

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967066</b>         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/05/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AMISTAD 308 LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8420 SW 2ND STREET<br/>MIAMI, FL 33144</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                      | Initial Comments<br><br>A re-licensure survey was conducted at Amistad 308, Llc. on . . . . . The provider had a deficiency at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | A 000                                                                                  |                                                                                                                          |  |                                                        |
| A 084<br>SS=D                                              | 59A-36.011(6) FAC 429.52(6), FS Training -<br>Assis Self-Admin Meds & Med Mgmt<br><br>59A-36.011<br>(6) ASSISTANCE WITH THE<br>SELF-ADMINISTRATION OF MEDICATION AND<br>MEDICATION MANAGEMENT. Unlicensed<br>persons who will be providing assistance with the<br>self-administration of medications as described in<br>rule 59A-36.008, F.A.C., must meet the training<br>requirements pursuant to section 429.52(6), F.S.,<br>prior to assuming this responsibility. Courses<br>provided in fulfillment of this requirement must<br>meet the following criteria:<br>(a) Training must cover state law and rule<br>requirements with respect to the supervision,<br>assistance, administration, and management of<br>medications in assisted living facilities;<br>procedures and techniques for assisting the<br>resident with self-administration of medication<br>including how to read a prescription label;<br>providing the right medications to the right<br>resident; common medications; the importance of<br>taking medications as prescribed; recognition of<br>side effects and adverse reactions and<br>procedures to follow when residents appear to be<br>experiencing side effects and adverse reactions;<br>documentation and record keeping; and<br>medication storage and disposal. Training shall<br>include demonstrations of proper techniques,<br>including techniques for control, and<br>ensure unlicensed staff have adequately<br>demonstrated that they have acquired the skills<br>necessary to provide such assistance.<br>(b) The training must be provided by a registered | A 084                                                                                  |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

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| A 084                                                      | Continued From page 1<br><br>nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to:<br>1. Read and understand a prescription label;<br>2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including:<br>a. Assist with oral dosage forms, _____ dosage forms, and _____ and _____ dosage forms;<br>b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions;<br>c. Recognize the need to obtain clarification of an "as needed" prescription order;<br>d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders;<br>e. Complete a medication observation record;<br>f. Retrieve and store medication;<br>g. Recognize the general signs of adverse reactions to medications and report such reactions;<br>h. Assist residents with _____ syringes that are prefilled with the proper dosage by a pharmacist and _____ that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection;<br>i. Assist with _____;<br>j. Use a _____ to perform _____ testing;<br>k. Assist residents with _____ and continuous positive airway pressure (CPAP) devices, excluding the titration of the _____. | A 084                                                                          |                                                                                                                          |  |                                                        |

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| A 084                                                      | <p>Continued From page 2</p> <p>levels;</p> <p>l. Apply and remove stockings and hosiery;</p> <p>m. Placement and removal of _____, bags, excluding the removal of the _____ or manipulation of the _____ site; and,</p> <p>n. Measurement of _____ rate, temperature, and _____ rate.</p> <p>(c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online.</p> <p>(d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n.</p> <p>429.52</p> <p>(6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training</p> | A 084                                                                          |                                                                                                                          |                          |                                                        |

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| A 084                                                      | <p>Continued From page 3</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview the facility failed to ensure that one out of six sampled staff (Staff E) that was unlicensed and assisted residents with self-administration of medications provided evidence of having completed an initial training of 6 hours in assistance with self-administration of medications or having completed the additional hours of training after having a 4 hours initial training.</p> <p>Findings included:</p> <p>A review of staff records showed that Staff E was hired on . . . . . Staff E had completed 4 hours of assistance with self-administration of medications on . . . . . and 2 hours update on . . . . . There were no 6 hours of initial training.</p> <p>On . . . . . at 12:55 PM Staff B stated that Staff E had been working at assisted living facilities for a long time and she should have the old trainings.</p> <p>Class III</p> | A 084                                                                          |                                                                                                                          |                          |                                                        |