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
	AL11932598	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCE OF STUART, INC. (THE	1048 N. FORK ROAD STUART, FL 34994

(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 Relicensure and Generator Monitoring survey was conducted on [redacted] at Residence of Stuart, Inc (The). The facility had deficiencies identified related to the Relicensure at the time of the survey.	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 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.	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 (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. (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	A 052		

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A 052	Continued From page 2 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 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	A 052		

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A 052	Continued From page 3	A 052		

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.
(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

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A 052	Continued From page 4 assessing a resident's condition. (h) All trained staff must adhere to the facility's [redacted] 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, interview and record review, the facility failed to ensure unlicensed staff assisting with self-administered medications followed state required protocols related to the assistance with self-administered medications for 1 of 3 sampled residents (Resident #1); and failed to ensure Staff A followed [redacted] control standards when handling medications for 2 of 3 residents observed during medication provision (Resident #2, #5). The findings included: On [redacted] at 9:00 AM, 2 small cups of medications,which had been previously removed from their labeled, pharmacy-provided bubble-pack, were observed sitting on top of the medication cart located against the wall in the main sitting/Dining room. These cups of medications were unsecured and unattended. On [redacted] at approximately 9:10 AM, Staff A approached the Medication cart and explained that the 2 small medication cups belonged to Resident #1, who had just returned from the hospital on Hospice services. One of these medication cups contained medication that had just been discontinued, and it was set aside to be destroyed when the Hospice nurse arrived later that morning.	A 052		

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A 052	Continued From page 5 On at 9:12 AM, Resident #1 was provided the medications that had been previously removed from the labeled, pharmacy-provided bubble-pack and placed in small medication cup. Staff A informed her of the medications being provided. She was observed by Staff A to swallow all of the medication. On at approximately 12:30 PM, Staff B, was observed removing Resident #2's medication from medication cart, using her to break the foil of bubble-pack, and removing pill from plastic bubble using her bare (ungloved) and placing pill in medication cup. Staff B was not observed to have immediately washed or sanitized her prior to assisting with Resident #2's medications. On at approximately 12:35 PM, Staff B was observed removing Resident #5's bubble pack from medication cart and popping pill into medication cup. She then handed the cup to Resident #5 and observed him take the medication. Staff B did not sanitize prior to assisting with Resident #5's medications. On at 3:35 PM, the Manager was informed of concerns observed during medication observations. Class III	A 052		
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 6 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 observation, interview and record review, the facility failed to ensure staff recorded in the Medication Observation Record (MOR) each time a medication was provided and taken by 2 of 6 sampled residents whose medication record was reviewed (Residents #4 and Resident #5. The findings included:	A 054		

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A 054	Continued From page 7 During a review of the facility's Medication Observation Record for the current 6 residents residing in the facility and receiving assistance with self-administered medications, it was found that 2 of the resident's records were missing staff initials signifying prescribed medications were provided to the resident at their prescribed times. 1) Resident #4's MOR showed no staff initials documenting provision of the following medications at their prescribed times: a) 10 mg on at 8:00 PM b) 0.5% cream on and at 8:00 PM c) 2% cream on //22 and at 8:00 PM d) 0.5 mg on at 8:00 PM e) 10 mg on at 8:00 PM f) Qvar Redihaler 40 mcg on at 8:00 PM 2) Resident #5's MOR showed no staff initials documenting provision of the following medications at their prescribed times: a) 1% Suspension on at 5:00 PM b) Lantanoprost 0.005% Solution on at 6:00 PM c) 1 gm on at 4:00 PM and 6:00 PM d) Levetiracet 750 mg on at 6:00 PM e) 50 mg on at 6:00 PM f) 0.5 mg on at 6:00 PM g) Mycophen 500 mg on at 6:00 PM h) 100 mg on at 6:00 PM i) 3 mg on at 6:00 PM	A 054		

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A 054	Continued From page 8 On . . . . . at 1:26 PM, Resident #4 was interviewed. When asked if she received her medications on time, every day, she responded, "Yes." Resident #5 was interviewed on at 1:35 PM. When asked if he ever missed getting any medications, he responded, "No." An interview was conducted with the facility manager on . . . . . at 3:30 PM. He was informed of the missing initials on the MOR for Resident #4 and Resident #5. He acknowledged that he and Staff B had missed charting the medications for Resident #4 and #5, but he knew that these residents had received the medications on these dates and times. Class	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	A 055		

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A 055	Continued From page 9 being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 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	A 055		

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A 055	Continued From page 10	A 055		

use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider.
(e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f).
(f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.
(g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure all centrally-stored medications were kept in a locked medication cart at all times. This had the potential of affecting 4 of 6 sampled residents were were able to ambulate independently (Resident #1, #2, #4, and #5).

The findings included:

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A 055	Continued From page 11 On [redacted] at 9:00 AM, 2 small cups of medicaitons were observed sitting on top of the medication cart located against the wall in the main sitting/Dining room. These cups of medications had been left unattended and unsecured prior to my approaching and asking the facility manager (Staff A) about observing a medication pass. On [redacted] at approximately 9:10 AM, Staff A approached the Medication cart and explained that the 2 small medication cups belonged to Resident #1, who had just returned from the hospital on Hospice services. One of these medication cups contained medication that had just been discontinued, and it was set aside to be destroyed when the Hospice nurse arrived later that morning. These medications included: [redacted], 81 mg, [redacted] 40 mg, [redacted] 10 meq, and Ginko [redacted] 120 mg. The second cup contained the medications Resident #1 was going to be taking that morning: [redacted] 5 mg (2 tabs), [redacted], Probiotic Acidophilus tablet, [redacted] 100 mg, [redacted] 1 mg, Laratadine 10 mg, and [redacted] 100 mg. On [redacted] at 9:12 AM, Resident #1 was provided her medications and informed what medications were being given. She was observed by Staff A to swallow all of the pills provided. The discontinued cup of medications sat unsecured on top of the medication cart (photographic evidence obtained). On [redacted] at approximately 9:20 AM, Resident #2 came out of her room and [redacted] over to the medication cart. She stood looking at the top of the cart, and then went [redacted] to her room. She didn't touch anything on the cart, but the small cup of medications waiting to be destroyed was	A 055		

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A 055	Continued From page 12 still sitting there, unsecured and unattended by staff. Four of the 6 residents residing in the facility are , , , , to some degree, and they are able to ambulate without assistance. On at 3:35 PM, the Manager acknowledged the need to keep all medications secured, and it was discussed at this time that medications are not to be removed from their packaging, placed in med cup, and saved until a later time (pre-pouring). Class III	A 055		