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 11/09/2023

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: 2023013082), a second revisit to complaint investigation (complaint number: 2023009948), and a third revisit to complaint investigation (complaint number: 2023006581) were conducted at Sodalis of Largo on . Deficiencies were identified at the time of 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 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	{A 052}		

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

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{A 052}	Continued From page 2 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 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	{A 052}		

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{A 052}	Continued From page 3 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 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 maintain control standards during the medication pass. Furthermore, the facility failed to ensure proper	{A 052}		

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{A 052}	Continued From page 4 assistance with self-administration of medications by not comparing medication labels to medication observation records and not advising resident the names and doses of their medications for two Residents (#3 and #6) and placed one Resident (#6) at risk for harm or injury from a medication error. Findings Included: During an observation of the medication pass with Staff D (an unlicensed Medication Technician) for Resident #6, conducted on at 09:20am, Staff D did not advise Resident #6 of the names and doses of the medications. Staff D assisted Resident #6 with the prescribed medications , 81mg, 0.25mcg, Bicarb 650mg, C 500mg, , 50mg, 5mg, 5mg, 100mg, 500mg with D 200units, and 1gram. During an observation of the medication pass with Staff D (an unlicensed Medication Technician) for Resident #3, conducted on at 09:24am, Staff D pulled all pill packs for Resident #3 from the medication cart and entered the resident's room with the pill packs, computer, and book. Staff D placed the pill packs, computer, and book on the resident's cluttered dining table and did not provide a barrier. Staff D did not compare the medication labels with the medication observation records. Staff D popped pills from each of the pill packs into a plastic medication cup and handed the plastic pill cup with the medications to Resident #3. Staff D documented the medications as given in the computer. Staff D attempted to state the names of three of the	{A 052}		

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{A 052}	Continued From page 5 medications from memory which included " , meman, and serline" but did not advise Resident #3 of the names and doses of all the medications. Upon return to the medication cart, the pill packs were reviewed and included Ginko 30mg, 10mg, 25mg, 5000mcg, Tab-A-Vite, , 0.5mg, and , 137mcg. Staff D did not sanitize the pill packs or the book before placing them inside of the medication cart. Staff D did not sanitize the computer before placing it on top of the medication cart. A review of Resident #3's medication observation records, conducted on , revealed that the resident's prescribed medication , 137mcg was documented as given at 06:00am. During an interview with the Administrator and Staff D, conducted on at 12:15pm, Staff D denied punching a , tablet from Resident #3's pill pack and giving it to the resident. The Administrator agreed that Staff D should have carried only the medications that were due at the time into the resident's room after comparing the medication labels to the medication observation records. During an interview with the Administrator, conducted on at 12:35pm, the Administrator stated that Resident #3's primary care provider ordered laboratory work to be obtained. A review of the laboratory work dated at 12:29pm for Resident #3, conducted on , revealed that Resident #3's primary care provider ordered a , -stimulating hormone level, a	{A 052}		

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{A 052}	Continued From page 6 triiodothyronine level ( ), thyroxine level ( ), a , ( ), and a comprehensive panel (CMP) related to a medication error (photographic evidence obtained). During an interview with the Administrator and Health and Wellness Director, conducted on at 02:00pm, the Administrator and Health and Wellness Director agreed that there were ongoing medication issues. The Administrator agreed to provide Resident #3's laboratory work report. As of , Resident #3's laboratory work report was not provided. Class II	{A 052}		