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 third revisit to complaint investigation (complaint number: 2023006581), a revisit to complaint investigation (complaint number: 2023013082), and a second revisit to complaint investigation (complaint number: 2023009948) 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 [illegible] 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	A 054		

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A 054	Continued From page 1 , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing 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 update medication observation records (MORs) and count sheets immediately each time medications were offered or given to three Resident (#5, #8, and #11) of nine sampled residents. Furthermore, the facility failed to maintain MORs with medication directions of use for each medication for two Residents (#5 and #8) of nine sampled resident. Findings Included: A MORs review for Resident #5, conducted on , revealed that Resident #5's prescribed was not documented as applied from through at 08:00am. There was no specific location noted of where to apply the . Resident #5's prescribed 25mg as needed had no reason noted to give the medication. Resident #5's prescribed - 5-325mg count sheet was off by one pill. There were thirty-nine pills in the pill pack and the count sheet noted that there were forty pills left in the pill pack. A MORs review for Resident #8, conducted on , revealed that Resident #8's prescribed Nystop 100,000 unit/gram powder was not documented as applied from through at 05:00pm. The Nystop noted to apply on affected area. There was no specific location identified of where to	A 054		

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A 054	Continued From page 2 apply the Nystop powder. Resident #8's prescribed 3mg and , 325mg were ordered as needed. There were no reasons noted of when to give the medications. A MORs review for Resident #11, conducted on , revealed that Resident #11's prescribed , 1000mcg/ml injection was not documented as given to the resident on at 08:00am. During an interview with the Administrator, conducted on at 12:15pm, the Administrator stated that unlicensed Medication Technicians were supposed to compare medication labels to residents' MORs and that the medication labels were supposed to match the MORs. 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 issues with medication documentation. The Administrator and Health and Wellness Director agreed that Resident #5's prescribed , was not documented as applied as prescribed and the MORs did not note the location of where to apply the . The Administrator and Health and Wellness Director agreed that Resident #5's prescribed , " count was off by one tablet. The Administrator and Health and Wellness Director agreed that Resident #8's prescribed Nystop was not documented as applied as prescribed and did not note the location of where to apply the powder. The Administrator and Health and Wellness Director agreed that Resident #8's MORs did not noted the reason to give the	A 054		

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A 054	Continued From page 3 resident's as needed medication . . . . and , . The Administrator and Health and Wellness Director agreed that Resident #11's prescribed , was not documented as given. (Photographic evidence obtained) 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; 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	A 055		

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A 055	Continued From page 4 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 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	A 055		

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A 055	Continued From page 5 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 and record review, the facility failed to store discontinued medication separately from medication that were in current use for one Resident (#9) of on sampled resident. Findings Included: A review of the Registered Nurse's visit report dated . . . . . , conducted on , revealed that the Registered Nurse's visit report noted that there were discontinued refrigerated medications stored in the Memory Care unit's medication refrigerator with medications that were in current use. A medication review for Resident #9, conducted on at 10:30am, revealed that	A 055		

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A 055	Continued From page 6 Resident #9's discontinued [redacted] 325mg continued to be stored in the medication cart with medication that were in current use for Resident #9. The order for the [redacted], medication noted [redacted], 325mg take two tablets every six hours for seven days. The [redacted] was filled on [redacted] and there were fifty-six pills that were in two pill packs. A review of Resident #9's medication orders for [redacted] and [redacted], conducted on [redacted], revealed that there were no orders for [redacted], for [redacted] and [redacted]. During an interview with Staff E (Memory Care Coordinator), conducted on [redacted] at 10:30am, Staff E agreed that Resident #9's [redacted] was for seven days only and that the medication was filled on [redacted]. During an interview with the Administrator and Health and Wellness Director, conducted on [redacted] at 02:00pm, both agreed that discontinued medications were supposed to be stored separately from medications in current use. (Photographic evidence obtained) Class III	A 055		
{A 056} SS=G	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	{A 056}		

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{A 056}	Continued From page 7 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 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	{A 056}		

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{A 056}	Continued From page 8 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: 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.	{A 056}		

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{A 056}	Continued From page 9 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain directions of use on medication labels for four Residents (#5 and #8). Also, the facility failed to notify primary care providers and responsible parties when residents did not take their medications as prescribed for ten Residents (#5, #6, #8, #9, #10, #11, #14, #15, and #16). Additionally, the facility failed to provide medications within the standard timeframe of one hour before and one hour after the medications were scheduled for two Residents (#3 and #6). Furthermore, the facility failed to provide medications as prescribed and failed to fill or refill prescriptions in a timely manner for nine Residents (#6, #8, #9, #10, #11, #12, #14, #15, and #16) of eleven sampled residents which placed all eleven residents at risk for worsening of acute and . . . . signs and symptoms, more difficulty of treating acute and symptoms, increase in health exacerbations, and an increase in hospitalizations and health care costs. Findings Included: During an observation of the medication pass with Staff D (an unlicensed Medication Technician) for Resident #6, conducted on11/09/2023 at 09:20am, 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. At 09:24am, Staff D assisted Resident #3 with the prescribed medications included Ginko . . 30mg, 10mg, . 25mg,	{A 056}		

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{A 056}	Continued From page 10 5000mcg, Tab-A-Vite, , 0.5mg, and 137mcg. A review of MORs for Resident #3, conducted on , revealed that the resident's prescribed medications Ginko 30mg, 10mg, 25mg, 5000mcg, Tab-A-Vite, and , 0.5mg were due to be given at 08:00am and 137mcg was due at 06:00am. A medication review for Resident #5, conducted on , revealed that the medication label for Resident #5's , , did not note a location to apply the cream. The medication label for Resident #5's as needed , , 25mg did not note the reason to give the medication. A review of MORs for Resident #6, conducted on , revealed that the resident's prescribed medications , 81mg, 0.25mcg, Bicarb 650mg, C 500mg, , 50mg, 5mg, 5mg, 100mg, 500mg with D 200units, and 1gram were due to be given at 08:00am. Resident #6's prescribed -Vilanterol 200-25mg inhaler was documented as not given on and at 08:00am and 1% , cream on , , , and at 08:00am and 05:00pm, on , , and at 05:00pm, and on at 08:00am due to refused, not in cart, medication on order, resident refuses, and on order. A review of MORs for Resident #8, conducted on , revealed that Resident #8 had	{A 056}		

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{A 056}	Continued From page 11 prescribed medications that were documented as not give to the resident which included 500mcg from . . . . . through at 08:00am, on at 08:00am, from . . . . . through . . . . . at 08:00am, from through at 08:00am, on . . . . . at 08:00am, on at 08:00am, and from through . . . . . at 08:00am and Nystop 100,000 unit/gram , powder from . . . . . through . . . . . at 05:00pm due to on order, "?", order, discontinued, medication on order, not in cart, and refused. A medication review for Resident #8, conducted on , revealed that the Nystop medication label did not note where to apply the , powder. Resident #8's prescribed . . . . 3mg and . . . . , . . 325mg as needed medication labels did not note the reason to give the medications. A MORs review for Resident #9, conducted on , revealed that Resident #9 had prescribed medciations that were documented as not given to the resident which included Trelegy 100-62.5-25mg inhaler from . . . . . through . . at 08:00pm, from . . . . . through . . . . . at 08:00pm, and from . . . . . through at 08:00pm due to the medication was "on order, not in cart, ordered, and not in cart - discontinued?". A MORs review for Resident #10, conducted on . . . . . , revealed that Resident #10 had prescribed medications that were documented as not given to the resident which included 300mg on at 08:00am and 05:00pm, on . . . . . at 08:00am, and on at 05:00pm and , , -	{A 056}		

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{A 056}	Continued From page 12 0.. (2.5)mg/ml ... on ..., , and at 08:00am and 12:00pm, on ... and ... at 12:00pm, on at 08:00am, 12:00pm, and 05:00pm, and on at 05:00pm due to the medication was on order, refused, and not in cart. Resident #10's prescribed .. 875-125mg was noted to take one tablet twice every day for ten days and was docuemented as given on at 09:00am and 05:00pm and on ... at 09:00am. According to the order and documentation, Resident #10 should have received three doses equivalent to three tablets. A medication review for Resident #10, conducted on ..., revealed that the ... 875-125mg pill pack had one pill missing from the pack. The pill pack was filled on ... with twenty pills when filled. There were nineteen pills that remained in the pill pack. A review of MORs for Resident #11, conducted on , revealed that Resident #11 had prescribed medications that were documented as not given to the resident which included , ... Iron 15mg on ... at 08:00am and , 10mg on ... and ... at 12:00am due to the medications were on order and not in the medication cart. Resident #11's prescribed , Benzoate 5mg was noted to take two tablets every day for fourteen days and was documented as given on and ... at 08:00am. The , .. Benzoate was documented as not given on ... at 08:00am due to awaiting delivery. According to the order, Resident #11 should have received three doses of the medication equivalent to six tablets.	{A 056}		

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{A 056}	Continued From page 13 A medication review for Resident #11, conducted on [redacted], revealed that the [redacted], Benzoate 5mg pill pack had one pill missing from the pack. The pill pack was filled on [redacted] with twenty-two pills when filled. There were twenty-one pills that remained in the pill pack. A review of MORs for Resident #14, condcuted on [redacted], revealed that Resident #14 had prescribed medication that were documented as not given to the resident which included [redacted], 0.5mg from [redacted] through [redacted], D3-50 50000 units on [redacted] and [redacted] at 08:00am, [redacted], 2mg on [redacted] and at 08:00am, Refresh Tears 0.5% [redacted], solution on [redacted] at 06:00pm, and [redacted] 10meq on [redacted] at 08:00am due to on order, not on cart, not in cart, and awaiting medication delivery. A review of MORs for Resident #15, conducted on [redacted], revealed that Resident #15 had prescribed medications that were documented as not given to the resident which included [redacted] 0.1% [redacted], cream on [redacted] and [redacted] at 08:00pm, on [redacted] at 09:00pm, and from [redacted] through [redacted] at 09:00pm, [redacted] 3mg from [redacted] through [redacted] at 09:00pm, and [redacted] 12% [redacted], cream on [redacted] and [redacted] at 05:00pm and from [redacted] through [redacted] at 05:00pm due to refused and not in cart. A review of MORs for Resident #16, conducted on [redacted], revealed that Resident #16 had prescribed medications that were documented as not given to the resident which included	{A 056}		

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	AL11922285	A. BUILDING: _____ B. WING _____	R-C 11/09/2023

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{A 056}	Continued From page 14 10mg from through at 05:00pm, from through at 05:00pm, from through at 05:00pm, on at 05:00pm, at 05:00pm, from through at 06:00pm, on at 06:00pm, and on at 06:00pm due to need refill order, not in cart, ordered, on order, and awaiting medication delivery. During an interview with Resident #12, conducted on at 09:45am, Resident #12 stated that sometimes the facility does not have one or two of her medications. During an interview with Resident #16, conducted on at 09:40am, Resident #16 stated that sometimes the facility was out of one or another of her medications. During an interview with Staff E (Memory Care Coordinator), conducted on at 10:30am, Staff E agreed that Resident #5's medication label did not note the location of where to apply the and the medication label for the as needed did not note a reason to give the medication. Staff E agreed that Resident #8's Nystop cream medication label did not note the location of where to apply the cream and the medication labels for the as needed medications and did not note the reasons to give the medications. Staff E agreed that Resident #8's as needed medication medication label did not note the reason to give the medication. Staff E agreed that Resident #10 did not receive the medication as prescribed. Staff E agreed that Resident #11 did not receive	{A 056}		

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{A 056}	Continued From page 15 the agent medication , Benzoate as prescribed. During an interview with the Administrator and Health and Wellness Director, conducted on at 02:00pm, the Administrator and the Health and Wellness Director agreed that there were ongoing issues in getting medication filled or refilled in a timely manner and that Residents #6, #8, #9, #10, #11, #14, #15, and #16 MORs had medications that were documented as not given due to the unavailability of the medications. The Administrator and Health and Wellness Director agreed that Resident #8 did not receive the prescribed Nystop as prescribed. The Administrator and Health and Wellness Director agreed that Resident #10 did not receive two medications and as prescribed. The Administrator and Health and Wellness Director agreed that Resident #11 did not receive the prescribed medication , Benzoate as prescribed. The Health and Wellness Director stated that Resident #8 did not receive medications as prescribed due to ongoing issues with the pharmacy and was frequently out of his medications. The Administrator was unable to provide notifications to primary care providers and responsible parties that Residents #5, #6, a#8, #9, #10, #11, #14, #15, and #16 did not take their medication as prescribed. (Photographic evidence obtained) Class II	{A 056}		
{A 056} SS=D	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies	{A 056}		

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{A 058}	Continued From page 16 429.42 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, 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	{A 058}		

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{A 058}	Continued From page 17 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 observation, record review, and interview, the facility failed to ensure all medications concerns were corrected (Cross Reference: A0052 and A0056). Findings Included: Due to the uncorrected Class III deficiencies and new medication deficiencies (Cross Reference: A0054 and A0055) 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	{A 058}		

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{A 058}	Continued From page 18 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 and the Health and Wellness Director, conducted on at 02:15pm, the Administrator and the Health and Wellness Director verbalized understanding that the facility was required to continue to employ or contract with a licensed Pharmacist Consultant or Registered Nurse Consultant due to the facility's uncorrected medication Class III deficiencies and new Class III medication deficiencies. Class III	{A 058}		