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
	AL11953622	A. BUILDING: _____ B. WING _____	R-C 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE POINTE	9797 BAY PINES BLVD SAINT PETERSBURG, FL 33708

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{A 000}	Initial Comments A revisit to complaint investigation (complaint number: 2023013206), a biennial survey, a complaint investigation (complaint numbers: 2023015344 and 2023015580), and a generator monitoring were conducted at The Pointe 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 tablets per day." The revised instructions,	{A 056}		

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{A 056}	Continued From page 1 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 or complimentary prescription drugs are not	{A 056}		

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{A 056}	Continued From page 2 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 provide medications within the standard timeframe of one hour before and one hour after the medications were scheduled for three Residents (#3, #14, and #15) of three sampled residents. Furthermore, the facility failed to provide medications as prescribed and failed to fill or refill prescriptions in a timely manner for four Residents (#3, #8, #14, and #16) of four sampled residents. Moreover, the facility failed to notify primary care providers and responsible parties when the residents did not take their medications as prescribed for four Residents (#3, #8, #14, #15, and #16) of five sampled residents. Findings Included: During an observation of the medication pass with Staff D (an unlicensed Medication Technician) for Resident #3, #14, and #15, conducted on at 01:10pm, Staff D assisted Resident #15 with the prescribed	{A 056}		

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{A 056}	Continued From page 3 medication ....., 25mg. At 01:20pm, Staff D assisted Resident #3 with the prescribed medication .... , 500mg. At 01:23pm, Staff D assisted Resident #14 with the prescribed medication , 0.25mg. A review of Resident #3's MORs, conducted on , revealed that Resident #3's prescribed medication .... , 500mg was scheduled at 12:00pm. Resident #3's prescribed medication Preservision was documented as not given on and ..... at 07:00am due to the unavailability of the medication. During an observation of Resident #14's 300mg pill pack, conducted on ..... at 01:30pm, Resident #14's pill pack had one capsule left in the pack. The medication label noted that there were fourteen capsules filled on ..... There was evidence that seven capsules were filled and not fourteen as there were six capsules that were removed from the pill pack and one capsule that remained in the pill pack (photographic evidence obtained). A review of Resident #14's MORs, conducted on , revealed that Resident #14's prescribed medication , 0.25mg was scheduled at 12:00pm. Resident #14's prescribed medication ... 300mg take one capsule every twelve hours for seven days was scheduled to be taken from ..... through ..... at 05:00pm which was for six days once every day (photographic evidence obtained). A review of Resident #15's MORs, conducted on , revealed that Resident #15's prescribe medication ....., 25mg was scheduled at 12:00pm.	{A 056}		

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{A 056}	Continued From page 4 During an interview with Resident #8's family member, conducted on at 12:43pm, Resident #8's family member stated that the facility had issues with giving the correct medications to residents. During an observation of Resident #8's medications with Staff D, conducted on at 03:00pm, Resident #8 had a bottle of (Strength 650 Mg per tablet) with the resident's name written on the bottle with a permanent marker.. Resident #8's , 30mg medication label noted to take one capsule four times every day. Resident #8's bottle of Powder was empty. A review of Resident #8's MORs, conducted on , revealed that Resident #8's MORs noted , 325mg take two tablets every six hours. Resident #8's MORs noted , 30mg take one capsule twice every day. Resident #8's prescribed medication (, / ,) 2.5/325mg was documented as not given on and at 08:00am, 02:00pm, and 08:00pm and on at 08:00am due to the unavailability of the medication. Resident #8's prescribed medication Powder was documented as not given on , , and at 08:00pm and on at 08:00am due to the unavailability of the medication. Resident #8's prescribed agent , Powder was documented as not given on and at 08:00am due to the unavailability of the medication. Resident #8's prescribed medication , 50mcg was documented as not given on at 07:00am due to the resident's refusal.	{A 056}		

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{A 056}	Continued From page 5 A review of Resident #16's MORs, conducted on , revealed that Resident #16's prescribed medication , 10mg was documented as not given from through at 08:00am and 08:00pm due to the unavailability of the medication (photographic evidence obtained). During an interview with Staff G, conducted on at 12:53pm, Staff G stated that there were issues with medications being ordered and not available to give to residents. During an interview with the Health and Wellness Director, conducted on at 02:41pm, the Health and Wellness Director agreed that Resident #16 did not receive the medication , as prescribed and the medication continued to be unavailable. At 03:13pm, the Health and Wellness Director agreed that Resident #3 did not receive the medication Preservision Areds as prescribed. The Health and Wellness Director agreed that Resident #8 did not receive the medications , , , , , Miralx Powder, , Powder, and , as prescribed. The Health and Wellness Director agreed that Resident #8's , and , medication label did not match the resident's MORs. The Health and Wellness Director agreed that Resident #14 did not receive the medication as prescribed. The Health and Wellness Director was unable to provided evidence that Resident #3, #8, #14, #15, and #16's primary care providers and responsible parties were notified that the residents did not receive medications as prescribed. During an interview with the Administrator,	{A 056}		

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{A 056}	Continued From page 6 conducted on . . . . . at 01:45pm, the Administator agreed that the standard timeframe for unlicensed Medication Technicians to provide residents their medication was within one hour before and one hour after the scheduled time. At 03:30pm, the Adminsitator agreed that there were 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.	A 058		

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A 058	Continued From page 7 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 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	A 058		

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A 058	Continued From page 8 regarding medicinal drugs were corrected as required (Cross Reference: 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 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 Regional Director and Administrator, conducted on . . . . . at 04:00pm, the Regional Director and 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 and new medication deficiencies. Class III	A 058		