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
	AL11966134	A. BUILDING: _____ B. WING _____	C 12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN CARE CENTER, AL	6 RESTON PLACE PALM COAST, FL 32164

(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 An abbreviated relicensure survey was conducted at Good Samaritan Care Center on [redacted]. Deficient practice was identified at the time of the visit.	A 000		
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, 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	A 056		

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A 056	Continued From page 1 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 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:	A 056		

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A 056	Continued From page 2 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 observations, record reviews, and interviews, the facility failed to ensure changes to resident medications were properly recorded in the resident's medication observation record (MOR) and accompanied by a medication order from the resident's health care provider, for 1 of 5 residents of the facility. The findings include: An observation of Resident 4 was conducted in her bedroom on at 2:00 pm when she was assisted with self-administration of medications by the Administrator. She reviewed the MOR, sanitized her and dispensed one tablet (an opiod , medication) from a pharmacy-issued pill bottle into the small metal cup. She handed the cup to Resident 4 with the glass of water. After Resident 4 took the pill, the Administrator repeated this process with one , tablet (an , medication) and then again with one ( ) tablet (an ,). Review of the label on the prescription	A 056		

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A 056	Continued From page 3 bottle found it instructed to give one 50 milligram (mg) tablet in the morning, one at noon (12:00 pm) and one before bed. The label directed to take one 0.5 mg tablet twice a day, as needed. The label said take 100 mg once a day. Photographic evidence was obtained. In contrast, a review of the MOR found entries for the to be given at 6:00 am, one at 2:00 pm, and one at 10:00 pm. There was only one entry for , to be given at 3:00 pm. was scheduled at a dose of 50 mg, instead of 100 mg, daily. Photographic evidence was obtained. An interview was conducted with the Administrator at this time and she was asked about the discrepancies between the prescription labels and the MORs. She was also asked for the physician's orders for each medication for clarification. The Administrator explained Resident 4's doctor wanted her to be taken every 8 hours, so the time for the 12:00 pm/noon dose was changed to 2:00 pm. The , was changed from twice a day as needed to once a day, routinely. Finally, the Administrator explained the dose was wrong on the MOR; it was supposed to be 100 mg instead of 50. She took her pen and corrected the MOR by crossing out the "50 mg" and changing it to "100 mg". A review of Resident 4's records was conducted with the Administrator, in search of the corresponding physician's orders for the aforementioned medications. The Administrator was unable to match up the medication orders with the corresponding physician notes. A telephone call was placed to the pharmacy on	A 056		

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A 056	Continued From page 4 .. at 2:18 pm. The Pharmacy Assistant pulled up Resident 4's physician's order for .., which she said was received electronically from the doctor on . Instructions were to take one tablet in the morning, one at noon and one at bedtime. The physician's order for Resident 4's .., was electronically received on and instructs to take 0.5 mg twice a day, not once a day. A second pharmacy was called on .. at 2:25 pm, since Resident 4's is dispensed from a different location. The Pharmacy Assistant pulled up Resident 4's .. order and said it was last refilled on . The order was to give 100 mg once a day, not 50 mg like the bottle instructed. The Administrator acknowledged at this time that Resident 4's labels, physician's orders and MOR did not match. She acknowledged the discrepancies, saying she needed to call the doctor for clarification of the administration times and intended dosing schedule for , . Class III	A 056		