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
	AL11966458	A. BUILDING: _____ B. WING _____	C 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL TAMPA ASSISTED LIVING	5010 N 40 STREET NORTH TAMPA, FL 33610

(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 numbers: 2022018186 and 2022018345) was conducted at Central Tampa Assisted Living on . Deficiencies were identified at the time of survey.	A 000		
A 052 SS=G	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, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (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.	A 052		

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A 052	Continued From page 1 (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 . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or 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 of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or 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. (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.	A 052		

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A 052	Continued From page 2 (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 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	A 052		

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A 052	Continued From page 3 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. 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. Additionally, the facility failed to follow their policy and procedures for assistance of self-administration of meds for eleven Residents (#2, #3, #4, #5, #6, #7, #8, #9,	A 052		

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A	Continued From page 4 #10, #12, and #13) of eleven sampled residents that required assistance with self-administration of meds. The failure to follow proper assistance with self-administration of meds placed all residents at risk for harm and injury from med errors and sent Resident #4 to the hospital after receiving Resident #5's meds. Findings Included: During interviews with Residents #5, #6, #7, #8, #12, and #13, conducted on at 10:42am through 11:55am, Residents #5, #6, #7, #8, #12, and #13 stated that the unlicensed Medication Technicians (Med Techs) do not tell the residents the names and doses of their meds. During observations of the med pass with Staff I (an unlicensed Med Tech) with Residents #2, #9, and #10, conducted on from 01:10pm through 01:26pm, Staff I did not follow the proper assistance with self-administration of meds and did not follow the facility's policy and procedures to properly assist Resident #2 with their prescribed , 0.5mg, Resident #9 with their prescribed , 325mg, and Resident #10 with their prescribed , 325mg med. Staff I did not open Resident #2's pill pack in front of the resident. Staff I did not compare Residents #2, #9, or #10's med labels with their medication observation records (MORs). The electronic MORs were not open and the paper MORs were opened to Resident #11's MORs throughout the entire med pass. Staff I did not read the name and dose of the med from the med label to Resident #2. Staff I did not document Residents #2, #9, and #10's meds as given immediately when the meds were given. The facility used both electronic and paper MORs for the documentation of meds given to residents.	A 052		

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A 052	Continued From page 5 A review of the facility's assistance with med self-administrated undated policy and procedures, conducted on , revealed that the required steps for unlicensed Med Techs to follow were that unlicensed Med Techs were to obtain residents' meds and their MORs and verify the med labels with the MORs and check the med expiration dates. The unlicensed Med Techs were to open pill packs in the presence of the residents and read the med labels to the residents. The unlicensed Med Techs were to record the meds as given on the resident's MORs when giving the meds. A review of the facility's undated policy and procedure for med supervision, conducted on , the policy stated that unlicensed staff were to assist residents with their meds in accordance with 58A-5.0191, Florida Administrative Code. The procedures stated that unlicensed staff were to compare resident's med labels with their MORs. The unlicensed staff were to read the med labels to residents letting them know what they were getting and open the pill packs in front of the residents. The unlicensed staff were to immediately document the meds as given on the resident's MORs. A review of a letter undated from the facility's Pharmacist consultant, conducted on , revealed that the facility had ongoing WiFi Internet issues which made the documentation of medications that were given to residents on their electronic MORs system was difficult due to Internet disconnectivity. The Pharmacist consultant recommended that the facility use paper MORs until their Internet issues were resolved and that the facility was not supposed to use the electronic med documentation system	A 052		

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A 052	Continued From page 6 until the Internet issues were resolved. During an interview with Staff D, an unlicensed Med Tech, conducted on at 01:45pm, Staff D stated that unlicensed Med Techs were supposed to use both paper and electronic MORs and were supposed to use paper MORs when the computer's Internet system was down. During an interview with the Wellness Coordinator, conducted on at 10:57am, the Wellness Coordinator stated that she was unaware of any residents that received the wrong medications. A record review for Resident #4, conducted on , revealed that Resident #4 was admitted to the facility on and discharged from the facility on . Resident #4's health assessment dated noted that the resident required assistance with self-administration of meds. There was an incident report dated that noted that former Staff E gave Resident #4 the wrong meds and Resident #4 was sent to the emergency department at the local hospital. There were no documented notifications to Resident #4's primary care provider that the resident received the wrong meds. An employee record review for Staff E, conducted on , revealed that there was no evidence in the employee's record that she gave the wrong meds to Resident #4 on . An employee record review for Staff H, conducted on , revealed that Staff H was hired as an unlicensed Med Tech on and her employment was terminated on when the employee did not show up for her work duties.	A 052		

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A 052	Continued From page 7 There was a write-up in Staff H's employee record dated issued by the Wellness Coordinator and signed by the Wellness Coordinator and the Administrator. The write-up was issued for giving Resident #4 the wrong meds and not following the facility's policy and procedures for a proper med pass during the morning 09:00am med pass on . A review of Resident #2's MORs, conducted on , revealed that Resident #2's electronic and paper MORs had prescribed meds given to the resident twice which appeared as the resident was double dosed on the meds which included: 10mg on and at 09:00pm; 325mg on at 09:00am and 05:00pm, on at 05:00pm, and at 09:00am; and, Levothyroxin 50mcg on , , at 07:30am. Resident #2's MORs had meds that were not documented as given to the resident on many dates and times from through . A review of Resident #3's MORs, conducted on , revealed that Resident #3's electronic and paper MORs had prescribed meds given to the resident twice which appeared as the resident was double dosed on the meds which included: , 40mg on , , and at 09:00am and , 100mg on and at 09:00pm. Resident #3's MORs had meds that were not documented as given to the resident on many dates and times from through . A review of Resident #5's MORs, conducted on , revealed that Resident #5's	A 052		

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A 052	Continued From page 8 electronic and paper MORs had prescribed meds given to the resident twice which appeared as the resident was double dosed on the meds which included: Levothyroxin 75mcg on , , , and at 07:00am and , 1mg on at 05:00pm. Resident #5's MORs had meds that were not documented as given to the resident on many dates and times from through . During an interview with Staff I, an unlicensed Med Tech, conducted on at 01:30pm, Staff I stated that she had not had a chance to sign out the morning meds for 09:00am for any residents yet. During an interview with the Administrator, conducted on at 12:26pm, the Administrator stated that former Staff H gave former Resident #4 the wrong meds on and that no staff immediately informed the Administrator of the med error. At 02:35pm, the Administrator agreed that unlicensed Med Techs were supposed to pop pills from pill packs in front of residents and read the med names and doses to the residents. The Administrator agreed that unlicensed Med Techs were supposed to compare med labels to the residents MORs and immediately document the meds as given when they give the med. The Administrator agreed that it appeared that Residents #2, #3, and #5 were double dosed on their meds due to the facility using both electronic and paper MORs. The Administrator agreed that there continued to be ongoing issues with unlicensed Med Techs not immediately updating when meds were offered or given to residents. Class II	A 052		

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