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
	AL11922285	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SODALIS OF LARGO	333 16TH AVENUE SOUTHEAST LARGO, FL 33771

(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 complaint investigation (complaint number: 2023006581) and a complaint investigation (complaint numbers: 2023009948 and 2023011224) were conducted at Sodalis of Largo on . Deficiencies were identified at the time of 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	{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 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 a medication was offered to four Residents (#1, #2, #10, and #11) of four sampled residents. Findings Included: A [illegible] MORs review for Resident #1, conducted on , revealed that Resident #1's MORs had prescribed medications that were not documented as given on at 08:00am to the resident which included 20 milligram (mg), , 5mg, and [illegible] 25mg. A [illegible] MORs review for Resident #2, conducted on , revealed that Resident #2's MORs had prescribed medications that were not documented as given to the resident which included [illegible] 10mg, [illegible] 60mg, and , 25mg on , [illegible], and at 08:00pm and , 2.5mg and [illegible] 10 milliequivalent on , , and [illegible] at 05:00pm. A [illegible] MORs review for Resident #10, conducted on , revealed that Resident #10's MORs had prescribed medications that were not documented as given to the resident which included [illegible] 2mg , 100mg on and [illegible] at 05:00pm and [illegible] 3mg from through at bedtime.	{A 054}		

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{A 054}	Continued From page 2 A , MORs review for Resident #11, conducted on , revealed that Resident #11's MORs had prescribed medications that were not documented as given to the resident on at 08:00am which included Acidophilus Probiotic, , 81mg, and 10mg. During an interview with the Administrator, conducted on at 02:45pm, the Administrator agreed that Resident #1, #2, #10, and # , MORs had medications that were not documented as given to the residents. Class III	{A 054}		
{A 055} SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request;	{A 055}		

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{A 055}	Continued From page 3 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If	{A 055}		

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{A 055}	Continued From page 4 centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to store discontinued medications separately from medications that were in current use for one Resident (#7) of one sampled resident. Findings Included: During an observation of the medication cart with Staff M, conducted on ..... at 11:15am, Resident #7 had two medications which	{A 055}		

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{A 055}	Continued From page 5 included 500mg and 100mg. There were thirteen pills in the pill pack. There were seventeen pills in the pill pack. Both medications appeared in current use. During an interview with Staff M, conducted on at 11:15am, Staff M stated that she thought that the medication for Resident #7 was discontinued. A record review for Resident #7, conducted on , revealed that Resident #7's order for was discontinued on due to Resident #7 had to this medication. During an interview with the Administrator, conducted on at 02:45pm, the Administrator agreed that discontinued medications were to be stored separately from medication that were in current use. Class III	{A 055}		
{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 6 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 7 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 review, and interview, the facility failed to provide prescribed medications as ordered for two Residents (#7 and #8) of six sampled residents. Additionally, the facility failed to ensure that prescribed medications were filled or refilled in a timely	{A 056}		

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{A 056}	Continued From page 8 manner and failed to notify residents' primary care providers (PCP) that the residents were not taking their medications as prescribed for two Residents (#2 and #11) of six sampled residents. Furthermore, the facility failed to obtain the circumstances under which it would be appropriate for residents to request as needed medications for three Residents (#8, #10, and #11) of six sampled residents. Findings Included: A medication observation records (MORs) review for Resident #2, conducted on , revealed that Resident #2's MORs had prescribed medication documented as not given to the resident due to the medications were not in the medication cart or awaiting delivery which included 10 milligram (mg) on , , and at 08:00pm and 300mg on and at 08:00am. Resident #2's prescribed medication 0.5mg/2ml suspension via and 160-4.5 inhaler were documented as not given to Resident #2 on and at 05:00pm due to the resident self-administered this medication. Resident #2's prescribed medication , , / 0.5-3mg (2.5) mg/3ml via was documented as not given to Resident #2 on , , , and at 05:00pm and 09:00pm and and at 05:00pm due to the resident self-administered this medications and documented as not given to the resident on and at 09:00pm due to the medication was not in the medication cart.	{A 056}		

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{A 056}	Continued From page 9 A record review for Resident #2, conducted on , revealed that Resident #2 required assistance with self-administration of medications according to Resident #2's health assessment form dated . There were no orders that the resident was able to self-administer medications. There was no evidence that Resident #2's PCP was notified that the resident was not taking medications as prescribed. A MORs review for Resident #7, conducted on , revealed that Resident #7 was prescribed the 100mg to take twice every day for ten days. There were four doses documented as given on at 08:00pm, at 08:00am and 08:00pm, and at 08:00am. A MORs review for Resident #8, conducted on , revealed that Resident #8 was prescribed the 500mg to take every twelve hours for seven days. There were two doses documented as given on at 08:00pm and at 08:00am. Resident #8 had the prescribed medication , , 0.06% spray ordered as needed. There were no circumstances noted under which it would be appropriate for Resident #8 to request this medication. During an observation of Residents #7 and #8's medications with Staff M, conducted on at 11:15am, revealed that Resident #7's pill pack had seventeen of twenty pills dispensed remaining in the pill pack. Resident #8's pill pack had thirteen of fourteen pills dispensed remaining in the pill pack. A MORs review for Resident #10, conducted on	{A 056}		

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{A 056}	Continued From page 10 , revealed that Resident #10's MORs had the prescribed medication , 0.5mg ordered as needed. There were no circumstances noted under which it would be appropriate for Resident #10 to request this medication. A MORs review for Resident #11, conducted on , revealed that Resident #11's MORs had prescribed medications documented as not given to the resident due to the medications were not in the medication cart which included 325mg from through and 125 micrograms (mcg) from through . Resident #11 prescribed medication plus ( ) ordered as needed. There were no circumstances noted under which it would be appropriate for Resident #11 to request this medication. A record review for Resident #11, conducted on , revealed that Resident #11's observation notes noted that the facility notified Resident #11's Pharmacy of the medications that were not available to give the resident on at 11:13am during the survey. There was no evidence that the facility notified Resident #11's PCP of not receiving medications as prescribed. There was no evidence found that the facility attempted to obtain Resident #11's 325mg and 125 mcg prior to . During interview with the Health and Wellness Director, conducted on at 11:05am, the Health and Wellness Director stated that there were a lot of residents with medications in their rooms with no order to self-administer the	{A 056}		

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{A 056}	Continued From page 11 medications. During an interview with the Administrator, conducted on at 02:45pm, the Administrator agreed that Residents #7 and #8 did not receive their prescribed as prescribed and that both residents missed one dose of their medications. The Administrator agreed that Residents #2 and #11 had medications that were documented as not given. The Administrator was unable to provide evidence that Residents #2 and #11 PCPs were notified that the residents were not receiving their medications as prescribed. The Administrator agreed that Residents #8, #10, and #11 prescribed as needed medications did not have the circumstances under which it would be appropriate for residents to request the as needed medications. 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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A 058	Continued From page 12 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		

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A 058	Continued From page 13 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 observation, record review, and interview, the facility failed to ensure all medications concerns were corrected (Cross Reference: A0054, A0055, and A0056). 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 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 Administrator, conducted on at 03:00pm, the Administrator 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922285	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

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A 058	Continued From page 14 Class III	A 058		
{A 160} SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [illegible]; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of [illegible]. (c) A log listing the names of all temporary emergency placement and respite care residents	{A 160}		

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{A 160}	Continued From page 15 if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years.	{A 160}		

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{A 160}	Continued From page 16 (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an up-to-date admission and discharge log that included the dates of discharge, reasons for discharge, and places discharged to, for four former Residents (#3, #4, #5, and #6) of four sampled former residents. Findings Included: A review of the facility's list of residents, conducted on , revealed that Residents #3, #4, #5, and #6 were not listed as current in-house residents. The list of residents noted that there were 67 residents that resided in	{A 160}		

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{A 160}	Continued From page 17 the facility. A review of the admission and discharged log, conducted on , revealed that Residents #3, #4, #5, and #6 had no discharge data and appeared to be current in-house residents. The admission and discharge log did not include Residents #3, #4, #5, and #6's dates of discharge, reasons for discharge, or the places that they were discharged to. Resident #3 was admitted on . Resident #4 was admitted on . Resident #5 was admitted on . Resident #6 was admitted on . During an interview with the Administrator, conducted on at 10:07AM, the Administrator stated that he understood what was required and that it would need to be corrected. Class III	{A 160}		