

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969190	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

DISCOVERY VILLAGE AT TAMPA PALMS

**17470 BROOKSIDE TRACE CT
TAMPA, FL 33647**

(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 survey (#202300002) was completed at Discovery Village at Tampa Palms Assisted Living Facility on . Discovery Village at Tampa Palms Assisted Living Facility had deficient practice identified at the time of the survey.	A 000		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known 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	A 054		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 054	Continued From page 1 medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to update Medication Observation Records (MORs) immediately each time medications were offered to 3 Residents (Resident #1, Resident #2, and Resident #3) of three sampled residents. Findings Included: On a record review of several medications for the months of , and showed documentation that ordered medications were given late for Resident#1. Further review of Resident#1 records showed Resident#1 had missed dosage of medications for the following: 2 mg tab ordered one tab by at bedtime at 10pm on , and On a record review several medications for the months of , and showed documentation that ordered medications were given late for Resident#2. On a record review several medications for the months of , and showed documentation that ordered medications were given late for Resident#3. During an interview with the Executive Director, on at 11:07 a.m. the Executive Director (ED) reviewed the medication observation records(MORS) with surveyor and confirmed that a multiple medications were documented as given late for resident#1, #2, and #3. The ED, stated, if	A 054		

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NAME OF PROVIDER OR SUPPLIER DISCOVERY VILLAGE AT TAMPA PALMS			STREET ADDRESS, CITY, STATE, ZIP CODE 17470 BROOKSIDE TRACE CT TAMPA, FL 33647		
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A 054	Continued From page 2 the MORS reads that it is given late then it probably was given late. It is her understanding that some of the nurses at the facility who provided medications assistance do not documents given until after they are done with their medication rounds and that could take hours. However, all the medication technicians should be documenting at the time the medications are given. The ED confirmed staff who documented late medications with Resident's #1, #2 and #3 were not licensed personnel and that MORS were not documented immediately upon each medication were offered. Class III	A 054			