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
	AL11967286	A. BUILDING: _____ B. WING _____	R-C 05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT ST PETE	1001 9TH STREET NORTH SAINT PETERSBURG, FL 33701

(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 revisit to a complaint investigation (#2023003346) was conducted at Best Care Senior Living at St. Pete on . Deficiencies were 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 maintain accurate Medication Observation Records (MORs) for three (Resident #2, Resident #4, and Resident #5) of five sampled residents. Findings Included: In an interview with Resident #2 conducted on [redacted] at 9:32am they stated the facility had run out of their (,). In an interview with Resident #5 conducted on [redacted] at 9:37am they stated the facility had run out of their (,) for the last five days. In an interview with Resident #4 conducted on [redacted] at 11:28am they stated the facility was out of his [redacted]. A review of the MOR for Resident #2 conducted on [redacted] revealed orders for , 1mg tablet to be taken twice daily. The exceptions listed "refused" for the 8:00pm dose on [redacted]. A review of the MOR for Resident #4 conducted on [redacted] revealed orders for [redacted] 10mg tablet, take one tablet by [redacted] every 6 hours for , . The exceptions listed "refused" on [redacted]. A review of the MOR for Resident #5 conducted on [redacted] revealed orders for [redacted] 1mg tablet, give one tablet by [redacted] three times	A 054		

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A 054	Continued From page 2 daily. The exceptions listed "refused" on , , and . In an interview conducted with Staff A conducted on at 11:18am she confirmed the medications marked with exceptions of "refused" were not in the medication cart for Resident #2, Resident #4 and Resident #5. In an interview conducted with the Administrator on at 11:26am she stated that she agreed the MORS were marked incorrectly for several residents showing as "refused" when medications were not refused and instead were not available to be given. She stated "I think it is just easier for them (Medication Technicians) to put refused instead of the "other" where you enter a note." Photographic evidence obtained. Class III	A 054		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and,	A 056		

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A 056	Continued From page 3 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care	A 056		

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A 056	Continued From page 4 provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the Facility failed to ensure that prescriptions for residents who received assistance with self-administration of medication were refilled in a timely manner and failed to provide medications according to health care	A 056		

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A 056	Continued From page 5 provider's orders for five residents (Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5) of five sampled residents. Findings Included: In an interview with Resident #2 conducted on at 9:32am they stated the facility had run out of their ( ) and they had concerns about their medication. In an interview with Resident #5 conducted on at 9:37am they stated the facility had run out of their ( ) five days earlier and they did not understand why the refill was taking so long, as they had been on the medication for years. Additionally, they stated it was not the first time they had run out and it happened every time a refill was due. In an interview with Resident #1 conducted on at 9:43am they stated the facility ran out of their for and stated they can only refill them every 7 days. In an interview with Resident #4 conducted on at 11:28am they stated the facility was out of his and and that he had transportation issues for the management needed, and it got rescheduled . Additionally, he stated he was not hopeful they would provide a partial prescription to cover him until the as they promised. In an interview with Resident #3 conducted on at 9:40am they stated they were waiting on a medication that the doctor said would be ordered on Monday ( ) and	A 056		

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A 056	Continued From page 6 that there were problems with the medications at the facility. A record review of the , 2023 Medication Observation Record (MOR) for Resident #1 conducted on revealed an order for , 10/325mg, take one tablet by every 6 hours for . Times were scheduled for 12:00am, 6:00am, 12:00pm, and 6:00pm. Exceptions were noted on as "not in cart" and on as "waiting on pharmacy". A record review of the , 2023 Medication Observation Record (MOR) for Resident #2 conducted on revealed an order for , 1mg tablet twice daily for , at 8:00am and 8:00pm. Exceptions were noted on as "waiting on pharmacy". A record review of the , 2023 Medication Observation Record (MOR) for Resident #3 conducted on revealed an order for , 50mg oral tablet. Take one tablet by two times a day at 8:00am and 8:00pm. Exceptions were noted on , and as "waiting on pharmacy". A record review of the , 2023 Medication Observation Record (MOR) for Resident #4 conducted on revealed an order for , 0.5mg tablet, take one tablet by three times daily. Exceptions were noted on and as "waiting on pharmacy". Additionally, there was an order for , 10mg tablet, take one tablet by every 6 hours for . It was scheduled for 12:00am, 6:00am, 12:00pm and 6:00pm. There were exceptions noted on and	A 056		

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A 056	Continued From page 7 as "waiting on pharmacy." No doses were marked as given for , , or . A record review of the , 2023 Medication Observation Record (MOR) for Resident #5 conducted on revealed an order for , 1mg tablet, give one tablet by three times daily at 6:00am, 2:00pm and 10:00pm. Exceptions were notated on ,,2023 and as "waiting on pharmacy". No doses were marked as given on , or . An attempted facility record review for MOR exceptions for the full month of , , 2023 was requested. The date of , was provided. , 1mg for Resident #5 was marked with an exception as "not in the cart" and "none on ." An interview with Staff A conducted on at 11:18am revealed medications in question were not in the cart for Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5. Additionally, they stated that Resident #5 had been asking them for for the past two days. In a record review conducted on of the facility Medication policy on page 62 under section VIII "Medicaton Labeling and Orders" it read "The facility shall make every reasonable effort to ensure residents who receive assistance with self-administration or medication administration are refilled in a timely manner." In an interview with the Administrator conducted on at 10:15am she stated that they	A 056		

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A 056	Continued From page 8 managed the medications for Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5. Additionally, she stated that due to ordering limitations by the nurse practitioner she felt all new residents would need to be seen by the medical doctor in order to prevent continued medication refill issues. At 11:22am she revealed that the staff responsible for medication refills and running the MOR exception reports was out sick, and that she was her -up. At 11:32am she stated she had not run an exception report herself since the responsible staff had been out sick since Friday ( ). At 12:22pm she was unable to state why the orders for for Resident #2 was not at the pharmacy or why the orders for for Resident #5 were just being sent that day to the pharmacy after being out for five days. Photographic Evidence Obtained. Class III	A 056		