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
	AL11910844	A. BUILDING: _____ B. WING _____	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK MANOR	3600 OAK MANOR LANE LARGO, FL 33774

(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 complaint investigation (Complaint Number: 2022008356) was conducted at Oak Manor Senior Living Assisted Living Facility on [redacted]. Deficiencies were identified at the time of survey.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review and the facility failed to provide the appropriate care and services to one (Resident #1) of three sampled residents that required . . . . . monitoring for . . . . . management. The facility failed to monitor Resident #1's diet intake, failed to timely initiate a physician's order or notify the physician of adverse laboratory results. Furthermore, the facility failed to obtain medical orders to address the change in medical condition for Resident #1. The facility's noncompliance placed Resident #1 at imminent risk of harm to include	A 025		

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A 025	Continued From page 2 Findings included: On [redacted] a record review of Resident Health Assessment 1823 for Resident #1 dated [redacted] revealed he was admitted to assisted living facility on [redacted] with [redacted] and [redacted]-A. Resident #1 required assistance with self-administration of medication and supervision with bathing, [redacted], eating and self-care. Resident #1 required regular diet. A record review conducted on [redacted] of Resident #1's chart revealed that a non-Veterans Administration (VA) primary care physician ordered an A1C (test that measures the average [redacted] levels) laboratory [redacted] draw on [redacted]. A1C was ordered as a part of the routine labs. Laboratories were drawn on [redacted]. An additional record review conducted on [redacted] for Resident #1 revealed that the laboratory draw ordered on [redacted], were drawn on [redacted]. A record review conducted on [redacted] for Resident #1 revealed A1C laboratory results dated [redacted]. The results reflected an A1C of 7.7% (normal range below 5.7%, any reading above 5.7% indicates pre-[redacted] or [redacted]). A record review conducted on [redacted] for Resident #1 revealed that the facility faxed the A1C laboratory results to the Veterans Administration (VA) Hospital on [redacted]. An observation on [redacted] at 9:50 a.m. of Resident #1's room revealed sugary cereals, bags of potato chips, a freezer full of ice cream and drinks in the refrigerator. An interview was conducted on at 1:53	A 025		

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A 025	Continued From page 3 p.m. with the non-VA physician office staff. She stated that they were Resident #1's primary care physician office and provided physician services to the assisted living facility residents. She stated the primary care physician office went through Resident #1's medical records at the end of 2021 and ordered laboratories. She stated the physician saw Resident #1 at the facility on , , on and on . She stated on there was a visit progress note that the physician noted Resident #1's A1C was 7.7%. (Per CDC.Gov A normal A1C level is below 5.7%, a level of 5.7% to 6.4% indicates , , and a level of 6.5% or more indicates .) In an interview conducted on at 2:35 p.m. with Director of Nursing (DON), the DON stated "I have no idea who ordered the labs" for Resident #1 when asked who the ordering physician was who wrote the laboratory order. The Assistant Director of Nursing (ADON) further stated "I must of have just found it [results] and sent them to the VA" when asked about the delay in reporting the laboratory results. "I don't know who wrote the lab order. The VA runs their own labs, and the results are not forwarded to us." A record review conducted on of MOR for Resident #1 for the month of revealed 500 milligrams, one tablet twice a day was started in the evening at 8:00 PM. A record review conducted on of Resident #1's , MOR revealed 500 milligrams, one tablet twice a day started and was discontinued on , 1000 milligrams one tablet twice a day started .	A 025		

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A 025	Continued From page 4 A record review conducted on for Resident #1 revealed a VA medication list dated stating 1000 milligrams to replace 500 milligrams. Further review revealed another VA medication list dated revealed orders for test strips, lancets, and 1000 milligrams was issued on . An interview conducted on at 2:30 p.m. with Staff B (medication technician/caregiver), she confirmed that the order in the MOR for Resident #1 stated 1000 milligrams, twice a day and the bottle of medication that was currently being used was labeled as 500 milligrams, twice a day. Staff B stated, "I have been giving the 500 milligrams of ." An observation conducted on 2:30 p.m. of medication cart in building #1 revealed a medication bottle belonging to Resident #1 for 500 milligrams, twice a day along with current medications that Resident # 1 was receiving. A sealed medication bottle labeled " 1000 milligrams, twice a day for to replace 500 milligrams dose as long as veteran tolerates" was in the overflow drawer of the medication cart. A record review conducted on of the , and , MOR revealed that the Assistant Director of Nursing, Staff A (medication technician/caregiver), Staff B(medication technician/caregiver), Staff D (medication technician/caregiver), Staff E (medication technician/caregiver), Staff G (medication technician/caregiver), Staff H (medication	A 025		

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A 025	Continued From page 5 technician/caregiver), Staff I (medication technician/caregiver), and Staff J (medication technician/caregiver), assisted Resident #1 with self-administration of medication and signed off that . . . 1000 milligrams twice a day was given, although the sealed medication bottle dated . . . . . was observed on . . . . . in the overflow drawer of the medication cart. In an interview with Staff I (medication technician/caregiver), conducted on . . . . . at 7:11am, she stated that we are not notified of resident order changes, we just follow what is in the computer. In an interview with Staff J (medication technician/caregiver), conducted on . . . . . at 1:56 pm she confirmed that she gave medications to Resident #1, and she was not aware of any changes in his medications. In an interview with Staff B (medication technician/caregiver), conducted on . . . . . at 2:30 pm she confirmed the order in the medication observation record for Resident #1 stated that 1000 milligrams 1 pill two times a day. She confirmed that she has been giving Resident #1 500 milligrams 1 pill two times a day. A record review on . . . . . of the . . MOR for Resident # 1 revealed a notation to "check . . . . . Q (every) AM one time a day for . . . control" with a starting date of . . . . . The . . . MOR revealed documentation that . . . . was monitored only on . . . . . , ... , and . . . . . but no results were documented to reflect the . . . . levels.	A 025		

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A 025	Continued From page 6 In an interview conducted on [redacted] at 2:35 p.m. with the DON, the DON stated the facility had the [redacted] monitor, but the facility did not have an order to use it. On [redacted] an attempted record review was conducted of Resident #1's record. The record did not include any documentation that the facility contacted the Veterans Administration (VA) or Resident #1's primary physician regarding the received [redacted], questions related to the direction for its use or follow up with the VA on received orders for lancets and test strips. On [redacted] at 10:11 AM, an observation of the history of Resident #1's personal [redacted] revealed a reading dated [redacted] with a [redacted] of 308. No additional readings were observed in the [redacted]. An interview conducted on [redacted] at 7:42 a.m. with Staff A (medication technician/caregiver), she stated she did not assist Resident #1 with [redacted] testing, the resident does them himself and the facility documents the results. In an interview conducted on [redacted] at 10:00 a.m. with Staff B (medication technician/caregiver), Staff B stated, "I watch the residents do their [redacted] by themselves and I only document that they did it, not the actual result In an interview conducted on [redacted] at 2:35p.m. with the ADON, he stated he was called to Resident # 1's room on [redacted] at around 8:15 a.m. by Staff B. He observed Resident #1 with agonal breathing with agonal breathing (gasping) and was non-verbal. He stated, "I called 911, but after emergency management services	A 025		

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A 025	Continued From page 7 got here, I don't remember as of how that went down." In an interview conducted on at 2:35p.m. with the DON, the DON stated, the facility called emergency management services (911) for Resident # 1 on . He was transported to the hospital at this time. "I don't know his results for that morning, because it was not documented in the computer." A review of Emergency Management Services ( ) records dated on for Resident #1 revealed was called on at 8:21 a.m. for records revealed Resident #1 had level on at 8:40 a.m. of 589. A review of Hospital medical records for Resident #1 dated were review on revealed Chief complaint of and high levels. Per medical records Resident # 1 was received at the hospital with a diagnosis of: 1. (medical condition that describes abnormalities of the water, , and other chemicals that adversely affect function) 2.Lactic acidosis (medical condition characterized when excessive accumulates due to a problem with the body's oxidative metabolism) 3. (a complication of that results from increased levels of a chemical called ketones in the . It causes excessive thirst, frequent , fatigue, and) A review of Hospital medical records dated on for Resident #1 revealed a level on at 9:15 a.m. of	A 025		

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A 025	Continued From page 8 637. Records noted Resident # 1 was intubated on at 11:46 a.m. due to and requiring medications. Due to severe Resident #1 was placed on an drip. Resident #1 was admitted to the A review of Hospital medical records on for Resident #1 revealed that as of Resident # 1 remains hospitalized. Class I	A 025		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all	A 030		

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A 030	Continued From page 9 residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . ., Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . ., neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with	A 030		

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A 030	Continued From page 10 convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.	A 030		

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A 030	Continued From page 11 (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . , for health care services, the provision of or arrangement of transportation to health care . . , ... and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the	A 030		

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A 030	Continued From page 12 case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state	A 030		

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A 030	Continued From page 13 that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . . . or . . . . . under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility	A 030		

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	AL11910844	A. BUILDING: _____ B. WING _____	06/13/2022

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A 030	Continued From page 14 failed to ensure a safe, clean, and pest free environment for one (Resident #1) of 3 sampled residents. Findings included: A room observation conducted on . . . . . at 9:50 am of Resident #1's, who had been in the hospital, for the past 11 days , revealed the following: a freezer packed full of cup size containers of ice-cream, a Styrofoam container with food covered in a black substance and gnats and roaches crawling on it, an unmade bed with sheets in disarray, an open Styrofoam container of uneaten food on the recliner, a chair piled with unfolded sheets and clutter on the dresser, floor and shelves (photographic evidence obtained). In an interview with the Administrator conducted on at 9:50 am he stated that he was not aware of what's in the room. He stated "I understand that he doesn't let anyone in the room. There are medications cups on the floor so a staff must be coming in his room. [Resident #1] has been gone for 11 days and obviously staff have not been in the room. There should have been . . in here. Staff should have been in here. It is obvious that no one has been in this room. My expectation of staff in this situation would be to go into the room when giving care or meds or housekeeping when they clean the room once a week. If the resident refuses to let staff come in the room, then they should have reported that to administration and for them to take the appropriate action. Then report to me if the resident keeps refusing, so that I can look into the situation. Obviously no facility staff have been in this room." Class III	A 030		

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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 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 .	A 052		

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A 052	Continued From page 16 (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], or [illegible] 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.	A 052		

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A 052	Continued From page 17 (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 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	A 052		

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A 052	Continued From page 18 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. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.	A 052		

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A 052	Continued From page 19 This Statute or Rule is not met as evidenced by: Based on observation, Record Review and interview the facility failed to ensure proper assistance with self-administration of medications (meds) according to the required steps in 429.256 Florida Statutes for 3 (Residents #2, #4, #5) of 4 residents sampled that required assistance with self-administration of medications. Findings Included: An observation on at 7:07 a.m. of assistance with self-administration of medications in building 1, with Staff I, unlicensed personnel, dispense medications at cart and walked to the resident's room, did not read medication out loud to Resident # 4. An observation on at 7:15 a.m. of assistance with self-administration of medications in building 2, with Staff A, unlicensed personnel, did not dispense medications with resident present and residents room door was closed, did not read medication out loud to Resident # 2. An observation on at 7:20 a.m. of assistance with self-administration of medications in building 1, with Staff I, unlicensed personnel, dispense medications at cart and walked to the resident's room t, did not read medication out loud to Resident # 5. A record review conducted on of facility's undated policy & procedures titled	A 052		

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A 052	Continued From page 20 "Assisting in self administration of medication management" revealed the following on Page 2, line 2: 2. Check to make sure the resident is in room and aware that you are there to prepare medications. An interview conducted on at 9:37 a.m. with Assistant Director of Nursing, he confirmed that the facility's policy for a medication technician passing medications were not being followed. Class III	A 052		
A 056 SS=J	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (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: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (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. (c) If the directions for use are "as needed" or "as directed," the health care provider must be	A 056		

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A 056	Continued From page 21 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. (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 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. (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. (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. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or	A 056		

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A 056	Continued From page 22 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: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to follow physician orders after a change in directions for use was ordered for one (Resident #1) of three sampled residents. The facility failed to provide an increased dosage of a . . . . . medication which led to the resident being critically , , , requiring after being hospitalized. The facility's noncompliance placed Resident #1 at imminent risk of harm to include . . . . . Finding included: A record review conducted on of Resident #1's Medication Observation Record	A 056		

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A 056	Continued From page 23 (MOR) for the month of , revealed an order for 500 milligrams, one tablet twice a day to be discontinued on and 1000 milligrams one tablet twice a day to start . An interview conducted on at 2:30 p.m. with Staff B. Staff B confirmed that the order in the MOR for Resident #1 stated 1000 milligrams, twice a day and the bottle of medication that was currently being used was labeled as 500 milligrams, twice a day. Staff B stated, "I have been giving the 500 milligrams of ." Staff B stated the bottle of 1000 milligrams, twice a day was delivered on , and "[Resident #1] has not been receiving these, the bottle is not opened." (Photographic evidence obtained) An observation conducted of medication cart in building #1 revealed a medication bottle belonging to Resident #1 for 500 milligrams, twice a day along with current medications that Resident # 1 was receiving. A sealed medication bottle labeled " 1000 milligrams, twice a day for to replace 500 milligrams dose as long as veteran tolerates" was located in the overflow drawer of the medication cart. A record review conducted on of the MOR the month of , and , revealed that the Assistant Director of Nursing, Staff A (medication technician/caregiver), Staff B(medication technician/caregiver), Staff D (medication technician/caregiver), Staff E (medication technician/caregiver), Staff G (medication technician/caregiver), Staff H (medication technician/caregiver), Staff I (medication technician/caregiver), and Staff J	A 056		

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A 056	Continued From page 24 (medication technician/caregiver) all assisted Resident #1 with self-administration of medication and signed off that . . . 1000 milligrams twice a day was given, although the sealed medication bottle dated / 2022 was observed on in the overflow drawer of the medication cart. In an interview with Staff I (medication technician/caregiver), conducted on at 7:11am she stated that we are not notified of resident order changes, we just follow what is in the computer. In an interview with Staff J (medication technician/caregiver), conducted on at 1:56 pm she confirmed that she gave medications to Resident #1, and she is not aware of any recent changes in his medications. In an interview with Staff B (medication technician/caregiver), conducted on at 2:30 pm she confirmed the order in the medication observation record for Resident #1 stated that . . . 1000 milligrams 1 pill two times a day. She confirms that she has been giving Resident #1 . . . 500 milligrams 1 pill two times a day. In a phone interview with Staff E (medication technician/caregiver), conducted on . . . . . at 2:32 pm she stated that Resident #1 did not have any medications changes in the month of , . A record review conducted on . . . . . of an undated policy and procedures titled "Assisting in self-administration of medication management" noted the following: 6. You should compare the EMAR [electronic	A 056		

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A 056	Continued From page 25 medication administration record] to the MEDICATION. You look at the first medication on the EMAR and then get the medication from the BINGO card (the EMAR is alphabetical so your BINGO cards should be as well). You CONFIRM that the name on the card is the same as the name on the EMAR. You CONFIRM that the medication name, strength, dose and directions are the SAME as the EMAR. In an interview conducted on at 7:07 a.m. with Staff I, she stated she just follows whatever is in the computer, "we are not really told about changes in orders." In an interview conducted on at 7:42 a.m. with Staff A, Staff A stated the nurse lets a medication technician know when medication orders are changed for a resident and then we pass it in report to the next shift. In an interview conducted on at 10:00 a.m. with Staff B, Staff B stated, "when I compare the Medication Observation Record (MOR) to the bottle, I would know then if orders changed." Staff B stated we had the for a while, but the facility did not have an order to use. An interview conducted on at 9:37 a.m. with the Assistant Administrator he stated that the facility policy for a Medication Technicians passing medication, was not followed. A record review conducted on of a Veterans Administration medication list printed on revealed an order for test strips and lancets dated for Resident #1.	A 056		

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A 056	Continued From page 26 A record review on ... of the MOR for Resident # 1 for ... revealed an order to "check ... Q (every) AM one time a day for ... control" with a starting date of ... A record review on ... of the MOR for Resident # 1 for ... shows documentation that ... was monitored only on ..., and but no results were document to reflect the ... levels. On at 10:11 AM, an observation of the history of Resident #1's personal ... revealed a reading dated with a ... of 308. In an interview conducted on ... at 2:35 p.m. with the Director of Nursing (DON), the DON stated the facility had the ... monitor, but the facility did not have an order to use it. In an interview conducted on at 2:35p.m. with the DON, the DON stated, the facility called emergency management services (911) for Resident # 1 on ... He was transported to the hospital at this time. "I don't know his ... results for that morning, because it was not documented in the computer." On an attempted record review was conducted of Resident#1's record. The record did not include any documentation that the facility contacted the VA or Resident #1's primary physician regarding the received or questions related to the direction for it's use. A review of the record for revealed no documentation of Resident #1 condition on the morning of or that the resident was	A 056		

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(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 27 sent out to the hospital. In an interview conducted on at 2:35p.m. with the ADON, he stated he was called to Resident # 1's the room by Staff B. He observed Resident #1 with agonal (gasping) breathing and was non-verbal. He stated, "I called 911, but after emergency management services got here, I don't remember as of how that went down." A review of Emergency Management Services ( ) records on for Resident #1 revealed was called on at 8:21 a.m. for records revealed Resident #1 had level on at 8:40 a.m. of 589. Hospital medical records dated for resident #1 were reviewed on revealed Chief complaint of and high levels. Per medical records Resident # 1 was received at the hospital with a diagnosis of: 1. (medical condition that describes abnormalities of the water, , and other chemicals that adversely affect function) 2.Lactic acidosis (medical condition characterized when excessive accumulates due to a problem with the body's oxidative metabolism) 3. (a complication of that results from increased levels of a chemical called ketones in the . It causes excessive thirst, frequent , fatigue, and) Hospital medical records dated for resident #1 were reviewed on revealed a level on at 9:15 a.m. of	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910844	A. BUILDING: _____ B. WING _____	06/13/2022

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A 056	Continued From page 28 637. Records noted Resident # 1 was intubated on at 11:46 a.m. due to , and requiring medications. Due to severe Resident #1 was placed on an drip. Resident #1 was admitted to the . A review of Hospital medical records on for Resident #1 revealed that as of Resident # 1 remains hospitalized. Class I	A 056		
A 165 SS=D	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;	A 165		

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A 165	Continued From page 29 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 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	A 165		

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A 165	Continued From page 30 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 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 interview the facility failed to submit an Adverse Incident Report within one business day of the occurrence of a condition that required the transfer of the resident from the facility to the hospital were the resident was intubated due to the not providing supervision and oversight necessary to identify a significant change in condition for one (Resident #1) of 3 sampled residents. Findings included:	A 165		

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A 165	Continued From page 31 An attempted record review conducted on . . . . . , revealed that an adverse incident report had not been completed for an event that occurred on . . . . . for Resident #1. Record review conducted on . . . . . revealed that Resident #1 had an medication order change for . . . . from 500 milligrams 1 tablet two times a day to 1000 milligrams 1 tablet two times a day. Record review Resident #1's medication observation conducted on revealed that the Resident #1's . . . . . levels were not being monitored daily as ordered. An interview conducted on at 9:00 AM with the Director of Nursing she stated that an incident report was not done on for Resident #1, because the facility does not do an incident report when just sending a resident to the hospital for not feeling well. An interview conducted on . . . . . at 4:30 PM with the administrator he stated that he was not aware that the resident was being sent out to the hospital because of his decline in health due to medications orders not being followed. Class III	A 165		