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
	AL11970069	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON MANOR OF PUNTA GORDA LLC	10211 TAMIAMI TRL PUNTA GORDA, FL 33950

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CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	CZ830		

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CZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	CZ830		

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CZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to submit within 30 days of initial licensure and annually and maintain documentation of a current Comprehensive Emergency Management Plan (CEMP), approved by the local emergency management agency to ensure the safety and welfare of all residents. The findings included: Review of approval letter dated , for facility Environmental Emergency Plan (EPP), the letter indicated the EPP will not take place of the facility CEMP that is requested annually. It will become an annex/addition to the original CEMP and must be updated annually. Further review of the EPP approval letter indicated it does not include CEMP plan approval. On at 11:30 a.m., request was made to Executive Director (ED) for CEMP with approval letter. The ED stated she sent the CEMP in sometime in and received a rejection letter with corrections that needed to be completed sometime in . She said the CEMP has not been resubmitted. The ED said, "I am out of compliance and did not submit the CEMP with 30 days as required after receiving licensure, and do not have the evidence of the rejection letter." The Executive Director confirmed the facility currently does not have and approved CEMP since opening in .	CZ830		

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CZ830	Continued From page 3 Unclassified	CZ830		
A 000	Initial Comments An unannounced complaint survey #202300790 was conducted on . . through . . at Hampton Manor of Punta Gorda LLC, an assisted living facility in Punta Gorda, Florida. Complaint #202300790 was substantiated at tags A0053, A0054, A0077, A0165 at Class I Level. The following is a description of the deficiencies. .	A 000		
A 053	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including . . testing, must be in compliance with the federal Clinical	A 053		

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A 053	Continued From page 4 Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure staff who provide medication administration did so in accordance with the scope of their license and followed physician orders. The facility failed to follow its policy and procedures to document and reconcile medications when administered and ensure facility staff maintain medications in a secure manner for 6 (Resident #1, #2, #5, # 6, #7, #8) of 8 residents reviewed. Further the facility failed to maintain the log which resulted in multiple missing and unaccounted for and other medications. Failure to ensure Resident #1 received the medications as ordered resulted in Resident #1 receiving twice as much as ordered on and placing Resident #1 and had the potential to affect all dying residents. The findings included:	A 053		

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A 053	Continued From page 5 Facility Policy titled: Medication Management Plan (undated): Policy: To ensure understanding of the medication procedures and responsibilities for the administration of ordered drugs to residents of Hampton Manor. All licensed nursing staff (RN/LPN), and Certified Medication Aides must meet qualification requirements prior to administering medications to residents [Certified Medication Aides CANNOT administer medications in Assisted Living Facilities in the State of Florida, this Policy does not follow State Regulations.] . . . i. Medication Administration: 2. The recording of the administration of medications shall be by the staff person who administers the medications immediately following administration of medication to the resident, observation of the resident actually taking the medication and prior to administration of another resident's medication. Facility Policy titled: Assistance with Self-Administration of Medications (undated) . . . Assistance with self-administration of medication includes: . . . Keep a record of when a resident assistance with self-administration under this section. . . . Medication Aides may not: Prepare syringes for injection or the administration of medications by any injectable route. Facility policy titled: Policy (undated): . . . . . count sheet must reflect receiving quantity of medication, name of medication and resident receiving medication. Medication must be counted at shift change by oncoming and off going medication aide. Counts must be documented and signed for by staff members conducting count. Facility policy titled: Medication (undated): Disposition of Medication Policy: 1. Medication:	A 053		

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A 053	Continued From page 6 Controlled Substances: b. The facility shall maintain a readily available record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. 1. Record review for Resident #1 revealed the resident was admitted to the facility on . Resident #1 was admitted to hospice services on with diagnoses including medical diagnosis unspecified protein calorie , , disorientation unspecified, repeated . Physician orders in the record or provided by Hospice included: On , (Used to treat moderate to severe ,) 20 milligrams (mg) per milliliter (ml) oral concentrate prefilled syringes 5 mg by under the every 6 hours around the clock. tablet 0.5 mg every 6 hours by under the for , and restlessness. Updated physician orders dated , , 20 mg/ml prefilled syringes 5 mg every 4 hours by under the as needed for , and ( ), contact hospice to administer. Another change order dated , , 20 mg/ml prefilled syringes 10 mg every 4 hours by under the as needed for , / , . Review of the Controlled Medication Record for the , revealed on the pharmacy delivered a total of 60 syringes of single dose of , 5 mg for Resident #1. The Controlled Medication Record showed the physician's order to assist with self-administration	A 053		

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A 053	Continued From page 7 of , 5 mg every six hours around the clock was not followed on , as no routine every 6 hours medication was provided once the medication was obtained. On the hospice physician discontinued the previous order for , and ordered , 5 mg (0.25 ml) every four hours as needed by or for , or . The order specified to contact hospice to administer. On , the Controlled Medication Record showed the facility LPN Resident Care Manager administered one dose of , to Resident #1 at 9:30 a.m. On a Med tech signed at 9:00 p.m. for a dose of , 5 mg. There was no documentation of coordination with hospice to administer the as needed , at 9:00 p.m., as per the hospice physician's orders. The Controlled Medication Record showed documentation the facility's Resident Care Manager (RCM) administered , 5 mg on to Resident #1 at 2:15 p.m., and 9:00 p.m. There was no documentation the facility collaborated with hospice before administering the , as per the physician's order which specified to contact hospice to administer. On at 3:00 p.m., and three hours later at 6:00 p.m., the documentation on the Controlled Medication Record showed the facility's Med Techs signed for the doses of , . This was not in accordance with the Physician's orders which specified to administer , every four hours as needed, and to contact hospice to administer	A 053		

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A 053	Continued From page 8 On . . . . . the hospice physician discontinued the previous order for , 5 mg every four hours as needed. The physician ordered , 10 mg (0.5 ml) every four hours as needed by . . . or . . . . , for , / , , (Difficulty breathing). On at 12:20 p.m., and 6:20 p.m., Med Tech Staff L signed the Controlled Medication Record for , 5 mg each dose. This was not in accordance with the physician's orders for , 10 mg every four hours as needed. There was no documentation the facility coordinated with hospice to administer the . . , . . . as per the specification in the physician's orders dated . . . On at 8:00 a.m., 1:00 p.m., 8:00 p.m. the Controlled Medication Record showed the RCM administered 10 mg of , to Resident #1. On . . . . . at 12:00 a.m., the RCM documented administering . . , ... 5 mg to Resident #1 without the benefit of a physician's order. On at 3:00 a.m., 7:00 a.m., the Controlled Medication Record showed Med Tech Staff L signed for the . . , . . 10 mg. Per the documentation on the Controlled Medication Record Resident #1 received . . , ... three hours apart on . . . . . at 12:00 a.m., and 3:00 a.m. without the benefit of a Physician's order. On . . . . . , the Controlled Medication Record showed Resident #1 received , 10 mg at 1:30 a.m., then 3:41 a.m. (two hours and 11 minutes apart). The next dose was signed on	A 053		

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A 053	Continued From page 9 . ..... at 5:41 a.m. (two hours from the previous dose), followed by a dose on at 7:55 a.m. (2 hours and 14 minutes from the previous dose). The , doses for at 1:30 a.m., 3:41 a.m., 5:41 a.m. and 7:55 a.m. were all signed by facility's Med Techs. There was no documentation of coordination with hospice for each dose of , Administered on . ..... The next dose of , 10 mg was documented on the Controlled Medication Record by a facility Med Tech was on at 8:12 p.m. On ..... the facility's Med Techs signed the Controlled Medication Record for , ... 10 mg on 12:10 a.m., 2:10, 4:09 (two hours from the previous dose) and 6:10 (two hours from the previous dose of 4:09) Complete review of the Controlled Medication Record showed Resident #1 a total of 36 single dose syringes of , . 5 mg were signed out. Resident #1 expired at the facility on . 24 syringes of , ... were unaccounted for. On at 1:19 p.m., during an interview, med tech Staff A said that on . . . at 7:55 a.m., she administered Resident #1, two - 5 mg doses of . , . medication. Staff A said she counted the , dosages documented for Resident #1 at that time. She said the count was incorrect and she did not document the dosage on the log, as there was no place to document the correct amount remaining due to the pre-documented numbers filled in on the sheet. She confirmed there were 11 syringes remaining at 7:55 a.m. on ..... Staff A said the last count she recalls, that was correct, was on with a total of 41	A 053		

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A 053	Continued From page 10	A 053		

doses. She made a check mark next to the number when the count was completed. Staff A said Resident #1 was not able to assist staff with his medication nor able to speak. She said she took the prefilled syringes and put the medication in the resident under his , administering the medication.

Record review of Resident #1's Electronic Medication Observation Record (EMOR) for the month of revealed the order for 100 mg/5ml concentrate take 5 mg by under every 6 hours around the clock.
Review of the Electronic Medication Observation Record (EMOR) for , through , revealed 17 doses of were documented on the EMOR. The EMOR showed documentation of 3 of the 17 doses signed for as given.
The EMOR exceptions notes had documentation on at 2:58 p.m., Resident #1 did not receive any , the resident had ,

The controlled substance medication record form noted Med H signed out 10 mg on at 12:10, 2:10, 4:09 and 6:10.
The EMOR showed documentation Med Tech Staff A documented on Resident #1 refused all medications, including .
Further review of the EMOR revealed no evidence of documentation of the physician ordered changes for medication on and to allow for accurate documentation by staff.

On at 9:23 a.m., interview with Pharmacy consultant/Representative for Center Pharmacy confirmed on , 60 single dose syringes of were delivered for Resident #1.

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A 053	Continued From page 11 On at 4:30 p.m., during an interview, the Executive Director (ED) reviewed the controlled medication record for Resident #1 and confirmed the documentation on the log indicates multiples doses of , were missing/unaccounted for. The ED reviewed Resident #1's MOR and confirmed on and the physician changed the order for the , . The changes were not transcribed on the MOR. On at 12:53 p.m., Med Tech Staff H said Resident #1 was unable to speak or assist staff with the medications. She said she would get the prefilled syringe of , medication, put it in his and squeeze the medication under his . Med Tech Staff H said she gave him 10 mg of , every 2 hours. Staff H said there was no order or documentation on the MOR to give the , 10 mg every 2 hours, she did as instructed by the RCM. On at 4:55 p.m., during an interview, the Hospice physician said there was never any order to give , 10 mg every 2 hours to Resident #1. She said giving , every 2 hours to Resident #1 would have caused increased and , distress, and could result in harm. That would be a lot to give Resident #1 who is not tolerant of , , especially as he was only receiving the medication starting . It would have hastened his passing. On at 5:00 p.m., the RCM said she received the order late Friday and the pharmacy doesn't input orders on the electronic MORS on weekends/Saturdays. She said when she called the pharmacy no one answered.	A 053		

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A 053	Continued From page 12 On at 9:23 a.m., the Licensed Pharmacist/Representative for Center Pharmacy, said they have a contract with Hampton Manor of Punta Gorda. The business hours are Monday through Friday Saturday . He said the facility staff and/or the physician send the orders, they input the orders on the electronic MOR and adjust for any changes immediately as they get the orders. They have 24/7 service, there is always someone there to input the orders to the electronic MORs after hours. On at 11:07 a.m., during an interview, Medication Tech (MT) Staff A said she was informed by the Resident Care Manager (RCM) Resident #1's , medication had changed and was to be given 10 mg every 2 hours. Staff A said she told the RCM she was uncomfortable giving the medication as instructed without an order for 10 mg every 2 hours (routine). On at 11:15 a.m., during an interview, MT Staff B said staff were instructed by the RCM that Resident #1's , medication was changed and to be given 10 mg every 2 hours, and she saw no evidence of documentation of a written order for that medication change. On on 12:40 p.m., during a telephone interview, MT Staff F said the RCM gave Resident #1 the , by crushing it and mixing it with the . She saw the RCM give Resident #1 - 2 syringes of , with . On at 1:25 p.m., during an interview, MT Staff E said he was called on to work from p.m. on and was told by the RCM to give Resident #1 10 mg of , every 2 hours	A 053		

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A 053	Continued From page 13 and did as he was instructed. 2. Record review revealed Resident #2 was admitted to the facility on and was admitted to Hospice services on . Diagnoses included of , secondary of bone dorsalgia unspecified (,). Record review showed a physician order dated for , 5 mg every 3 hours as needed by / , for , / . On at 11:15 a.m., during an interview, MT Staff B said on she observed and counted 3 syringes of 5 mg of , remaining in the medication cart after Resident #1 expired and was approached by MT Staff D who informed her, she was instructed by the RCM to collect the remaining syringes of , medication belonging to Resident #1. MT Staff B said she refused to give them to MT Staff D. On at 1:12 p.m., during an interview, MT Staff C said she saw the RCM giving Resident #2 4 syringes of , under his all at once. On at 11:50 a.m., during an interview, the ED said the RCM confirmed taking Resident #1's remaining 3 syringes of 5 mg of , and administering them to Resident #2. On at 5:15 p.m., the RCM said the pharmacy had not delivered the , for Resident #2. She said on , she took the three remaining syringes of , 5 mg that belonged to Resident #1 and gave them to	A 053		

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A 053	Continued From page 14 Resident #2 between 10:30 a.m. to 3:15 p.m. (4 hours and 45 minutes). Resident #1 had , on . Resident #2 received 3 doses of , 5 mg in 4 hours and 45 minutes instead of the , 5 mg every six hours as needed as per the physician's order. The RCM verified she did not document the , administered to Resident #2. On , record review revealed Resident #2 expired on . The record contained no evidence of documentation on a Controlled Medication Record for , and no medication located in the facility for Resident #2. On at 12:26 p.m., during an interview, the Pharmacy Representative confirmed the delivery of 60 syringes of , to the pharmacy on for Resident #2. Review of the facility's surveillance video on revealed that on at 6:47 p.m., the pharmacy delivered 60 syringes of , 5 mg for Resident #2 after he , on at 3:18 p.m. On at 9:00 a.m., review of video surveillance with the Administrator revealed: On at 6:47 p.m., the pharmacy driver delivered a package of medications to the receptionist at front desk. On at 6:54 p.m., the receptionist handed the package of medications to Med Tech Staff G. Med Tech Staff G placed the package of medications in the medication cart. On at 11:40 p.m., Med Tech Staff G removed the bag of medications from medication cart. She removed medications cards (bubble packs) from the bag. Med Tech Staff G then appears to pull a pack of syringes from the	A 053		

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A 053	Continued From page 15 medication deliver bag. She wrote a note on the bag and took the bag to Nurses Station 1. Med Tech Staff G was seen leaving the medication bag on top of the medication cart where it remained unsecured until at 6:44 a.m., when the morning Med Tech removed the bag from the medication cart and placed it on the shredder. On at 5:41 p.m., the RCM is seen on the surveillance video taking and opening the medication bag on top of the shredder. The RCM took a bag of syringes and placed it on the table at Nurses Station 1. She walked down the hall and then returned. She took the bag of syringes into her office. She returned to the medication cart without the bag of syringes and continued to work. On at 10:05 a.m., during an interview, the ED confirmed the video surveillance shows the Resident Care Manger taking the , medications into her office. The ED confirmed the facility has no evidence of documentation on the Controlled Medication Record for the , medication. The 60 syringes of , delivered for Resident #2 cannot be found in the facility, and are missing or unaccounted for. The ED said she searched facility, medication carts, medication room, and Resident Care Manager's office with the Interim Nurse Manager and did not find the 60 syringes of , delivered for Resident #2. 3. Record Review revealed Resident #7 was admitted to the facility on . The Health Assessment Form 1823 for Resident #7 listed diagnoses of , , , , ( ), and . On at 8:10 a.m., during an interview, the	A 053		

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A 053	Continued From page 16 interim nurse manager said Resident #7's sons were both very upset. They said one day, they came to take their father to a doctor's , , and found he was very drowsy and could not even walk. They told me to make sure not to give him anymore. She said she looked at the book and told the sons their father was not receiving . Resident #2's sons said the RCM told them she administering and to their father on a trial basis to ease his , . The interim nurse manager said the family is very involved in his care and knows in great detail all the medications he is taking. On at 8:20 a.m., during an interview, the Executive Director (ED) said both sons were at the facility last night and told her about both the and the . The ED said she did not know how the RCM gave the meds without any orders. On at 10:00 a.m., during a telephone interview, Resident #7's son said on he came to pick up his dad to take him to the dermatologist. He said his dad was so drowsy, he was incoherent, and he was not even making any sense. He could hardly stand up. The son said when they returned to the facility the RCM told him she gave his dad the night before when his dad complained to her about , in his . The RCM told the son she would try different medications on a trial basis to see the one that was effective to relieve his , . The son said he thought she had doctor orders for the medications. Record review for Resident #7 found no orders for or . 4. Record review revealed Resident #5 was	A 053		

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A 053	Continued From page 17 admitted to the facility on . . . . diagnoses of 's, , , and memory , ... The resident was admitted to Hospice services on . Record review revealed a physician order dated . . . . . for , . 5 milligram, prefilled syringe, every 12 hours by or under the . . . . for , . / . . . . . . Review of the Controlled Medication Record showed on the pharmacy delivered 30 individual dose syringes of . , . . The Controlled Medication Record noted a total of 20 syringes of , were signed out from . . . . through . . . . . Resident #5 expired on . . The MOR for failed to reveal documentation Resident #5 received the 20 doses of , signed on the Controlled Medication Record. On . . . . . observation of Resident #5's supply of , revealed six syringes of , remained, one of the syringes was empty. Four syringes of , were unaccounted for. 5. Record review revealed Resident #6 was admitted to the facility on . . . . . with diagnoses of , , ... left female . . . . . and . . . . . . Record review for Resident #6 found an order for . (, medication) 50 mg, 1 tablet every 6 hours as needed for , . . Review of the EMOR for . . . . . and . . . . . revealed Resident #6 received one	A 053		

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A 053	Continued From page 18 tablet on . . . . Review of the Controlled Medication Record for Resident #6 revealed there were 2 Controlled Medication Records for Resident #6's . . . The first Controlled Medication Record revealed on . . . . . Resident #6 had 71 . . . . pills on a handwritten note on the Controlled Medication Record #1 read, "As of . . . . . " 60 tablets of remained, leaving 11 tablets of . . . . . unaccounted for. Second Controlled Medication Record for Resident #6's . . . . . documented the resident had 11 pills on , with an end count of 2 pills. There was no documentation Resident #6 received the missing 13 tablets of . On at 2:40 p.m., during an interview, MT Staff D said she know we had an issue with for Resident #6. She was missing some pills and I went to the RCM and she completely dismissed me. I knew the resident did not like taking the medication. I went and asked the resident. She told me "No, I stopped taking them a long time ago." I knew that but I wanted to make sure. So, I went to the RCM and confronted her. She brushed me off. "She is the boss when it comes to nursing what was I supposed to do?" On . . . . . at 7:34 a.m., during an interview, Resident #6 said, "God no, I haven't taken . . . . . in a very long time. It upsets my . No. I don't take . The girls know." 6. Record review revealed Resident #8 was admitted to the facility on and discharged on . . . . . Resident #8 diagnoses included . . . . , unspecified ,	A 053		

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A 053	Continued From page 19 disturbance, and . Record Review for Resident #8 showed documentation on that the RCM took a verbal order from the ARNP (five days after the resident was discharged) for 0.5 mg, one tablet by twice daily as needed. On at 10:20 a.m., during a telephone interview, the pharmacy representative confirmed the delivery on , of 30 tablets of 0.5 mg. On , there was no Controlled Medication Record for for Resident #8. On at 10:28 a.m., the Interim Nurse Manager verified the facility received 30 tablets of five days after Resident #8 was discharged. She said they could not locate the . Class I	A 053		
A 054	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 receives assistance with self-administration of	A 054		

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A 054	Continued From page 20 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 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 , 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 review, observation, and interview, the facility failed to follow physicians' orders. The facility failed to ensure changes in medications were updated and promptly recorded on the Electronic Medication Observation Record (EMOR). Facility failed to maintain proper record of resident medication administration or assistance with self-administration of medications. The facility failed to follow its policy and procedures to document and reconcile medications when administered and maintain a Controlled Medication Record to track medications for 6 (Resident #1, #2, #5, #6, #7, and #8) of 8 residents reviewed. Failure to maintain Controlled Medication Record resulted in multiple missing and unaccounted medications. Failure to track the medications allowed for medication to be taken from 1 resident and utilized on another	A 054		

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A 054	Continued From page 21 resident without physician knowledge, consent, or orders. The findings included: Facility Policy titled: Medication Management Plan (undated): Policy: To ensure understanding of the medication procedures and responsibilities for the administration of ordered drugs to residents of Hampton Manor. All licensed nursing staff (RN/LPN), Certified Medication Aides [Medication Aides CANNOT administer medications in Assisted Living Facilities in the State of Florida], must meet qualification requirements prior to administering medications to residents . . . i. Medication Administration: 2. The recording of the administration of medications shall be by the staff person who administers the medications immediately following administration of medication to the resident an observation of the resident actually taking the medication and prior to administration of another resident's medication. Facility Policy titled: Assistance with Self-Administration of Medications (undated) . . . Assistance with self-administration of medication includes: . . . Keep a record of when a resident assistance with self-administration under this section. . . . Medication Aides may not: Prepare syringes for injection or the administration of medications by any injectable route. Facility policy titled: Policy (undated): . . . count sheet must reflect receiving quantity of medication, name of medication and resident receiving medication. Medication must be counted at shift change by oncoming and off going medication aide. Counts must be documented and signed for by staff members	A 054		

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A 054	Continued From page 22 conducting count. Facility policy titled: Medication (undated): Disposition of Medication Policy: 1. Medication: Controlled Substances: b. The facility shall maintain a readily available record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. 1. Record review for Resident #1 revealed the resident was admitted to the facility on . Resident #1 was admitted to hospice services on with diagnoses including medical diagnosis unspecified protein calorie , , disorientation unspecified, repeated . Physician orders in the record or provided by Hospice included: On , (Used to treat moderate to severe ,) 20 milligrams (mg) per milliliter (ml) oral concentrate prefilled syringes 5 mg by under the every 6 hours around the clock. Updated physician orders dated , , prefilled syringes 5 mg every 4 hours by under the as needed for , and ( ), contact hospice to administer. Another changed order dated , , 20mg/ml prefilled syringes 10 mg every 4 hours by under the as needed for , / , . Review of the Controlled Medication Record for the , revealed on the pharmacy delivered a total of 60 syringes of single dose of , 5 mg for Resident #1. The Controlled Medication Record showed the	A 054		

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A 054	Continued From page 23 physician's order to assist with self-administration of , 5 mg every six hours around the clock was not followed. On the hospice physician discontinued the previous order for , and ordered , 5 mg (0.25 ml) every four hours as needed by or , for , or . The order specified to contact hospice to administer. On , the Controlled Medication Record showed the facility LPN Resident Care Manager administered one dose of , to Resident #1 at 9:30 a.m. On a Med tech signed at 9:00 p.m. for a dose of , 5 mg. There was no documentation of coordination with hospice to administer the as needed , at 9:00 p.m., as per the hospice physician's orders. The Controlled Medication Record showed documentation the facility's Resident Care Manager (RCM) administered , 5 mg on to Resident #1 at 2:15 p.m., and 9:00 p.m. There was no documentation the facility collaborated with hospice before administering the , as per the physician's order which specified to contact hospice to administer. On at 3:00 p.m., and three hours later at 6:00 p.m., the documentation on the Controlled Medication Record showed the facility's Med Techs signed for the doses of , . This was not in accordance with the Physician's orders which specified to administer , every four hours as needed, and to contact hospice to administer On the hospice physician discontinued	A 054		

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A 054	Continued From page 24 the previous order for , 5 mg every four hours as needed. The physician ordered , 10 mg (0.5 ml) every four hours as needed by or , for / , (Difficulty breathing). On at 12:20 p.m., and 6:20 p.m., Med Tech Staff L signed the Controlled Medication Record for , 5 mg each dose. This was not in accordance with the physician's orders for , 10 mg every four hours as needed. There was no documentation the facility coordinated with hospice to administer the , as per the specification in the physician's orders dated . On at 8:00 a.m., 1:00 p.m., 8:00 p.m. the Controlled Medication Record showed the RCM administered 10 mg of , to Resident #1. On at 12:00 a.m., the RCM documented administering , 5 mg to Resident #1 without the benefit of a physician's order. On at 3:00 a.m., 7:00 a.m., the Controlled Medication Record showed Med Tech Staff L signed for the , 10 mg. Per the documentation on the Controlled Medication Record Resident #1 received , three hours apart on at 12:00 a.m., and 3:00 a.m. without the benefit of a Physician's order. On , the Controlled Medication Record showed Resident #1 received , 10 mg at 1:30 a.m., then 3:41 a.m. (two hours and 11 minutes apart). The next dose was signed on at 5:41 a.m. (two hours from the previous	A 054		

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A 054	Continued From page 25 dose), followed by a dose on at 7:55 a.m. (2 hours and 14 minutes from the previous dose). The , doses for at 1:30 a.m., 3:41 a.m., 5:41 a.m. and 7:55 a.m. were all signed by facility's Med Techs. There was no documentation of coordination with hospice for each dose of , . Administered on . The next dose of , 10 mg was documented on the Controlled Medication Record by a facility Med Tech was on at 8:12 p.m. On the facility's Med Techs signed the Controlled Medication Record for , 10 mg on 12:10 a.m., 2:10, 4:09 (two hours from the previous dose) and 6:10 (two hours from the previous dose of 4:09) Complete review of the Controlled Medication Record showed Resident #1 a total of 36 single dose syringes of , 5 mg were signed out. Resident #1 expired at the facility on . 24 syringes of , were unaccounted for. On at 1:19 p.m., during an interview, med tech Staff A said on at 7:55 a.m., she administered Resident #1, 2 - 5 mg doses of , medication. Staff A said when she counted the , dosages documented for Resident #1 at that time. She said the count was incorrect and she did not document the count on the log, as there was no place to document the correct amount remaining due to the pre-documented numbers filled in on the sheet. She confirmed there were 11 syringes remaining at 7:55 a.m. on . Staff A said her last prior count she recalls that was correct was on with a total 41 doses where she made a check	A 054		

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A 054	Continued From page 26 mark next to it when the count was completed. Record review of Resident #1's Electronic Medication Observation Record (EMOR) for the month of , revealed the order for , 100 mg/5ml concentrate take 5 mg by under every 6 hours around the clock. Review of the Electronic Medication Observation Record (EMOR) for , through , revealed 17 doses of were documented on the EMOR. The EMOR showed documentation of 3 of the 17 doses signed for as given. The EMOR exceptions notes had documentation on at 2:58 p.m., Resident #1 did not receive any , the resident had , The controlled substance medication record form noted Med H signed out , 10 mg on at 12:10, 2:10, 4:09 and 6:10. The EMOR showed documentation Med Tech Staff A documented on Resident #1 refused all medications, including , Further review of the EMOR revealed no evidence of documentation of the physician ordered changes for , medication on and to allow for accurate documentation by staff. On at 4:30 p.m., during an interview, the Executive Director (ED) reviewed Resident #1's EMOR and confirmed no documentation of the physician ordered medication changes dated for and were recorded on EMOR. On at 5:00 p.m., during an interview, the Resident Care Manager confirmed the , for Resident #1 was being given around the clock	A 054		

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A 054	Continued From page 27 and not as needed as per physician orders, and EMOR had not been updated with the medication order changes for [redacted] and [redacted]. Regarding the missing medications, the RCM said she worked the weekend ([redacted] and [redacted]) and she did administer medication to Resident #1 without documenting the medications as given. Further, the Resident Care Manager said it was late Friday when she got the order change, and the pharmacy doesn't input orders on the EMORS on weekends/Saturdays and when she called the pharmacy no one answered. On [redacted] at 9:23 a.m., during an interview with Pharmacy Consultant/Representative confirmed on [redacted], 60 syringes of [redacted], was delivered for Resident #1. The Pharmacy Consultant/Representative said they have a contract with Hampton Manor of Punta Gorda and hours of business are Monday through Friday [redacted] Saturday [redacted], He states the facility staff and or the physician send the orders and they input the orders on the EMOR and make adjustments for any changes immediately as they get orders. He said they have 24/7 service, there is always someone there to input the orders to the EMORs after hours. On [redacted] at 4:55 p.m., during an interview, the Hospice physician said there has never been any orders for Resident #1 to be given [redacted], [redacted] 10 mg every 2 hours. She said for the nurse to instructing the staff to give it every 2 hours to Resident #1 would have caused increased [redacted], [redacted], distress and that's problematic and could result in harm. The physician said that would be a lot to give Resident #1 who is not tolerant of [redacted], especially as he was only receiving the medication from [redacted] and would have hastened his passing.	A 054		

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A 054	Continued From page 28 2. Record review for Resident #2 revealed an admission date of and admission to hospice services on with diagnosis including: , of , secondary of bone, dorsalgia unspecified (,). Record review revealed a Physician order dated at 1:52 p.m., was for , 5 mg every 3 hours as needed by / , for , /. Review of Resident #2's EMOR revealed no documentation recorded of , medication being administered by RCM on . On , record review revealed Resident #2 expired on . The record contained no evidence of documentation on a Controlled Medication Record for , given to Resident #2 nor for the 60 - 5 mg , syringes delivered to the facility on . On at 12:50 p.m., during an interview, the Resident Care Manager (RCM) said on she contacted the Hospice Nurse for Resident #2 to give report of high rate, with a , , and was informed an order would be sent for , . On 5:15 p.m., the RCM said the pharmacy had not delivered the , for Resident #2. She said on , she took the three remaining syringes of , 5 mg that belonged to Resident #1 and gave them to Resident #2 between 10:30 a.m. to 3:15 p.m. (4 hours and 45 minutes). Not given as ordered. The RCM verified she did not document the	A 054		

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A 054	Continued From page 29 , administered to Resident #2. Resident #2 , , on at 3:18 p.m. On at 11:50 a.m., during an interview, the Executive Director said the RCM confirmed taking Resident #1's remaining 3 syringes of 5 mg of , , and administering them to Resident #2. On at 1:12 p.m., during an interview, MT Staff C said, "I saw her giving Resident #2 at least 4 syringes of , all at once." On at 9:00 a.m., review of video surveillance with the Executive Director revealed: On at 6:47 p.m., the pharmacy driver delivered a package of medications to the receptionist at front desk. (After Resident #2 had , at 3:18 p.m. earlier that day) On at 6:54 p.m., the receptionist handed the package of medications to Med Tech Staff G. Med Tech Staff G placed the package of medications in the medication cart. On at 11:40 p.m., Med Tech Staff G removed the bag of medications from medication cart. She removed medications cards (bubble packs) from the bag. Med Tech Staff G then appears to pull a pack of syringes from the medication deliver bag. She wrote a note on the bag and took the bag to Nurses Station 1. Med Tech Staff G was seen leaving the medication bag on top of the medication cart where it remained unsecured until at 6:44 a.m., when the morning Med Tech removed the bag from the medication cart and placed it on the shredder. On at 5:41 p.m., the RCM is seen on the surveillance video taking and opening the medication bag on top of the shredder. The RCM took a bag of syringes and placed it on the table	A 054		

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A 054	Continued From page 30 at Nurses Station 1. She walked down the hall and then returned. She took the bag of syringes into her office. She returned to the medication cart without the bag of syringes and continued to work. On [redacted] at 10:05 a.m., the Executive Director confirmed the video surveillance showed the RCM taking the bag of syringes of [redacted] into her office. She confirmed the facility did not have the Controlled Medication Record for the 60 syringes of [redacted] delivered for Resident #2 on [redacted] at 6:47 p.m. She said the [redacted] is currently unaccounted for. On [redacted], the Executive Director said she searched the RCM's office with the Interim Nurse Manager and did not find any syringes of [redacted]. 3. Record Review revealed Resident #7 was admitted to the facility on [redacted], with diagnoses of [redacted], and [redacted]. On [redacted] at 8:10 a.m., during an interview, the interim nurse manager said Resident #7's sons were both very upset because they said one day, they came to take their father to a doctor's [redacted], and he was very drowsy and could not even walk. So, they told me make sure not to have him on [redacted] anymore. The interim Nurse Manager said she looked at the [redacted] book and Resident #7 was not on [redacted]. The sons told her that the RCM told them she was giving their Father some [redacted] and [redacted] on a trial basis to ease his [redacted]. They said their dad was on [redacted] at first and then on [redacted]. She said the family is very involved in his care and know in great detail, all the medications he is taking.	A 054		

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A 054	Continued From page 31 On . . . . . at 10:00 a.m., in a telephone interview, Resident #7's son said on he picked up his dad to take him to the dermatologist. His dad was drowsy, incoherent, and was not making any sense. He could not even stand up. When they returned to the facility the RCM told him she gave . . to his dad the previous night when Resident #7 complained to her about , in his . . . . The RCM told the son she would try different medications on a trial basis to see which one was effective to relieve his , . The son said he thought there was a physician's order for the medications. On . . . . , record review for Resident #7 found no orders for or . A review of the EMOR for Resident #7 found the resident did not have a prescription for or . . . . . Controlled Medication Record was reviewed for Resident #7 and revealed no documented of or . 4. Record review revealed Resident #5 was admitted to the facility on . . . . . with diagnoses of 's, , , and memory , ... The resident was admitted to hospice services on . Record review showed the physician's order dated . . . . included . , . 5 milligrams, prefilled syringe, every 12 hours by for , . /. . . . . On . . . . at 1:38 p.m. the order was changed to 5 mg every 3 hours as needed. Review of the EMOR showed it was not updated, but hospice nurses were providing Resident #5's end of life medication coverage.	A 054		

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A 054	Continued From page 32 Review of the Controlled Medication Record showed on the pharmacy delivered 30 individual dose syringes of . The Controlled Medication Record for Resident #5 revealed , refilled syringe 5 milligram twice a day by or , / with a documented count of 9 syringes on the log on . Observation of the bag on revealed 6 syringes in the bag, 1 syringe was empty, 4 syringes had 5 mgs of , and 1 syringe had 2 mgs of , leaving 4 syringes unaccounted. 5. Record review revealed Resident #6 was admitted to the facility on . The Health Assessment Form 1823 dated included the diagnoses , , of the , , and . Record review for Resident #6 found an order for 50 mg tablet take 1 tablet every 6 hours if needed for , . On at 7:34 a.m., during an interview, Resident #6 said, "God no, I haven't taken in a very long time. It upsets my . No, I haven't taken this pill in a long, long time. Review of the Controlled Medication Record for Resident #6 revealed there were 2 Controlled Medication Records for Resident #6's . The first Controlled Medication Record revealed on Resident #6 had 71 pills left. On the Controlled Medication Record documented, "as of 60 pills." For a total of 11 pills unaccounted for. Second Controlled Medication Record for Resident #6's documented the resident had 11 pills on . The Controlled Medication Record	A 054		

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A 054	Continued From page 33 showed an end count of 2 pills. A total of 13 pills were unaccounted for between the two prescriptions. The form was signed by the facility's Resident Care manager (RCM). 6. Record review revealed Resident #8 was admitted to the facility on [redacted] and was discharged from the facility on [redacted]. Record review for Resident #8 found an order for [redacted] 0.5 mg one tablet by [redacted] twice daily as needed. The order was dated [redacted], five days after Resident #8's discharge. Review of EMOR for Resident #8 revealed the [redacted] 0.5 mg one tablet by [redacted] twice daily as needed was added to the EMOR on [redacted], 5 days after discharge date; however, no medication given to Resident #8. On [redacted] at 10:20 a.m., during a telephone interview, the pharmacy representative confirmed the delivery of 30 tablets of [redacted] on [redacted]. Class 1	A 054		
A 077	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who	A 077		

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A 077	Continued From page 34 has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator.	A 077		

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A 077	Continued From page 35 Administrators who attended core training prior to , , , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must	A 077		

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A 077	Continued From page 36 satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , . . . , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility's Executive Director failed to perform her duties as required. Failed to oversee the Resident Care Manager and ensure appropriate care for 6 (#1, #2, #5, #6, #7 and #8) of 8 residents reviewed. Failure to properly supervise and oversee the Resident Care Manager resulted with residents not receiving medications according to physician orders. Failure to accurately document medications. Failure to properly supervise facility's resident care manager resulted to missing/unaccounted medications (Refer to A0053 Medication - Administration and A0054 Medication - Records).	A 077		

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A 077	Continued From page 37 The failure of the Executive Director to ensure systems were in place to prevent misappropriation of medications and ensure all residents received medications per physician's orders created a likelihood of serious harm, or to the current residents at the facility. The findings included: Review of job description for Executive Director signed and dated . . .. . indicating having read and reviewed the job description and agree to abide by it to the best of her ability for the duration of employment. Executive Director Position Description Job Summary: The executive director is responsible for leading the day-to-day operations of the community. . . The Executive Director plans, implements and evaluates all aspects of operations: The Executive Director recruits, trains team members, has a direct supervisory responsibility for team members in order to create and maintain a highly functioning team environment, maintain high customer satisfaction and ensures a quality-oriented workforce. . . Principle Duties and Responsibilities: The following essential functions are the fundamental job duties of the position to be completed with or without appropriate accommodation. . . Understand the community's care regulations and support the resident care program by regularly meeting with the resident care manager to discuss and address concerns of the department. . . Ensure adherence to the residents' bill of rights. . . Interview, hire, orient, train and evaluate staff. . . Operate the community in accordance with Hampton Manor's policies and federal, state, and local regulations. 1. On at 11:00 a.m., during a telephone	A 077		

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A 077	Continued From page 38 interview, the Executive Director (ED) said they have Quality Assurance (QA) quarterly reviews, which include nursing issues, monitoring of Medication Administration Records, checking off of [redacted], and employee and residents safety from [redacted]. She said the Resident Care Manager (RCM) would document any issues they were having during that period. The ED said the routine monitoring would be completed by the Resident Care Manager. She verified they did not have a formal QA program and no forms for auditing or reporting. She further verified she delegated to the nurse who ran the nursing department the responsibility for the QA of the nursing department. She would speak to the nurse quarterly to ask if their were any issues. She verified it was [redacted] when she heard about the medication issues for the first time. She was told the staff were concerned that the nurse was doubling the [redacted] for Resident #1. She said on [redacted] she requested the RCM bring her the [redacted] sheets for Resident #1. The nurse said she was busy with a family. The next day she reviewed the forms and could not make heads for tails of the documents. The ED said she asked for the Hospice orders and saw the order for 2 syringes every 4 hours. She said she did not note that is was PRN (as needed). She said she thought she would print the Electronic Medication Administration Record (EMOR) and look for holes (places with out a signature). When she looked at the [redacted] book she could not find any count sheets. The ED said they have no procedure for accepting delivery of the medications from the pharmacy. She said it usually goes to the nurses or a Med Tech, whichever is on duty. 2. Record review revealed the RCM/ LPN was hired on [redacted].	A 077		

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A 077	Continued From page 39 Record review found on the pharmacy delivered 30 syringes of , to the facility for Resident #5. A review of the Controlled Medication Record revealed 20 doses of , were signed out on the controlled medication record without documentation the resident received the , . The first discrepancy with the , was on , three days after the RCM began employment at the facility. On at 4:30 p.m., during an interview, the Executive Director (ED) reviewed the controlled medication record for Resident #1 and confirmed the documentation on the log indicates multiples doses of , missing/unaccounted for. The ED reviewed Resident #1's EMOR and confirmed no documentation of the physician order medication changes dated and were not recorded on EMOR. On at 11:55 a.m., during an interview, the ED verified she found out on about the , misuse from staff, but accepted the word of the RCM, that she had orders to give , to Resident #2. On at 10:05 a.m., during an interview, the ED said she thought Med Techs could administer medications to Hospice patients. She verified she had not reported the concerns of misappropriation of residents' medication and the allegation the RCM overdosed residents on , to the police, Adult Protective Services, or the Department of Health. Per record review and interviews conducted, there was a pattern of missing controlled	A 077		

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	AL11970069	A. BUILDING: _____ B. WING _____	02/02/2023

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A 077	Continued From page 40 substances and documentation of residents not receiving medications in accordance with the physician's orders. 3. Record review revealed Resident #8 was admitted to the facility on and was discharged from the facility on . Record review for Resident #8 found an order for 0.5 mg on tablet by twice daily as needed dated written by the RCM, five days after Resident #8's discharge. Record review for Resident #8 revealed that Resident #8 did not have a previous order of while she was in the facility. Review of Resident #8 EMORS for the month of revealed the , ( ) 0.5 mg recorded on the EMORS on five days after resident #8 was discharged from the facility. On at 10:20 a.m., during a telephone interview, the pharmacy representative confirmed the delivery of 30 tablets of on . On , the medication could not be located in the facility. There was no Controlled Medication Record on premises for for Resident #8. 4. Record review revealed Resident #6 was admitted to the facility on . Record review for Resident #6 found an order for 50 mg tablet take 1 tablet every 6 hours if needed for , . Medication observation review (MOR) for Resident #6 found she received one PRN dosage of on . Review of the Controlled Medication Record for Resident #6 revealed there were 2 Controlled	A 077		

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A 077	Continued From page 41 Medication Records for Resident #6's . The first Controlled Medication Record revealed on Resident #6 had 71 pills left. Then it was documented on that Resident #6 had 63 pills left. The next note on documented, "as of 60 pills." For a total of 11 pills being removed on . Second Controlled Medication Record for Resident #6's documented the resident had 11 pills on . Resident #6 received one pill each day from to with an end count of 2 pills. This would be 3 missing pills. The form was signed by the facility's Resident Care manager (RCM). No explanation provided on the record for the missing pills. On at 7:34 a.m., during an interview, Resident #6 said, "God no, I haven't taken in a very long time. It upsets my . No, I haven't taken this pill in a long, long time." 5. Record review revealed Resident #1 was admitted to the facility on and to hospice services on . The resident was not able to assist with self-administration of medications. Record review of physician orders revealed the physician ordered on , prefilled syringes 5 milligram (mg) every 6 hours by or for , and ( ). An updated physician order, dated , documented , prefilled syringes mg every 4 hours as needed by under the for , and ( ), contact hospice to administer. Another changed order, dated , documented , prefilled syringes 10 mg every 4 hours as needed by or	A 077		

Agency for Health Care Administration

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A 077	Continued From page 42 for Review of the Controlled Medication Record for the revealed on the pharmacy delivered a total of 60 syringes of single dose of 5 mg for Resident #1. The Controlled Medication Record showed the physician's order to assist with self-administration of 5 mg every six hours around the clock was not followed. On the hospice physician discontinued the previous order for and ordered 5 mg (0.25 ml) every four hours as needed by or for or . The order specified to contact hospice to administer. On the hospice physician discontinued the previous order for 5 mg every four hours as needed. The physician ordered 10 mg (0.5 ml) every four hours as needed by or for (Difficulty breathing). Complete review of the Controlled Medication Record showed Resident #1 a total of 36 single dose syringes of 5 mg were signed out. Resident #1 expired at the facility on . 24 syringes of were unaccounted for. Further review of the Controlled Medication Record for Resident #1 showed on the pharmacy delivered a total of 60 syringes of single dose of 5 mg for Resident #1. On at 9:23 a.m., interview with Pharmacy consultant/Representative for Center Pharmacy confirmed on , 60 single dose syringes of were delivered for Resident #1.	A 077		

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A 077	Continued From page 43 On [redacted] at 4:30 p.m., during an interview, the Executive Director (ED) reviewed the controlled medication record for Resident #1 and confirmed the documentation on the log indicates multiples doses of [redacted] were missing/unaccounted for. The ED reviewed Resident #1's MOR and confirmed on [redacted] and [redacted] the physician changed the order for the [redacted]. The changes were not transcribed on the MOR. On [redacted] at 12:53 p.m., Med Tech Staff H said Resident #1 was unable to speak or assist staff with the medications. She said she would get the prefilled syringe of [redacted] medication, put it in his [redacted] and squeeze the medication under his [redacted]. Med Tech Staff H said she gave him 10 mg of [redacted] every 2 hours. Staff H said there was no order or documentation on the MOR to give the [redacted] 10 mg every 2 hours, she did as instructed by the RCM. On [redacted] at 4:55 p.m., during an interview, the Hospice physician said there was never any order to give [redacted] 10 mg every 2 hours to Resident #1. She said giving [redacted] every 2 hours to Resident #1 would have caused increased [redacted] and [redacted] distress, and could result in harm. That would be a lot to give Resident #1 who is not tolerant of [redacted], especially as he was only receiving the medication starting [redacted]. It would have hastened his passing. On [redacted] at 5:00 p.m., the RCM said she received the order late Friday and the pharmacy doesn't input orders on the electronic MORS on weekends/Saturdays. She said when she called the pharmacy no one answered.	A 077		

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A 077	Continued From page 44 On [redacted] at 9:23 a.m., the Licensed Pharmacist/Representative for Center Pharmacy, said they have a contract with Hampton Manor of Punta Gorda. The business hours are Monday through Friday [redacted] Saturday [redacted]. He said the facility staff and/or the physician send the orders, they input the orders on the electronic MOR and adjust for any changes immediately as they get the orders. They have 24/7 service, there is always someone there to input the orders to the electronic MORs after hours. 6. Record review revealed Resident #2 was admitted to the facility on [redacted] and admitted to Hospice services on [redacted]. Diagnosis included [redacted] of [redacted], secondary [redacted] of bone. Record review showed a physician order dated [redacted] for [redacted] 5 mg every 3 hours as needed by [redacted], for [redacted]. On [redacted] 5:15 p.m., the RCM said the pharmacy had not delivered the [redacted] for Resident #2. She said on [redacted], she took the three remaining syringes of [redacted] 5 mg that belonged to Resident #1 and gave them to Resident #2 between 10:30 a.m. to 3:15 p.m. (4 hours and 45 minutes). Resident #1 had [redacted], on [redacted]. Resident #2 received 3 doses of [redacted] 5 mg in 4 hours and 45 minutes instead of the [redacted] 5 mg every six hours as needed as per the physician's order. The RCM verified she did not document the [redacted] administered to Resident #2. Resident #2 [redacted], on [redacted] at 3:18 p.m.	A 077		

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A 077	Continued From page 45 On [redacted] at 1:12 p.m., Med Tech Staff C said she saw the RCM giving Resident #2 at least 4 syringes of [redacted] all at once. On [redacted] at 9:00 a.m., review of video surveillance with the Executive Director revealed: On [redacted] at 6:47 p.m., the pharmacy driver delivered a package of medications to the receptionist at front desk. On [redacted] at 6:54 p.m., the receptionist handed the package of medications to Med Tech Staff G. Med Tech Staff G placed the package of medications in the medication cart. On [redacted] at 11:40 p.m., Med Tech Staff G removed the bag of medications from medication cart. She removed medications cards (bubble packs) from the bag. Med Tech Staff G then appears to pull a pack of syringes from the medication deliver bag. She wrote a note on the bag and took the bag to Nurses Station 1. Med Tech Staff G was seen leaving the medication bag on top of the medication cart where it remained unsecured until [redacted] at 6:44 a.m., when the morning Med Tech removed the bag from the medication cart and placed it on the shredder. On [redacted] at 5:41 p.m., the RCM is seen on the surveillance video taking and opening the medication bag on top of the shredder. The RCM took a bag of syringes and placed it on the table at Nurses Station 1. She walked down the hall and then returned. She took the bag of syringes into her office. She returned to the medication cart without the bag of syringes and continued to work. On [redacted] at 10:05 a.m., the Executive Director confirmed the video surveillance showed the RCM taking the bag of syringes of [redacted] into her office. She confirmed the facility did not have	A 077		

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A 077	Continued From page 46 the Controlled Medication Record for the 60 syringes of , delivered for Resident #2 on at 6:47 p.m. She said the , is currently unaccounted for. Review of the facility's surveillance video revealed on at 6:47 p.m., the pharmacy delivered 60 syringes of , 5 mg for Resident #2 after he , on at 3:18 p.m. 7. Record Review revealed Resident#7 was admitted to the facility on . On at 8:10 a.m., during an interview, the interim nurse manager said Resident #7's sons informed her the RCM was administering and medications to their dad on a trial basis with no physician orders. On at 10:00 a.m., during a telephone interview, Resident #7's son said on was given by the RCM then the RCM stopped that, and on , the RCM gave him , and he has been on since with no physician orders for the medications. On at 8:20 a.m., during an interview, the Executive Director (ED) said both sons were at the facility last night and told her about both the and the . The ED said she did not know how the RCM gave the meds without any orders. Record review for Resident #7 found no orders for or . On a review of the EMOR for Resident #7 found that resident did not have a prescription for or . Controlled Medication Record was reviewed for Resident #7 and documented no evidence that	A 077		

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A 077	Continued From page 47 Resident #7 was receiving . . or . . . . . Class I	A 077		
A 165	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; 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	A 165		

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A 165	Continued From page 48 (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 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.	A 165		

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A 165	Continued From page 49 (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 interview, observation, and record review, the Executive Director failed to develop a quality assurance program to access resident care practices including medication assistance/administration for 7 (Residents #1, #2, #3, #5, #6, #7 and #8) of 8 residents reviewed for medications. Failure to have a formal quality assurance system, with monitoring by someone other than the manager of the department being monitored, resulted in the practice of undocumented medications being given to residents, 24 doses of , going missing or being given to Resident #1 and #2 without documentation; misappropriation of 60 doses of , concentrate for Resident #2 going missing from the building, misappropriation of 30 doses of for discharged Resident #8; a total of 13 pills missing/unaccounted for Resident #3; 4 syringes of were missing/unaccounted for Resident #5; and 14 pills of missing	A 165		

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A 165	Continued From page 50 from Resident #6. The findings included: Executive Director Position Description included: The Executive Director is responsible for leading the day-to-day operations of the community, . . . The ED plans, implements and evaluates all aspects of operations. . . . Principle Duties and Responsibilities: The following essential functions are the fundamental job duties if the position to be completed with or without appropriate reasonable accommodation. . . . Understand the community's regulations and support the resident care program by regularly meeting with he Resident Care Manager to discuss and address concerns of the department. 1. On . . . . . at 11:00 a.m., during a telephone interview, the Executive Director (ED) said they have a Quality Assurance (QA) quarterly reviews, which include nursing issues, monitoring of Medication Administration Records, checking off of , and employee and residents safety from . . . . She said the Resident Care Manager (RCM) would document any issues they were having during that period. If identified would work with the team to put measures in place and put a plan in place to correct the issues. She said the only issue identified was at the end of last year about the challenges to staffing. She explained the routine monitoring would be completed by the nurse manager and she does not have any of those. She verified they have no written audit tools to be completed. She said they have had 3 nurses in the Resident care Manager position since opening in . . . . . She verified they did not have a formal QA program and no forms for auditing or reporting. She further verified she delegated to the nurse who ran the nursing	A 165		

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A 165	Continued From page 51 department the responsibility for the QA of the nursing department. She would speak to the nurse quarterly to ask if their were any issues. She verified it was when she heard about the medication issues for the first time. She was told the staff were concerned that the nurse was doubling the , for Resident #1. She said on she requested the RCM bring her the sheets for Resident #1. The nurse said she was busy with a family. The next day she reviewed the forms and could not make heads for tails of the documents. She also asked for the Hospice orders and for 2 syringes every 4 hours. She said she did not note that is was PRN (as needed). She said she thought she would print the Electronic Medication Administration Record (EMOR) and look for holes (places with out a signature). When she looked at the book she could not find any count sheets. She said they have no procedure for accepting delivery of the medications from the pharmacy. She said it usually goes to the nurses or a Med Tech, whichever is on duty. On at 11:55 a.m., during an interview, the Executive Director said she received a call from MT Staff F on Tuesday morning ( ) to tell her she was uncomfortable as she felt the RCM was overdosing Resident #1 with his , . MT Staff F told her she saw the RCM give Resident #1 - 2 doses of , . The ED told Staff F she would be in and see what is going on. Then she received a call from MT Staff G. Staff G called to report the same thing that Staff F reported. Staff G also voiced concerns about left-over , from Resident #1, being given to give to Resident #2. The ED said she called the RCM. The RCM said she spoke with the hospice. At that point the ED told the RCM to make sure she had it all	A 165		

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A 165	Continued From page 52 documented and hung up. The ED said when she arrived in the facility Resident #2 had just , and the RCM was busy with the family making funeral arrangements. She spoke to the RCM and the RCM assured her the hospice nurse was taking care of the orders and there was no issue. The RCM told the ED that there was a change in direction of medication for Resident #1. The , increased from 5 mg to 10 mg every 4 hours as needed. The ED said she went and retrieved the order, and it was to be given every 4 hours. The ED told staff the order had been increased and was to be given as 2 syringes = 10 mg. The ED said she requested the Controlled Medication Record, and the RCM told her she would give them to her once she finished with Resident #2's family. The ED told the RCM she would follow up with her the next day, but she did not go to the facility the next day. When the ED said when she returned to the facility on Thursday ( ) the state was already in and she had not done a full investigation. 2. Record review revealed Resident #5 was admitted to the facility on . The initial Health Assessment (HA) Form 1823, dated , listed diagnoses including 's, , memory , . Resident #5 was admitted to Hospice on with diagnosis listed as unspecified protein calorie , , and disorientation. Record review found Resident #5 had a physician order dated for , prefilled syringe 5 milligram twice a day by or Review of the Controlled Medication Record for	A 165		

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	AL11970069	A. BUILDING: _____ B. WING _____	02/02/2023

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A 165	Continued From page 53 Resident #5 revealed a documented count of 9 syringes of , on the log on . Observation of the bag on revealed 6 syringes in the bag, 1 syringe was empty, 4 syringes had 5 mgs of , and 1 syringe had 2 mgs of , . Therefore 4 syringes were missing/unaccounted for Resident #5. 3. Record review revealed Resident #8 was admitted to the facility on and was discharged from the facility on . Resident #8 admission's record review revealed diagnoses of 's , unspecified , disturbance, . Record review for Resident #8 found an order for 0.5 mg on tablet by twice daily as needed. The order was dated , five days after Resident #8's discharge. Record review for Resident # 8 revealed that Resident #8 did not have an order of while she was living in the facility. On at 10:20 a.m., during a telephone interview, the pharmacy representative confirmed the delivery of 30 tablets of on . On at 10:28 a.m., the Interim Nurse Manager confirmed the medication could not be located in the facility. There was no Controlled Medication Record on premises for for Resident #8. 4. Record review revealed Resident #6 was admitted to the facility on . The Health Assessment Form 1823 on the record was competed on listing diagnose including , , ( ),	A 165		

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A 165	Continued From page 54 left female , and Record review for Resident #6 found an order for 50 mg tablet take 1 tablet every 6 hours if needed for . On at 7:34 a.m., during an interview, Resident #6 said, "God no, I haven't taken in a very long time. It upsets my . No, I haven't taken this pill in a long, long time. Medication observation review (MOR) for Resident #6 found she received one PRN dosage of on . Review of the Controlled Medication Record for Resident #6 revealed there were 2 Controlled Medication Records for Resident #6's . The first Controlled Medication Record revealed on Resident #6 had 71 pills left from the first script. The note on documented, "as of 60 pills." For a total of 11 pills being removed. Second Controlled Medication Record for Resident #6's second scrip of documented the resident had 11 pills on . The Record showed Resident #6 had taken 1 to 2 doses daily from to and 1 dose on will an end count of 2 pills. This would be 2 missing pills. The form was signed by the facility's Resident Care manager (RCM). 5. Record review for Resident #1 revealed Resident #1 was admitted to the facility on and expired on . Resident #1 was admitted to hospice services on with diagnoses including medical diagnosis unspecified protein calorie ,	A 165		

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A 165	Continued From page 55 , disorientation unspecified, repeated . Physician orders in the record or provided by Hospice included: On , prefilled syringes 5 milligram (mg) every 6 hours by under the for , and ( ). Updated physician orders dated , prefilled syringes 5 mg every 4 hours as needed by under the for , and ( ), contact hospice to administer. Another changed order dated , , prefilled syringes 10 mg every 4 hours as needed by under the for , / , . On at 5:00 p.m., during an interview, the Resident Care Manager (RCM) LPN said the Resident #1 was not able to give himself the medication and the medication techs (MT) gave the medication. She said they physically placed the syringe in the resident and pushed the syringe, putting the medication under the and the medication was in prefilled syringes. She confirmed regulations did not allow unlicensed staff to administer medications, and confirmed the MTs were administering the medication and not assisting with them. She stated, "I could not work 24/7, which is why I had the med techs give the , to [Resident #1]" and confirmed she knew they were administering it, as the resident was not able to assist with the medication. She said she knew it was being given every 4 hours around the clock and not PRN as ordered. She said she did not realize the order was as needed she thought it was scheduled as the original order was scheduled. The RCM said she thought the med techs were able to administer medications if	A 165		

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A 165	Continued From page 56 the residents were on hospice services. She said she worked on and , the weekend, and gave the , medication, for which she confirmed there was no documentation the medication was given. The Resident Care Manager (RCM) LPN confirmed there was no documentation on the EMORs for the medication with updated changes of physician orders for (Tuesday), and (Friday). The RCM said it was late Friday when she got the order and the pharmacy doesn't input orders on the EMORS on weekends/Saturdays and when she called no one answered. The RCM confirmed there was no documentation on the log the medication was given and cannot be accounted for as there was no documentation and no signatures by who or if given. On at 11:07 a.m., during an interview, Medication Tech (MT) Staff A said she was informed by the Resident Care Manager (RCM) Resident #1's , medication had changed and was to be given 10 mg every 2 hours. On at 11:15 a.m., during an interview, MT Staff B said staff were instructed by the RCM that Resident #1's , medication was changed and to be given 10 mg every 2 hours, and she saw no evidence of documentation of a written order for that medication change. 6. Review of clinical record for Resident #2 revealed an admission date of and was admitted to hospice services on with diagnosis including: , of , secondary of bone, retention of unspecified, dorsalgia unspecified, history of . Review of the Physician orders included an	A 165		

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A 165	Continued From page 57 updated physician order dated at 1:52 p.m., was for , prefilled syringe 5 mg every 3 hours as needed by under the for , / . On at 11:15 a.m., during an interview, MT Staff B said on she observed and counted 3 syringes of 5 mg of , remaining in the medication cart after Resident #1 expired and was approached by MT Staff D informing her, she was instructed by the RCM to collect the remaining syringes of , medication belonging to Resident #1. On at 11:50 a.m., during an interview, the Executive Director said the RCM confirmed taking Resident #1's remaining 3 syringes of 5 mg of , and administering them to Resident #2. 7. Review of the Controlled Medication Record for Resident #3 revealed , 0.5 mg 1 tablet every 6 hours with a documented count of 48 pills on the log on . On , the Hospice staff received the medications with a count balance received of only 35 pills documented with a total of 13 pills missing/unaccounted for. 8. Record Review revealed Resident#7 was admitted to the facility on . The Health Assessment Form 1823 for Resident #7 listed diagnoses of without behavioral disturbances, , ( ) without , and . On at 8:10 a.m., during an interview, the interim nurse manager said Resident #7's sons	A 165		

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A 165	Continued From page 58 were both very upset because they said one day, they came to take their father to a doctor's ... and he was very drowsy and could not even walk. So, they told me make sure not to have him on ... anymore. The interim Nurse Manager said she looked at the book and he was not on ... . The sons told her that the RCM was telling them she was giving their Father some medication on a trial basis to ease his ... . They said their Father was on ... in the beginning and then on ... . The interim nurse manager said the family is very involved in his care and know in great detail, all the medications he is taking. Class I .	A 165		