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
	AL11969626	A. BUILDING: _____ B. WING _____	R 06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRIVE AT FERN PARK	7255 STRIVE PL FERN PARK, FL 32730

(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 revisit to the re-licensure survey and a complaint investigation #2022005687 was conducted at Strive at Fern Park on . The facility had uncorrected deficiencies at the time of the survey.	{A 000}		
{A 025} SS=D	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 ... or ... or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such ... or ... 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 ... 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 record reviews and interview, the facility failed to follow a health care provider's medication order for 2 of 4 sampled residents (#9 & #14). Findings: 1. Review of resident #9's record revealed a facility admission date of [redacted]. Review of an 1823 health assessment form, dated [redacted], revealed the resident's diagnoses were [redacted] type 2, [redacted] and [redacted] and revealed the resident required	{A 025}		

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{A 025}	Continued From page 2 assistance with self-administration of medications. Review of the resident's Medication Observation Record (MOR) revealed an entry for , 40 milligram (mg) capsule, take one capsule by once daily every morning. Documentation on the MOR indicated the medication was not given on both & with reason of "awaiting pharmacy". During an interview with the director of nursing (DON) on at 1:20 P.M., he said a 30-day supply of the medication was filled by the pharmacy on and therefore, should have been available to give on & . He said he assumed then that the person who gave medications that day just did not see the medication in the med cart. 2. Review of resident #14's record revealed a facility admission date of . Review of an 1823, dated , revealed the resident's diagnoses were , , and , and revealed the resident required assistance with self-administration of medications. Review of the resident's MOR revealed entries for 1 gram tablet, take one tablet by twice a day for an and for , 40 mg tablet, take one tablet by once daily in the morning before breakfast for health. Review of a health care provider's order, dated , revealed the was prescribed to be given for only 30 days.	{A 025}		

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{A 025}	Continued From page 3 Documentation on the MOR indicated the , was not given on with reason of "awaiting on pharmacy". During an interview with the DON on at 1:27 P.M., he said the , was available to be given on but, the staff could not locate it on the cart. On at 1:55 p.m., the DON said the was ordered to be given for only 30 days but, the facility gave it to the resident beyond that. On at 2:31 P.M., the DON said the facility's procedure when a medication could not be found in the cart included notifying a nurse. Neither resident's MOR nor record contained documentation to indicate a nurse was notified of any missing medications or that the pharmacy was called. Class III	{A 025}		
{A 054} SS=D	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; 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	{A 054}		

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{A 054}	Continued From page 4 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 record reviews and interview, the facility failed to properly update a MOR for 2 of 4 sampled residents (#14 & #15). Findings: 1. Review of resident #14's record revealed a facility admission date of [illegible]. An 1823, dated [illegible], indicated the resident's diagnoses were [illegible], and [illegible] and revealed the resident required assistance with self-administration of medications. Review of the resident's [illegible] MOR revealed there were "holes" where medications were not signed as given on [illegible]. Neither the MOR nor the	{A 054}		

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{A 054}	Continued From page 5 resident's record contained documentation to explain the omissions. 2. Review of resident #15's record revealed a facility admission date of [redacted]. An 1823, dated [redacted], indicated the resident's diagnoses were [redacted], major [redacted] and revealed the resident required assistance with self-administration of medications. Review of the resident's [redacted] MOR revealed there were "holes" where medications were not signed as given on [redacted]. Neither the MOR nor the resident's record contained documentation to explain the omissions. During an interview with the DON on [redacted] at 2:20 P.M., he confirmed the findings and said the facility's process was that a nurse was supposed to check the MORs for holes at the end of each shift. Class III	{A 054}		