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
	AL11969720	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICASA SENIOR LIVING	6021 DUVAL ST HOLLYWOOD, FL 33024

(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 An unannounced Complaint (#2022018891) survey was conducted on [redacted] at Micasa Senior Living. The facility had a deficiency identified at the time of the survey.	A 000		
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 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 [redacted] 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 [redacted], 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.	A 054		

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A 054	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure medications were obtained and provided as ordered by the Physician for 1 out of 1 sampled residents, Resident #1 as evidenced by the Medication Observation Records (MOR) did not reflect why Resident #1 did not receive her medications as ordered. The findings included: Review of the facility's undated "Assistance with Self-Administration of Medications" Policy and Procedures stated in part that the assistance with medications included taking the resident's medications from a properly labeled container from where it is stored and bringing it to the resident. Review of this document indicated that the prescribed amount of medication must be given to the resident and to document in the resident's medication record that the resident received assistance with self-administration of their medication. Review of the facility's undated "Ordering and receiving medications from pharmacy" Policy and Procedures revealed that the resident's Physician will fax the medication order to the pharmacy and the facility so the Care Coordinator will contact the pharmacy to verify the estimated day and time of medication delivery. Review of this document revealed that the Care Coordinator will check that the received medication matched the Physician order and the medications will be distributed to the residents by the Medication Technician staff members. (Photographic evidence was obtained). Review of Resident #1's MOR	A 054		

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A 054	Continued From page 2 documented that the resident's 40 milligram (mg) medication (used for high) was "withheld" per Physician order from to and from to . Review of this MOR revealed that the resident's 40 mg medication was "not available" on and from to . Further review of the resident's MORs did not document any details on the 40 mg medication's unavailability or the reason why or if the Physician withheld this medication for the resident. Review of Resident #1's MOR revealed that the resident's Benzonate 100 mg twice daily for 10 days used for ; Amox-Clav 500-125 mg 3 times daily for 10 days, an ; and 10 mg daily for 5 days, a , medications were ordered by the Physician on however were not started until . The combination of these 3 medications ordered could indicate the resident was suffering from an acute , event. Further review of the MOR revealed that the resident's , 400 mg medication, used for and , was ordered on and was not started until . Review of this MOR revealed that the resident did not receive her 8.6 mg medication on as prescribed. Further review of the resident's MORs did not provide any documentation for the reasons for the delays in obtaining these medications in or the missed dosage on . In an interview conducted with the Administrator on at 1:45 PM, she stated that upon consultation with the Care Coordinator, the facility	A 054		

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A 054	Continued From page 3 did not document the details regarding Resident #1's missed or withheld medications in and . . . . . She stated that she did not know whether there was a delay in ordering the medications from the pharmacy or provide any other reason why Resident #1 was not provided with these medications as prescribed by the Physician. Class III	A 054		