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 09/14/2023

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

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{A 000}	Initial Comments A second revisit to complaint investigation (complaint number: 2023006581), a revisit to complaint investigation (complaint number: 2023009948), and a complaint investigation (complaint numbers: 2023012585 and 2023013082) were conducted at Sodalis of Largo on . Deficiencies were identified at the time of survey.	{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	{A 056}		

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{A 056}	Continued From page 1 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 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	{A 056}		

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{A 056}	Continued From page 2 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 record review and interview, the facility failed to obtain instructions for use for as needed medications. Additionally, the facility failed to ensure that medications were filled or re-filled in a timely manner and failed to notify health care providers that residents did not receive medications as prescribed for seven Residents (#1, #2, #3, #4, #13, #14, and #15) of seven sampled resident that required assistance with self-administration of medications. Furthermore, the facility failed to provide assistance with self-administration of medications for one Resident (#15) of one sampled residents that required assistance with self-administration of medications. Findings Included: During an interview with Resident #1, conducted on _____ at 09:28am, Resident #1 stated that there were pharmacy issues and did not	{A 056}		

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{A 056}	Continued From page 3 receive her medications as prescribed because the facility was out of her medications. A Medication Observation Record (MORs) review for Resident #1, conducted on revealed that Resident #1 had prescribed medications that were documented as not given to the resident due to reasons such as not in chart, on order, re-order, awaiting cycle, on re-order, awaiting medication, not in cart, need refill, or medication on order which included 50mcg from through at 06:00am, 5% patch on and at 08:00am, 7.5mg from through at 12:00am, 4mg on , and at 12:00am, and Trelegy 200-62. Inhaler on at 08:00am. A MORs review for Resident #2, conducted on revealed that Resident #2 had prescribed medications that were documented as not given to the resident due to reasons such as awaiting cycle, on order, not in chart, on re-order, awaiting medication, or re-order which included 81mg from through at 08:00am, 10mg on at 08:00am, 20mg from through and through at 08:00am, and 125mg on , and through at 07:00am. Resident #2's prescribed as needed medication plus there was no reason noted in which to give the medication. A record review for Resident #2, conducted on	{A 056}		

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{A 056}	Continued From page 4	{A 056}		

, revealed that Resident #2 required assistance with self-administration according to Resident #2's health assessment form dated . There was no evidence that Resident #2's primary care provider or responsible party were notified that the resident did not receive the medications as prescribed.

A MORs review for Resident #3, conducted on revealed that Resident #3 had prescribed medications that were documented as not given to the resident due to reasons such as re-order, on order, needs script, awaiting cycle, not in cart, needs re-fill which included , 10mg on at 08:00am, , 2mg on at 08:00am, , 0.5mg on at 08:00pm, , 10mg take one tablet every day - documented as not given on at 08:00am, Prop 50mcg on , from through , and at 08:00am, 100mcg on at 08:00am, and 3mg from - and through at 08:00pm. Resident #3's prescribed as needed medication , 0.5mg there was no reason noted in which to give the medication.

A record review for Resident #3, conducted on , revealed that Resident #3 required assistance with self-administration according to Resident #15's health assessment form. There was no evidence that Resident #15's primary care provider or responsible party were notified that the resident did not receive the medications as prescribed.

A MORs review for Resident #4, conducted on

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{A 056}	Continued From page 5 revealed that Resident #4 had prescribed medications that were documented as not given to the resident due to reasons such as not in chart, refused, spit out, not in cart, or on order which included , , 2.5mg on at 08:00am, , 125mg on at 04:00pm, , 5mg on at 08:00am, - , 7.5-325mg on at 04:00pm, 1mg on , and at 08:00pm, and 50mg on , at 08:00pm. Resident #4's , 500mg was documented as not given on at 08:00pm. Resident #4's was ordered to be given for seven days. Resident #4's , was scheduled for six days at 08:00am and the resident had missed two doses of the medication. A record review for Resident #4, conducted on , revealed that Resident #4 required assistance with self-administration according to Resident #4's health assessment form dated . There was no evidence that Resident #4's primary care provider or responsible party were notified that the resident did not receive the medications as prescribed. A MORs review for Resident #13, conducted on revealed that Resident #13 had prescribed medications that were documented as not given to the resident due to reasons such as on order, refused, not charted, on order, or not in cart which included 40mg on at 08:00am, 3mg on , and at 08:00pm, , 25mg on at 08:00am, Poly-Iron 150mg on at 08:00am,	{A 056}		

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{A 056}	Continued From page 6 20 milliequivalent on 08:00am, and 0.1% , Cream from through at 08:00pm. A record review for Resident #13 conducted on , revealed that Resident #13 required assistance with self-administration according to Resident #13's health assessment form dated . There was no evidence that Resident #13's primary care provider or responsible party were notified that the resident did not receive the medications as prescribed. A MORs review for Resident #14, conducted on revealed that Resident #14 had prescribed medications that were documented as not given to the resident due to reasons such as on order, not in cart, awaiting medication, or need script which included , 75mcg on at 06:00am, Hippurate 1 Gram on and at 08:00pm, and Extended Release 600mg from through at 08:00pm, , , , and at 08:00am. A record review for Resident #14, conducted on , revealed that Resident #14 required assistance with self-administration according to Resident #14's health assessment form dated . There was no evidence that Resident #14's primary care provider or responsible party were notified that the resident did not receive the medications as prescribed. A MORs review for Resident #15, conducted on revealed that Resident #15 had medications that were documented as not given to the resident due to reasons such as not unavailable, refused, not in the cart, or that the	{A 056}		

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{A 056}	Continued From page 7 resident self-administered the medications which included 10mg on and at 05:00pm, 0.5mg/2ml treatment from through at 05:00pm, - 160-4.5 Inhaler through and through at 05:00pm, , 40mg on at 06:00am, 10 milliequivalent on at 05:00pm, at 08:00am and 05:00pm, at 05:00pm, and at 08:00am. Resident #15 had two as needed medications and there was no reason noted in which to give the medications which included , , - 0.5-e (2.5)mg/3ml treatment and 3mg. A record review for Resident #15, conducted on , revealed that Resident #15 required assistance with self-administration according to Resident #15's health assessment form dated . There was no order that Resident #15 was able to administer her own medications. There was no evidence that Resident #15's primary care provider or responsible party were notified that the resident did not receive the medications as prescribed. During an interview with the Health and Wellness Director, conducted on from 02:25pm through 02:42pm, the Health and Wellness Director agreed that according to Residents #1, #2, #3, #4, #13, #14, and #15's MORs, the residents did not receive their medications as prescribed by their primary care providers. The Health and Wellness Director stated that the facility was attempting to change to a different pharmacy due to the ongoing issues with medication fills and re-fill orders. The Health and Wellness Director agreed that the facility had	{A 056}		

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{A 056}	Continued From page 8 ongoing medication issues. 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 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,	{A 056}		

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{A 058}	Continued From page 9 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 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: A0056). Findings Included: Due to the uncorrected Class III deficiencies	{A 058}		

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{A 058}	Continued From page 10 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 Administrator, conducted on [redacted] 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 deficiencies. 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 160}		

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{A 160}	Continued From page 11 (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 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 [illegible], a copy of all such facility	{A 160}		

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{A 160}	Continued From page 12 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. (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	{A 160}		

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{A 160}	Continued From page 13 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 (#6, #7, #8, and #9) of four sampled former residents. Findings Included: A review of the facility's list of residents, conducted on [redacted], revealed that Residents #6, #7, #8, and #9 were not listed as current in-house residents. The list of residents noted that there were 59 residents that resided in the facility. A review of the admission and discharged log, conducted on [redacted], revealed that the admission and discharge log was an electronic record that was printed out and did not meet the requirements by having Residents #6, #7, #8, and #9 discharge data. The admission and discharge log did not include Residents #6, #7, #8 and #9's dates of discharge, reasons for discharge, or the places that they were discharged to. Resident #6 was admitted on [redacted]. Resident #7 was admitted on [redacted]. Resident #8 was admitted on [redacted]. Resident #9 was admitted on [redacted]. During an interview with the Health and Wellness Director, conducted on [redacted] at 9:56AM,	{A 160}		

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 09/14/2023

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

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{A 160}	Continued From page 14 the Health and Wellness Director stated that they no longer used the previous admission and discharge log and were told to use the electronic report instead. (Photographic evidence Obtained) Class III	{A 160}		