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
	AL11966084	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TITUSVILLE TOWERS	405 INDIAN RIVER AVENUE TITUSVILLE, FL 32796

(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
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	CZ821		

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CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821		

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CZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to electronically submit to the agency, a preliminary report within 1 business day of 1 of 7 sampled resident going to a hospital after receiving the wrong medications (#12). Findings: Review of resident #12's and 1823 health assessment forms revealed he required assistance with medications. His medical history included and . He was "alert and oriented x3". A medication error report indicated a medication tech gave him the wrong medications, which were , (used for 's and Restless), (,), (high ,) and (high ,). A 7:40 pm facility note indicated he confirmed the wrong room number and took medications for (resident #13's medications). He called 911 himself and was taken to a hospital.	CZ821		

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CZ821	Continued From page 4 A . . . . . hospital history and physical indicated he was seen after being administered another patient's medications. During an interview on at 4:51 pm, med tech H said when she gave resident #12 the wrong medications, she verified his first name and if his room number was 803 to which the resident responded "yes". The resident who lived in {resident #13} had the same first name as resident #12. The med tech said she did not ask the resident to verify his last name. She said the resident called 911 himself within . . minutes of receiving the medications. She said that prior to him going to the hospital she did not see any negative effects of him taking the medications. She said following the incident, nurse C told her that she needed to properly identify each resident by also using their last name and to not just believe what the resident said. The med tech said she thought she said the name of only one of the medications aloud. On at 5 pm, the facility manager said the facility did not have a policy pertaining to medication errors. During an interview on at 5:52 pm, resident #12 said his certified nursing assistant (CNA) at the time gave him his medications then a second CNA handed him a cup of pills and he took those too. He said the second CNA did not say anything before handing him the cup. He asked her why she gave him more when he'd already been given pills, she mumbled something then said she made a mistake. He said the facility's staff did not want to send him to the hospital, so he called 911 himself. He said he was at the hospital for about 24 hours. He said police came to the hospital and made a report. He said	CZ821		

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CZ821	Continued From page 5 he did not suffer any ill effects. Review of resident #12's medication record revealed he was also given his own medications on [redacted], which were Methadone (, relief), -plus (,), ( ), ( ), and ( ). During an interview on at 6:15 pm, the facility's manager said a preliminary report was not submitted to the agency. Unclassified	CZ821		
A 000	Initial Comments A complaint investigation #2022017274 was conducted at Titusville Towers on . The facility had deficiencies at the time of the survey.	A 000		
A 052 SS=G	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	A 052		

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A 052	Continued From page 6 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. (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	A 052		

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A 052	Continued From page 7 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. (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	A 052		

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A 052	Continued From page 8 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 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	A 052		

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A 052	Continued From page 9 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 record reviews and interviews, the facility failed to ensure unlicensed staff who assisted with medications followed the correct procedures on identifying the correct resident and saying the name and dose of the medications aloud for 2 of 7 sampled residents who were given the wrong medications (#11 and #12). Findings: Review of resident #12's and 1823 health assessment forms revealed he required assistance with medications. His medical history included and . He was "alert and oriented x3". A medication error report indicated a medication tech gave him the wrong medications, which were , (used for 's and Restless), ( ), (high) and , (high). A 7:40 pm facility note indicated the resident confirmed the wrong room number and took medications for (resident #13's medications). He called 911 himself and was taken to a hospital. A hospital history and physical indicated	A 052		

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A 052	Continued From page 10 he was seen after being administered another patient's medications. During an interview on at 4:51 pm, med tech H said when she gave resident #12 the wrong medications, she verified his first name only and asked the resident if his room number was 803, to which the resident responded "yes". The resident who lived in (resident #13) had the same first name as resident #12. She said the resident called 911 himself within minutes of receiving the medications. She said that prior to him going to the hospital she did not see any negative effects of him taking the medications. She said following the incident, nurse C told her that she needed to properly identify each resident by also using their last name and to not just believe what the resident said. The med tech said she thought she said the name of only one of the medications aloud when giving them. On at 5 pm, the facility manager said the facility did not have a policy pertaining to medication errors. During an interview on at 5:52 pm, resident #12 said his certified nursing assistant (CNA) at the time gave him his medications then a second CNA handed him a cup of pills and he took those too. He said the second CNA did not say anything before handing him the cup. He asked her why she gave him more when he'd already been given pills and she mumbled something then said she made a mistake. He said the facility's staff did not want to send him to the hospital, so he called 911 himself. He said he was at the hospital for about 24 hours. He said police came to the hospital and made a report. He said he did not suffer any ill effects.	A 052		

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A 052	Continued From page 11 Review of resident #12's medication record revealed he was also given his own medications on , which were Methadone (relief), -plus ( ), ( ), ( ), and ( ). Review of med tech H's personnel record revealed a 6-hour certificate of training on providing assistance with self-administered medications. 2. In review of facility notes on at 15:02 read, "Med tech I reported that she had given this resident #11 the wrong medication during her 1400 medication pass. When med tech I was doing her medication pass, resident #11 requested to be sent out 911 for right lower , that radiates to front of abdomen. was made aware of incident as well so resident could be monitored in the ER for any adverse effects". On at 3:26pm The ALF Manager stated she was unaware that staff was borrowing meds from one resident to give to another but was aware in the past that there had been med pass errors when wrong meds were given. On at 5:04pm Med Tech I stated, "No, I really don't recall who they belong too. I probably said here's your 2:00 and did not state the name and dose. I just take the meds in a cup and gave to resident #11. I have 3 -4 people on that floor that takes Oxy and ". On at 5:20pm Nurse C stated, I cannot recall if I was told who the medication	A 052		

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A 052	Continued From page 12 belonged too. I'm sure I asked who it was I just didn't write it down. On at 5:29pm Med Tech I stated, "if it's the one I'm thinking of, because I didn't fill out the report. I believe it was Resident #14. The room numbers are so close, 807 and 809. I think Resident #14 was 809 and Resident #11 in 807, or maybe the other way". "I called downstairs to tell nurse C and then I got resident #11 the right pills". "I was told by nurse C she already filled out the report and I need to sign". On at 5:31pm Med Tech I stated resident #11 was sent out for getting the wrong meds. She stated there was no training and just told to watch what you're doing and pay more attention. On at 6:05pm Resident #11 stated I do not recall being told I received the wrong medication by Med Tech I. This is the first I'm hearing about it. Resident 11 stated, I requested to go to the hospital due to the , that I was having. The hospital did not mention anything about the wrong meds. Class II	A 052		