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
	AL11967748	A. BUILDING: ______ B. WING ______	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR OF VENICE	1600 CENTER RD VENICE, FL 34292

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A 000	Initial Comments An unannounced complaint survey for #2021012560 and #2021015631 was conducted on to at Windsor of Venice, an assisted living facility in Venice, Florida. Complaint #2021012560 was substantiated at A052 and A165. Complaint #2021015631 was substantiated without citation. 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		

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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	A 052		

(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

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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	A 052		

(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 record review, and staff interview, the facility failed to follow physician's orders when providing assistance with self-administration of medication according to medications orders for 4 (Residents #1, #2, #7 and #8) of 4 residents reviewed. Failure to follow physicians' orders resulted to Residents #1's overdose on /1. Failure to follow physicians' orders is a direct threat to residents.

The findings included:

1. Record review for Resident #1 found she had an order for , SOL (liquid ,) 250/5 ml. take one half teaspoon full (2.5 ml) (125 mg) by every night at bedtime, originating on ..... Further review found a Resident Note dated at 9:48 a.m., documenting on .... at 7:45 p.m., a nurse on duty (unidentified) gave the resident 60 ml's of liquid .... instead of 2.5 ml as ordered. The nurse realized the mistake and notified the Health Care Director (HCD). Resident #1 was sent out to the hospital for evaluation and was admitted

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A 052	Continued From page 5 overnight. Upon return, the Resident Health Assessment Form 1823 dated , filled out by hospital, indicated resident had an "unintentional /drug overdose." During an interview on at 2:30 p.m., the Executive Director (ED) said she had been working here only for two weeks and she did not know the specifics of the event since no documentation was left behind by the previous ED. She did not know if the previous ED and HCC provided any in service or took statements from the staff involved. Interview on at 2:45 p.m., the Health and Wellness Director (HWD) said she had been working in the facility for a month. She was not aware of the issues that took place before her time. She did not have any record of statements regarding to the specifics related to the event or staff re-education. She said the facility has been auditing medication errors after the incident involving Resident #1. 2. Record review for Resident #2 found an order dated stating the following: "D/C and start 1 mg PO daily." Further review found a Resident Note dated indicating that Resident #2's daughter called because her mother had a on and she was supposed to start a new medication; however, her mother told her she was not getting the medication. The note documented the order was found on the chart, but not in "Quickmar" (system used to communicate with the pharmacy) so the order was faxed over, and receipt confirmed. Further documentation noted the family and Doctor was made aware on .	A 052		

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A 052	Continued From page 6	A 052		

A MOR review for Resident #2 found the resident was given up to , seven days after the d/c order. Further MOR review found that resident began receiving the new medication 1 mg on . Resident #2 received both on .

Interview on at 2:49 p.m., the Health Care Coordinator confirmed the error. She said the expectation is that the nurses call the pharmacy right away and make every afford to refill medications immediately. She said the person responsible for the error is no longer working there. He was terminated immediately. She said she is planning on re-educating the staff in medication errors.

3. Record review for Resident #7 found she had an order for , , inject 30 units , twice daily and , inject 5 units , every morning. Further record review found that nurse notified the health care coordinator that the resident did not receive her 8 a.m. on . MOR review for Resident #7 found she did not receive for a.m. or p.m. and a.m.

4. Record review for Resident #8 found he has an order for , inject 30 units , twice daily. Further review found a Resident note dated indicating that a nurse did not come and as a result the resident did not receive his medication. MOR review for Resident #8 found he did not receive on a.m. and p.m. and a.m.

Interview on at 3:00 p.m., the Executive Director said there was a disconnect in the way the agency staff that was coming in did not know that the was in a different software that the

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A 052	Continued From page 7 rest of the medication. She said she was also working to ensure they will have the same agency nurse coming for continuity of service. Class II .	A 052		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. . . . . ; 2. or , damage; 3. Permanent . . . . . . ; 4. or . . of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the	A 165		

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A 165	Continued From page 8	A 165		

resident's condition before the incident; or
7. An event that is reported to law enforcement or its personnel for investigation; or
(b) Resident elopement, if the elopement places the resident at risk of harm or injury.
(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.
(4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.
(6) ....., neglect, or .... must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct

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A 165	Continued From page 9 by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to maintain a risk management and quality assurance program whose purpose is to assess resident care practices, facility incident reports, and develop plans of action to correct and respond quickly to identify quality differences for 1 (Resident #14) of 2 adverse incidents reviewed.. The facility failed to submit an adverse incident to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S. The findings included: 1. Record review revealed Resident #14 had a prescription for , 10 mg -	A 165		

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A 165	Continued From page 10 325 mg, take 1 tablet 3 times a day for 30 days, started . Review of the internal incident report form from at 9:13 p.m., documented "Missing medication" and notification to facility staff and family. On , facility staff realized that Resident #14 did not have any more / medication and notified the Executive Director. Executive Director (ED) confirmed the lack of medication in place and called resident's pharmacy. Resident's pharmacy said they delivered 90 pills (a card with 60 pills and a second card with 30 pills) on and the resident was due for refill on . reconciliation form revealed the count started on 8/2621 with 60 pills documented and there were 30 pills missing. The Executive director notified the police and a deputy arrived in the facility on as a result of the report. Record review found no evidence the facility filed an adverse incident regarding the above-mentioned police investigation. Furthermore, there was no evidence of an internal investigation and quality assurance process to assess medication handling. The delivery signed slip for Resident #14's medication was requested but was not provided. Interview on at 10:00 a.m., the Health Care Coordinator said the issue took place before she began working for the facility and there was no documentation on record. Interview on at 12:45 p.m., the Area Director of Operations (ADO) confirmed the lack of adverse incident. He said the previous ED was responsible to complete the investigation, provide education and file the adverse incident. He said	A 165		

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A 165	Continued From page 11 there was nothing in the file and he could not provide more information. He said he did not come to the building for the time the previous ED was working for the facility. He said both the previous ED and Health Care Coordinator resigned. He said he believes the staff involved were terminated, but he did not know who they were since there was no internal investigation on record to share. Class III .	A 165		