most current Health Assessment AHCA form 1823 was completed and signed by a health care practitioner on .
The form noted Resident #7's diagnoses included and specified Resident #7 required help with taking medications.
The physician's orders for included an order with a start date of to inject 30 units , twice a day.
No MOR was available for review from through , making it impossible to determine if Resident #7 received assistance with self-administration of

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A 054	Continued From page 22 medications. The were requested on , , and but not provided. The MOR showed documentation the Med Techs assisted Resident #7 with self-administration of oral medications from through but lacked documentation the resident received assistance with self-administration of the . An entry that read "self" was entered on the MOR in the box for assistance with the administration. On at 11:41 a.m., in an interview the Advanced Practice Registered Nurse (APRN) said she did not know if Resident #7 self-administered her . She said she would think home health nurses would be responsible to administer the . On at 2:55 p.m., in an interview Resident #7 said she was aware when her was too high or too low and did not take the every day. Resident #7 said she did not use , but a vial of which she did not refrigerate and kept the needles in her room. On at 10:31 a.m., regular Caregiver/Med Tech Staff B said The Resident Care Coordinator/Med Tech Staff A and another Med Tech told her Resident #7 could and did take her own . She said she never knew any different and that's why she wrote "self" on the MOR for the injection. She said she had never seen Resident #7 self-administering her and did not know if she had an . On at 2:47 p.m., in an interview Resident Care Coordinator/Med Tech Staff A said Resident #7's family had said to put the in the resident's refrigerator, and she could do her own injections. Staff A said the facility never assessed Resident #7 to see if she could self-administer her medications. She said she did	A 054		

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A 054	Continued From page 23 not know if the resident was injecting her daily. 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. 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	A 055		

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A 055	Continued From page 24 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it 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	A 055		

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A 055	Continued From page 25 at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, and interview, the facility failed to ensure safe storage of centrally stored medications in a secured area away from facility residents. The findings included: On at 10:30 a.m., a room off the lobby in front of the facility was observed unlocked with the door opened. The room had a smaller room with a closet. The doors to the closet and the smaller room were wide open. The closet contained multiple boxes of unsecured medications and large plastic totes with more than 75 . . . packs of residents' medications, pill bottles, and patches, including several cards for Resident #1. Approximately 200 cards and bottles of medication were unsecured and accessible to any unauthorized person or resident. There were no facility staff in the area. The medications were left unattended from 10:30	A 055		

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A 055	Continued From page 26 a.m., until 10:45 a.m., when the Executive Director (ED) walked in the room and verified the medications were left unsecured while unattended. The ED said the closet and room should have been secured and the closet locked. On at 10:50 a.m., Resident Care Coordinator Staff A verified she did not lock the door and ensure the medications were locked when she left the room. Staff A said she removed the surplus of medications from the medications carts and stored them in the closet. She said some of the medications belonged to discharged or residents. She said she had not destroyed them or sent them to the pharmacy. She said Resident #1's brought the medications in , and she stored them in the closet since her admission. Class III .	A 055		