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
	AL11969078	A. BUILDING: _____ B. WING _____	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS SENIOR LIVING AT THE LODGES AT IDLEWI	18440 EXCITING IDLEWILD BLVD LUTZ, FL 33548

(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 # 2022016906) was conducted at Angels Senior Living at the lodges of idlewild Assisted Living Facility on . . . . . : Deficiencies were identified at the time of survey.	A 000		
A 056 SS=D	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 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	A 056		

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A 056	Continued From page 1 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 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	A 056		

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A 056	Continued From page 2 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 interview and record review, the facility failed to follow physician orders and assistance with the self-administration of medication of a medication and an to the incorrect resident (Resident # 2) which led to the resident being drowsy, loss of balance and requiring the administration of Narcan (, antagonist) after being sent to the Emergency Room. The facility's noncompliance placed Resident # 2 at imminent risk of harm to include . Findings included: A record review conducted on 11/17/2022 of Resident #2's Medication Observation Record (MOR) for the month of revealed she does not have orders for medication at 2:00p.m. A record review conducted on 11/17/2022 of Resident #1's Medication Observation Record (MOR) for the month of revealed an order for , 500 milligrams	A 056		

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A 056	Continued From page 3 tablets take two by . . . . tablets every 6 hours and , , 8 milligrams 1 tablet by . . . . . three times a day at 2:00 p.m. An interview conducted on . . . . . at 11:23 with Staff B, medication technician (med tech), she stated she was assigned the first-floor medications and there was another staff (Staff C, med tech) doing the second and third floor medications. There was a resident that on the first floor. The staff on the third floor gave me the medications for Resident #1 and she heard the name of Resident #2. Staff B continued to state that she was not familiar with the second and third floors. Immediately after giving Resident #2 the medications, she felt something off and confirmed with Staff C the resident name for the medications she was given, at that point she realized she had given the medications to the wrong resident. An interview conducted on at 12:36 p.m. with Staff C, med tech, she stated she was on the first floor because she was done with her noon medication pass. Resident #1 was her last resident, and she was on her way to give her the medications. A resident . in the process, and she had the medication cup with her so she asked Staff B to give the medications to Resident #1. After Staff B came , she asked her was she (Staff B) supposed to give medications to Resident #2 and that is when she realized Staff B gave the medications to the wrong resident. A facility record review conducted on 11/17/2022 of undated policy titled "Medication Management" made reference to medication process as follows: 1a. Right Resident -make sure you know the resident identify resident every time and confirm	A 056		

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A 056	Continued From page 4 by name, date of birth and picture on medication observation record. b. Check name, the name on the order and the patient use at least two identifiers, ask the resident to identify themselves c. Use unique identifiers when possible, such as bar codes an picture ID. A facility record review conducted of 11/17/2022 of staff schedule revealed Staff B and Staff C, continued the schedule for assisting in the self-administration of residents in the facility on [redacted]. An interview conducted on [redacted] at 12:45 p.m. with the Care and Wellness Director she stated they had assigned Staff B and Staff C to pass medications on [redacted]. Staff B gave Resident #2 the wrong medications. Staff B understood Resident #2's name instead of Resident #1 name. The Care and Wellness Director stated that she reviewed the medication procedure with both med techs. Class II	A 056		