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
	AL11968965	A. BUILDING: _____ B. WING _____	R-C 07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT HERITAGE MANOR	1908 E 131ST AVE TAMPA, FL 33612

(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 survey (2023004153) was conducted at Best Care Senior Living Heritage Manor on . Deficiencies were found at the time of the survey.	{A 000}		
{A 052} SS=D	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 helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage.	{A 052}		

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{A 052}	Continued From page 1 (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. (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.	{A 052}		

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{A 052}	Continued From page 2 (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 [illegible] 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 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	{A 052}		

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{A 052}	Continued From page 3 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 ensure proper assistance with self-administration of medications by not providing medications within one hours after the medications were scheduled, not comparing medication labels to Medication Observation Records (MORs), and not observing residents take their medications for three	{A 052}		

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{A 052}	Continued From page 4 Residents (#1, #2, and #3) of three sampled residents. Findings Included: During a medication pass observation with Staff A (an unlicensed Medication Technician) for Resident #1, #2, and #3, conducted on [redacted] from 09:14am through 09:28am, revealed the following: *Staff A provided Resident #1 with her prescribed 08:00am medications at 09:14am which included [redacted], 81mg, [redacted], 100mg, [redacted] 60mg, [redacted], 25mg, 3.125mg, [redacted], [redacted], 100mg, [redacted], 5mg, [redacted] 1gram, 0.25mcg, [redacted], 40mg, [redacted] 1mg, [redacted] 200mcg, [redacted], 5mg, and [redacted] 90mg. *Staff A did not provide Resident #1 with her prescribed [redacted]. *Staff A provided Resident #2 with her prescribed 08:00am medications at 09:24am which included [redacted] 12.5mg, 75mg, [redacted] 40mg, [redacted], 81mg, [redacted] 20mg. *Staff A provided Resident #3 with her prescribed 08:00am medications at 09:28am which included [redacted], 90mg, [redacted], 0.125mg, [redacted] 40mg, [redacted], 2.5mg, 500mcg, [redacted], 300mg, [redacted] 20mg, [redacted] 325mg. *Staff A did not compare Residents #2 and #3's medication labels to their MORs. *Staff A did not observe Residents #2 and #3 take and swallow their medications. During an interview with Staff A, conducted on	{A 052}		

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{A 052}	Continued From page 5 . . . . . at 09:35am, Staff A stated that the Health and Wellness Director gave residents their . . . . During an observation of Resident #1, conducted on at 09:35am, Resident #1 was sitting at the dining room table eating her breakfast which included bacon, eggs, and toast. During an interview with Resident #1, conducted on . . . . . at 09:35am, Resident #1 stated that she had not received her yet. During an interview with the Health and Wellness Director, conducted on . . . . . from at 11:09am, the Health and Wellness Director state that she gave and documented Resident #1's at 09:49am. The Health and Wellness Director agreed that the time that she gave Resident #1's was well after the 08:00am due time and breakfast meal. At 11:20am, the Health and Wellness Director agreed that unlicensed Medication Technicians were supposed to compare medication labels to the MORs and observe residents take their medications. Class III	{A 052}		
{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	{A 054}		

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{A 054}	Continued From page 6 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 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 observation, record review, and interview, the facility failed to immediately update Medication Observation Records (MORs) each time medications were offered to three Residents (#1, #2, and #3) of three sampled residents. Furthermore, the facility failed to have MORs free from errors for one Resident (#3) of three sampled residents. Findings Included: During a medication pass observation with Staff A (an unlicensed Medication Technician) for Resident #1, #2, and #3, conducted on	{A 054}		

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{A 054}	Continued From page 7 from 09:14am through 09:28am, revealed Staff A did not immediately document Residents #1, #2, and #3 medications as given assisted the residents with their prescribed medications. At 09:14am, Staff A assisted Resident #1 with 81mg, 100mg, 60mg, 25mg, 3.125mg, 100mg, 5mg, 1gram, 0.25mcg, 40mg, 1mg, 200mcg, 5mg, and 90mg. At 09:24am, Staff A assisted Resident #2 with 12.5mg, 75mg, 40mg, 81mg, 20mg. At 09:28am, Staff A assisted Resident #3 with 90mg, 0.125mg, 40mg, 2.5mg, 500mcg, 300mg, 20mg, 325mg. A review of Resident #1's MORs electronic documentation timestamp, conducted on , revealed that Staff A signed all of Resident #1's 08:00am medications as given at 08:14am. A review of Resident #2's MORs electronic documentation timestamp, conducted on , revealed that Staff A signed all of Resident #2's 08:00am medications as given at 08:14am. A review of Resident #3's MORs electronic documentation timestamp, conducted on , revealed that Staff A signed all of Resident #3's medications as given at 08:18am. Resident #3's prescribed 0.125mg was ordered to take one tablet every other day and alternate with two tablets every other day. The was listed on one line and there was no	{A 054}		

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{A 054}	Continued From page 8 documentation that noted whether one or two tablets were given each day from through ..... During an interview with Staff A, conducted on at 09:25am, Staff A stated that she just gave Resident #3 one ˘ pill. Staff A was unable to explain how she determined if Resident #1 was supposed to receive one or two pills today. Staff A stated that she just gave one pill. During an interview with the Health and Wellness Director, conducted on from 11:06am through 11:11am, the Health and Wellness Director agreed that the medication documentation timestamps for Residents #1, #2, and #3's 08:00am medications were documented as given by Staff A well before the medication pass observation. The Health and Wellness Director agreed that unlicensed Medication Technicians were supposed to immediately update MORs at the time they gave the medications. The Health and Wellness Director was unable to determine if Resident #3 was due for one or two pills of the prescribed ˘ medication. The Health and Wellness Director agreed that Resident #3's prescribed ˘ should have been on two separate lines so that unlicensed Medication Technicians would know whether to give one or two pills. 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	A 056		

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A 056	Continued From page 9 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, 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	A 056		

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A 056	Continued From page 10	A 056		

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 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

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A 056	Continued From page 11 prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide prescribed medications as ordered from health care providers for two Residents (#2 and #3) of two sampled residents. Findings Included: During a medication pass observation with Staff A (an unlicensed Medication Technician) for Residents #2 and #3, conducted on [redacted] from 09:24am through 09:28am, revealed that Staff A assisted Resident #2 with the resident's prescribed medications which included 12.5mg, [redacted] 75mg, [redacted] 40mg, [redacted] 81mg, and [redacted] 20mg. Staff A did not offer Resident #2 her prescribed medication [redacted] Spray. Staff A assisted Resident #3 with the resident's prescribed medications which included [redacted] 90mg, [redacted] 0.125mg, [redacted] 40mg, [redacted] 2.5mg, [redacted] 500mcg, [redacted] 300mg, [redacted] 20mg, and [redacted] 325mg. Staff A did not offer Resident #3 her prescribed [redacted] 650mg or Trelegy [redacted] 200 62.5-25mcg Inhaler. A Medication Observation Record review for Resident #2, conducted on [redacted], revealed that Resident #2 had the prescribed medication [redacted] Suspension 50mcg/ACT one puff into each nostril twice every day and due at 08:00am. The electronic documentation timestamp noted that Staff A documented this medication as given at 08:14am well before 09:24am when Staff A assisted	A 056		

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A 056	Continued From page 12 Resident #2 with her 08:00am medications. A Medication Observation Record review for Resident #3, conducted on , revealed that Resident #3 had the prescribed medications 650mg take one twice every day and Trelegy , 200 62.5-25mcg Inhaler inhale one puff every day which were both due at 08:00am. The electronic documentation timestamp noted that Staff A documented these medications as given at 08:18am well before 09:28am when Staff A assisted Resident #3 with her 08:00am medications. During an interview with the Health and Wellness Director, conducted on at 11:11am, the Health and Wellness Director stated that all medications were supposed to be offered to residents with the medications were due. Class III	A 056		
A 058 SS=D	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant	A 058		

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BEST CARE SENIOR LIVING AT HERITAGE MANOR	1908 E 131ST AVE TAMPA, FL 33612

(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 058	Continued From page 13 shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan	A 058		

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
	AL11968965	A. BUILDING: _____ B. WING _____	R-C 07/11/2023

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A 058	Continued From page 14 updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure documented Class III deficiencies regarding medicinal drugs were corrected as required (Cross Reference: A0052 and A0054). Findings Included: Due to the uncorrected Class III deficiencies concerning the facility's medication practices, the facility shall be required to employ the consultation services of a licensed Pharmacist Consultant or a Registered Nurse Consultant. The Consultant shall at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. This written statement serves as notification of the above stated requirement. During an interview with the Health and Wellness Director, conducted on at 11:25am, the Health and Wellness Director verbalized understanding that the facility was required to employ or contract with a licensed Pharmacist Consultant or Registered Nurse Consultant due to the facility's uncorrected medication Class III deficiency.	A 058		

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
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A 058	Continued From page 15 Class III	A 058		