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
	AL11965413	A. BUILDING: _____ B. WING _____	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COCONUT CREEK	4175 WEST SAMPLE ROAD COCONUT CREEK, FL 33073

(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 AMENDED REPORT An unannounced Relicensure, Complaint (#2020006021, #2021002716, and #2022011651) and Generator Monitoring survey was conducted on . . . . . at . . . . . Coconut Creek. The facility had deficiencies identified related to the Relicensure and Complaint (#2022011651) at the time of the survey.	A 000		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an . . syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and	A 052		

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A 052	Continued From page 1 helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.	A 052		

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A 052	Continued From page 2 (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's	A 052		

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A 052	Continued From page 3	A 052		

health care provider and documented in the resident's record.
(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,
2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.
(f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S.
(g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition.
(h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to properly assist 2 out of 3 residents (Residents #4 and Resident #5)

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A 052	Continued From page 4	A 052		

with self-administration of medications by not orally advising the residents of the medication names and/or dosages received; and failing to provide the medications at the prescribed times and correct dosage form.

The findings included:

Review of the facility Medication Policy under Appendix F states in part- Service Includes: Delivery of medications to residents within acceptable time parameters.

1) In an observation conducted on at 10:30 AM, Medication Technician (MT) Staff A assisted Resident #4 with the self-administration of 18 oral medications which included , , , , , , , , Radiance , , , , C, , , , , , Complete, and . Review of the pack revealed next to the prescription label, a green label documenting this medication was to be administered 'Before Meals.' In an observation conducted at this time, MT Staff A handed these medications to the resident without orally advising the resident of the medication names and dosages being provided. In an observation conducted after MT Staff A completed assisting with the self-administration of Resident #4's medications, she did not document these actions in the resident's Medication Observation Record (MOR).

Review of Resident #4's individual medication packages revealed that the resident's morning medications were each scheduled to be given from 7:30 AM to 9:00 AM. Review of the

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A 052	Continued From page 5 resident's MOR revealed that MT Staff A's initials were recorded before she assisted the resident with her morning medications on . (Photographic evidence was obtained). In an interview conducted with MT Staff A on at 10:40 AM, she stated that she was aware that she did not orally advise Resident #4 of the medication names and dosages she assisted the resident with. She stated that she documented in the resident's MOR representing that the resident received every morning medication before she performed this action with the resident. She also stated at this time, that she was aware that the morning medications she assisted Resident #4 with, were given after the prescribed time, which was up to one hour after the 7:30 AM to 9:00 AM depending on the medication. 2) In an observation conducted on at 11:15 AM, MT Staff B administered the oral medications for Resident #5 which included ER (Extended Release), and , capsule. In an observation conducted at this time, MT Staff B crushed the tablets and opened the , capsule to pour its contents into a plastic cup. In an observation conducted at this time, MT Staff B administered these medications to Resident #5 by completing the action of scooping the medication from the cup with a spoon and placing the spoon in the resident's for oral consumption. The powdered medication was not added to any medium such as apple sauce for easier consumption. It was also noted at this time that MT Staff B did not orally advise the resident of the medication names and dosages being provided. Review of	A 052		

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A 052	Continued From page 6 Resident #5's medication packs revealed the was an Extended Release form and should not be crushed as this would affect the dosing and could cause discomfort; the is normally administered before meals; and the , had a red label next to the prescription label which read 'Do Not Chew, Do Not Crush, Swallow Whole.' Despite these pharmacy prescription instructions, medications which should not have been crushed were crushed. Review of Resident #5's individual medication packages indicated that the resident's morning medications were each scheduled to be given at 9:00 AM although administered at 11:15 AM. (Photographic evidence was obtained). In an interview conducted with MT Staff B on at 11:25 AM, she stated that she was aware that she did not orally advise Resident #5 of all the medication names and dosages she administered for the resident. She stated that she was aware that the resident received medication administration and she was supposed to be assisting with self-administration of medications. She also stated at this time, that she was aware that the morning medications she administrated for Resident #5, were given after the permitted time range, which was up to one hour after 9:00 AM and this was due to the resident load she was responsible for that day. In an interview conducted with the Director of Nursing on at 12:05 PM, she stated she was not aware that MT Staff A and MT Staff B were overloaded and did not perform their medication passes within the permitted one hour period after each medication's prescribed time. She also stated that it was required for every staff	A 052		

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A 052	Continued From page 7 member to orally advise each resident with the medication names and dosages they received. The fact that medications which should not have been crushed were crushed, was not discussed at this time. Class III	A 052		
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 [illegible] 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 [illegible], the facility must, pursuant to Section	A 054		

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A 054	Continued From page 8 429.41, 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 and interview, the facility failed to properly document and update 1 out of 3 sampled residents (Resident #2) Medication Observation Record (MOR) to accurately represent the time the prescribed medication was administered to the resident. The findings included: Review of Resident #2's MOR dated from to revealed that the resident was prescribed to receive with (checks) before meals, with instructions including that if was below 90, to take juice and recheck in 15 minutes; and if was from 351 to 400 units, to administer 12 units of . Review of the MOR revealed the resident did not receive her doses on and at 12:00 PM due to an "Exception." Review of the MOR detailed page revealed that the resident's measured was 71 on at 12:14 PM with orders to recheck the resident's after eating food and to receive 4 units of . Review of this MOR did not reveal any rechecking of the resident's within 15 minutes on after 12:14 PM as ordered. Review of the MOR detailed page revealed the resident's measured was 357 on at 1:43 PM and the medication	A 054		

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A 054	Continued From page 9 was refused. Further review of this MOR documented that on at 1:43 PM, the resident received an injection on the upper left arm without further explanation of how many units of was administered. (Photographic evidence was obtained). In an interview conducted with the Director of Nursing on at 4:00 PM, she stated that she was not aware that Resident #2's MOR reflected omissions or inaccurate information relating to the resident's medication management performed by the facility nurses. She stated that the facility did not review these MORs so to identify and correct these errors. Review of the facility Medication Policy Appendix F states in part under Service Includes: Regular audits for quality assurance. Class III	A 054		