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
	AL11968907	A. BUILDING: _____ B. WING _____	04/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE COTTAGES AT THE SHORES	471 SHORES BLVD SAINT , FL 32086

(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 A relicensure survey was conducted in conjunction with a complaint investigation (complaint number #2021014752) at Riverside Cottages at the Shores on . Deficient practice was identified at the time of the visit.	A 000		
A 052 SS=D	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. (f) Keeping a record of when a resident receives	A 052		

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A 052	Continued From page 1 assistance with self-administration under this section. (g) Assisting with the use of a [illegible], including removing the cap of a [illegible], opening the unit dose of [illegible] solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the [illegible]. (h) Using a [illegible] to perform [illegible] level checks. (i) Assisting with putting on and taking off [illegible] stockings. (j) Assisting with applying and removing an [illegible] but not with titrating the prescribed [illegible] 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 [illegible] bags. (4) Assistance with self-administration does not include: (a) Mixing, [illegible], converting, or [illegible] 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 [illegible] of the body. (d) Administration of [illegible] preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with [illegible], [illegible], or [illegible] preparations. (g) Assisting with medications ordered by the physician or health care professional with	A 052		

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A 052	Continued From page 2 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 [illegible] 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 self-administration, trained staff may prepare and	A 052		

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A 052	Continued From page 3	A 052		

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 assessing a resident's condition.

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A 052	Continued From page 4 (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 observations, interviews with staff, and resident record reviews, the facility failed to orally advise residents of the name and dosage of the medications they were taking, and failed to practice hygiene procedures, for 2 of 2 (Residents 4 and 5) sampled. Additionally, it failed to provide medication as ordered for 1 of 2 sampled residents (Resident 4) out of a total of 2 residents observed to receive assistance with the self-administration of medications. The findings include: An observation of Employee A, Medication Technician, was conducted on at 10:40 am while assisting residents with medications. She reviewed the electronic medication observation record (eMOR) for Resident 5 and dispensed one , 40 milligram (mg) tablet (treats high ,) and one , 81 mg into her bare , then into a small paper souffle cup. Employee A then dispensed two D3 25 microgram (mcg) capsules into the cup. Explaining there was no Boost nutritional supplement on the medication cart, per the physician's order, Employee A walked away, leaving the medications unattended. Employee A returned to the cart, explained there was no Boost, and noted the eMOR. She took the medications and a cup of water to Resident 5. Without advising Resident 5 of the names or	A 052		

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A 052	Continued From page 5 dosages of the medication she had dispensed, Employee A handed the cup of pills to the resident who took them independently. Employee A returned to the medication cart and without sanitizing her , reviewed the eMOR and retrieved and dispensed one 7.5 mg tablet (a , medication) into her bare . She then transferred the pill into a small paper souffle cup. She repeated the process with a C 500 mg and an 40 mg (treats high) tablet, dispensing first into her , then into the cup. Employee A poured a cup of water and approached Resident 4, who was in the living room. Without advising Resident 4 of the names or dosage of the medications, Employee A handed the cup of pills to the resident who took them independently. A review of the eMOR and pharmacy labels on the medications dispensed was conducted with Employee A on at 10:55 am. Review of the eMOR found the 40 mg tablet provided to Resident 4 was supposed to be a 10 mg tablet. When the discrepancy was pointed out to her, Employee A said, "Oh, I didn't notice that." She said she was not sure if the order had changed. Employee A reviewed the pharmacy issued pack, and confirmed she had provided a 40 mg tablet instead of 10 mg. Employee A searched in the medication cart and found an unopened pack of 10 mg tablets. The card contained 7 tablets, and was dated . Employee A acknowledged the error and the importance of closely checking the labels against the eMOR. Photographic evidence was obtained of the eMOR and both cards. An interview was conducted with Administrator on	A 052		

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A 052	Continued From page 6 . . . . . at 1:55 pm. She was asked for the facility's policy and procedure on medication administration and if she had policy regarding the option for residents to opt-out of being read the names/dosage of their medications. The Administrator stated none of the residents had made that election. She provided the medication policy at 2:20 pm and said the facility had no formal policy for the Opt-out option. The Administrator acknowledged the residents should be provided the opportunity to opt-out of having their medications read to them. When advised of the observation Employee A failed to advise Residents 4 and 5 of the names and doses of their medication, she acknowledged the observation and expressed understanding of the alternate option. An interview was conducted with the Director of Nursing on at 2:10 pm. She said Resident 4 had a telehealth visit on . . . . . and the practitioner discontinued the 40 mg and started 10 mg tablets. She provided a copy of the prescription, which had an effective date and instructed " . . . . . 10mg tablet, 1 tablet orally for 30 days". Photographic evidence was obtained. The DON said the card containing the 40 mg tablets should have been removed from the cart. In a second interview on . . . . . at 3:45 pm, the Administrator was told Employee A had also used her bare . . . to dispense medications without sanitizing her . She said they had already identified that problem not long ago. The DON, who was also in the room, said, "We've got to fix this," the pharmacy already came in and staff have been trained in hygiene. Employee A received training on hygiene during her COVID 19 training on . . (she produced the	A 052		

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A 052	Continued From page 7 training certificate). The Administrator confirmed the practice was not her expectation. Class III	A 052		