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 |
|---|---|---|---|
| | AL11969617 | A. BUILDING: _____ B. WING _____ | 02/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAVEN ALF | 1514 HAVEN BEND TAMPA, FL 33613 |

| (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 160 SS=D | 59A-36.015(1) FAC Records - Facility<br><br>The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request.<br>(1) FACILITY RECORDS. Facility records must include:<br>(a) The facility's license displayed in a conspicuous and public place within the facility.<br>(b) An up-to-date admission and discharge log listing the names of all residents and each resident's:<br>1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [illegible]; and,<br>2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of [illegible].<br>(c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b).<br>(d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as | A 160 | | |

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 |
|---|---|---|---|
| | AL11969617 | A. BUILDING: _____ B. WING _____ | 02/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAVEN ALF | 1514 HAVEN BEND TAMPA, FL 33613 |

| (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 160 | Continued From page 1<br>described in rule 59A-36.019, F.A.C., that must be readily available by facility staff.<br>(e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C.<br>(f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C.<br>(g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C.<br>(h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by section 429.177, F.S.<br>(i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C.<br>(j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate.<br>(k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years.<br>(l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years.<br>(m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. | A 160 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969617 | A. BUILDING: _____ B. WING _____ | 02/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAVEN ALF | 1514 HAVEN BEND TAMPA, FL 33613 |

| (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 160 | Continued From page 2<br><br>(n) The facility's resident elopement response policies and procedures.<br>(o) The facility's documented resident elopement response drills.<br>(p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on attempted record review and interview the facility failed to maintain an admission discharge log of current and past residents.<br><br>Findings included:<br><br>An attempted record review of the facilitys' admission discharge log was conducted on<br>. . . . . .<br><br>An interview was conducted with the Administrator on at 10:12a.m. and when asked to see the admission discharge log he stated the facility does not have one.<br><br>Class III | A 160 | | |
| A 000 | Initial Comments<br><br>A biennial survey with a generator monitoring survey was conducted at Haven ALF on . The facility had deficiencies at the time of survey. | A 000 | | |
| A 010 SS=D | 429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency | A 010 | | |

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 |
|---|---|---|---|
| | AL11969617 | A. BUILDING: _____ B. WING _____ | 02/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAVEN ALF | 1514 HAVEN BEND TAMPA, FL 33613 |

| (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 010 | Continued From page 3<br><br>429.26 Appropriateness of placements; examinations of residents.-<br>(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility:<br>(a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.<br>(b) A facility may admit or retain a resident who requires the use of assistive devices.<br>(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.<br>(d)1. Except for a resident who is receiving | A 010 | | |

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 |
|---|---|---|---|
| | AL11969617 | A. BUILDING: _____ B. WING _____ | 02/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAVEN ALF | 1514 HAVEN BEND TAMPA, FL 33613 |

| (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 010 | Continued From page 4<br><br>hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:<br>a. Move, turn, or reposition without total physical assistance;<br>b. Transfer to a chair or wheelchair without total physical assistance; or<br>c. Sit safely in a chair or wheelchair without personal assistance or a physical .<br>2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.<br>3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.<br><br>(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.<br><br>(3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility.<br><br>59A-36.006<br>(4) CONTINUED RESIDENCY. Except as follows | A 010 | | |

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 |
|---|---|---|---|
| | AL11969617 | A. BUILDING: _____ B. WING _____ | 02/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAVEN ALF | 1514 HAVEN BEND TAMPA, FL 33613 |

| (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 010 | Continued From page 5<br>in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:<br>(a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.<br>(b) A resident requiring care of a [illegible] may be retained provided that:<br>1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner,<br>2. The condition is documented in the resident's record; and,<br>3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility.<br>(c) A [illegible] ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:<br>1. The resident qualifies for, is admitted to, and | A 010 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969617 | A. BUILDING: _____ B. WING _____ | 02/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAVEN ALF | 1514 HAVEN BEND TAMPA, FL 33613 |

| (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 010 | Continued From page 6<br><br>consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;<br>2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;<br>3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,<br>4. Documentation of the requirements of this paragraph is maintained in the resident's file.<br>(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.<br>(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.<br>(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.<br>(g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure that a change in condition requiring additional services were recorded on and Agency For Health Care Administration (AHCA) form 1823 for one (Resdient #1) of one sampled. | A 010 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969617 | A. BUILDING: _____ B. WING _____ | 02/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAVEN ALF | 1514 HAVEN BEND TAMPA, FL 33613 |

| (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 010 | Continued From page 7<br><br>Findings included:<br><br>A record review conducted on . . . . . revealed Resident #1 was admitted to Hospice services on . . . . . A record review on Resident #1 AHCA form 1823 was dated . . . . . There was no updated AHCA form 1823 in Resident #1 record when the change in condition occurred requiring Hospice services.<br><br>An interview was conducted on . . . . . at 10:49a.m. with Staff A when asked if there was an updated AHCA form 1823 for Resident #1 she stated they did not get one.<br><br>Class III | A 010 | | |
| A 051 SS=D | 59A-36.008(2) FAC Medication - Pill Organizers<br><br>(2) PILL ORGANIZERS.<br>(a) Only a resident who self-administers medications may maintain a pill organizer.<br>(b) Unlicensed staff may not provide assistance with the contents of pill organizers.<br>(c) A nurse may manage a pill organizer to be used only by residents who self-administer medications. The nurse is responsible for instructing the resident in the proper use of the pill organizer. The nurse must manage the pill organizer in the following manner:<br>1. Obtain the labeled medication container from the storage area or the resident,<br>2. Transfer the medication from the original container into a pill organizer, labeled with the resident's name, according to the day and time increments as prescribed,<br>3. Return the medication container to the storage area or resident; and,<br>4. Document the date and time the pill organizer | A 051 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969617 | A. BUILDING: _____ B. WING _____ | 02/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAVEN ALF | 1514 HAVEN BEND TAMPA, FL 33613 |

| (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 051 | Continued From page 8<br><br>was filled in the resident's record.<br>(d) If there is a determination that the resident is not taking medications as prescribed after the medicinal benefits are explained, it must be noted in the resident's record and the facility must consult with the resident concerning providing assistance with self-administration or the administration of medications if such services are offered by the facility. The facility must contact the resident's health care provider regarding questions, concerns, or observations relating to the resident's medications. Such communication must be documented in the resident's record.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation and interview, the facility failed to prevent the use of pill organizers by unlicensed staff for one resident (Resident#2) of one resident sampled.<br><br>Findings included:<br><br>An observation of Staff A, an unlicensed medication aide assisting with self-administration of medication with Resident #2 on ..... revealed that Staff A was using a pill organizer.<br><br>An interview was conducted with Staff A on ..... at 11:25a.m. and when asked who put Residents #2 medication in a pill organizer Staff A stated she had. When Staff A was asked if she was Nurse, Staff A stated she was not a Nurse.<br><br>Class III | A 051 | | |
| A 056 SS=D | 59A-36.008(7) FAC Medication - Labeling and Orders<br><br>(7) MEDICATION LABELING AND ORDERS. | A 056 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969617 | A. BUILDING: _____ B. WING _____ | 02/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAVEN ALF | 1514 HAVEN BEND TAMPA, FL 33613 |

| (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 056 | Continued From page 9<br>(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:<br>1. The resident's name; and,<br>2. The identification of each medicinal drug in the container.<br>(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.<br>(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.<br>(d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the | A 056 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969617 | A. BUILDING: _____ B. WING _____ | 02/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAVEN ALF | 1514 HAVEN BEND TAMPA, FL 33613 |

| (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 056 | Continued From page 10<br>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.<br>(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.<br>(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.<br>(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:<br>1. Practitioner's name,<br>2. Resident's name,<br>3. Date dispensed,<br>4. Name and strength of the drug,<br>5. Directions for use; and,<br>6. Expiration date.<br>(h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care | A 056 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969617 | A. BUILDING: _____ B. WING _____ | 02/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAVEN ALF | 1514 HAVEN BEND TAMPA, FL 33613 |

| (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 056 | Continued From page 11<br>provider must provide the resident with a written prescription, or a faxed or electronic copy of such order.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, record review and interview the facility failed to follow physician orders for one Residents (#2) of one sampled.<br><br>Findings included:<br><br>During a medication observation pass conducted on at 11:25 AM Staff A, a medication technician, was observed passing resident medications.<br><br>A record review of Resident #2 medication observation record (MOR) on revealed that his 100 milligram (MG) Fish oil and multi tablets are scheduled to be taken at 8a.m.<br><br>An interview was conducted on at 11:25a.m. with Staff A, when asked why the two medications were given so late, Staff A stated he takes so many medications in the morning we decided to split up some of his medications.<br><br>Class III | A 056 | | |