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
	AL11968003	A. BUILDING: _____ B. WING _____	12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF MELBOURNE	964 S HARBOUR CITY BLVD MELBOURNE, FL 32901

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A 000	Initial Comments A complaint investigation #2023015486 was conducted on [redacted] at Harborside at Melbourne Assisted Living Facility. There were deficiencies identified at the time of the survey.	A 000		
A 052 SS=D	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 or her . (d) Applying , medications. (e) Returning the medication container to proper storage.	A 052		

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A 052	Continued From page 1 (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 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.	A 052		

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A 052	Continued From page 2 (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 [illegible] 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 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	A 052		

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A 052	Continued From page 3 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 confirm that the medication was intended for resident and failed to orally advise the resident of the medication name and dosage for 1 of 4 residents sampled (#1). Findings:	A 052		

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A 052	Continued From page 4 A review of resident #1 record revealed a facility note documented by the Director of Resident Care (DRC) on [redacted] at 8:15pm titled Investigation Summary; Medication Error [redacted] which read - Resident experienced a medication error while in her apartment. According to the Med Tech she [redacted] the residents name with another resident with a similar name and handed the resident the wrong medication. Further review of resident #1 record revealed she was admitted on [redacted]. Her record contained a Resident Health Assessment form (1823) dated [redacted] Her diagnoses included [redacted], 's, and [redacted] of [redacted]. She was oriented to person, place, and time with mild [redacted]. She required assistance with self-administration of medications. Review of the facility notes revealed: On [redacted] documented at 1:34am by the DRC. Made aware resident took another residents medication. (no time of incident documented) On [redacted] documented at 8:06pm by the DRC. Received a call from the med tech who stated the resident was kneeling on the floor. On [redacted] at 1:30pm an interview with resident #1 was conducted. She was observed in the dining room. She said she did not know the staff member's name who gave her the wrong medication. She had never seen her before or since the incident. She thought it may have been her first day. She said the staff member did not tell her what the medications were. She just gave her the cup of medicine. She said the Nurse checked on her to make sure she was OK. They checked her [redacted] several times. She did not know what medication she took but knew	A 052		

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A 052	Continued From page 5 they were not her normal pills. On [redacted] at 2:05pm an interview with the DRC was conducted. She said the staff checked resident #1 [redacted] all day after notifying the doctor. Staff C was taken off the floor and she had to retake the 2-hour med pass refresher course. The other resident with the same first name did not receive the wrong medication. She confirmed the resident within 24 hours of receiving the wrong medications. She had no injury. She said the proper procedure/standard for assisting with self-administration of medication is to verify the right resident, medication, dose, and time. She said before staff C could go on the floor; she was observed by staff F to make sure she followed proper procedure. On at 2:30pm an interview with staff C was conducted. She said she did not normally work on the 5th floor. She usually worked the [redacted] shift. She said she prepared the medications for the morning medication pass but did not pay attention to the resident's last name. There were 2 residents with the same first name, but she was not aware of that. No other residents were affected. After resident #1 took the medication, she said they were not her normal medications. Staff C said she gave her pills during the morning medication pass. After resident #1 said the medications were not her normal meds, staff C said she noticed (by the name on the medication card) there were 2 residents with the same name, and she gave the wrong medication to resident #1. She said she got very nervous and did not notify her supervisor or anyone at that time. Later, (unable to say how long) A hospice nurse	A 052		

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A 052	Continued From page 6 asked her about resident #1 medication because resident #1 told her the medications were different. After being questioned by the hospice nurse, staff C told DRC. She said she was removed from the floor and had to retake the 2-hour med pass training. When the surveyor asked about the photo that was on the MOR, staff C said the electronic system was new at that time and not everyone had a photo. Said she verified using only the residents first name. She did not verify her last name. On at 2:45pm an interview with staff F was conducted. She said after staff C gave resident #1 the wrong medications, she had to retake the 2-hour refresher course. Staff F then observed her doing a med pass to assure she was following proper procedure. The incident happened very soon after staff C transferred from housekeeping to the nursing department. She said After the incident they had a meeting with the med techs about resident identifiers. She said there was no documentation of the meeting. She said the resident photos go on the Medication Observation Record (MOR) the same day now. She said there were no other medications errors she was aware of. A Review of resident #1 MOR revealed 7 medications ordered to be taken at 9am. A Review of resident #7 MOR, who had the same first name, revealed 11 medications to be taken at 9am including a medication for high , and a . Both medications can cause decreased , . Review of staff C record revealed she was hired on . Her record did not contain documentation regarding assistance with	A 052		

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A 052	Continued From page 7 self-administration of medication training. On [redacted] at 6:12pm an interview with the DRC was conducted. She said the medication error for resident #1 was reported to her at 10:45am on [redacted]. The medication error occurred during the 9am med pass. She confirmed staff C did not have documentation of participation in a 6-hour assistance with self-administration of medication training in her file. She said she did not know what happened to it, but she knows she took it. (Photographic Evidence Obtained) Class III	A 052		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label;	A 084		

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A 084	Continued From page 8 providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , , dosage forms, and , , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such	A 084		

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A 084	Continued From page 9 reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of rate, temperature, and , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in	A 084		

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A 084	Continued From page 10 sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure unlicensed persons who will be providing assistance with the self-administration of medications have documentation of the required 6-hour assistance with self-administration of medication training for 1 of 3 staff sampled. (C) Finding: On Staff C assisted with self-administration of medication for 9am medications with resident #1. She did not follow the proper procedure resulting in a medication error. A review of staff C record revealed she was hired on . . . . . Her record did not contain documentation regarding assistance with self-administration of medication training. On at 6:12pm an interview with the DRC was conducted. She confirmed staff C did not	A 084		

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A 084	Continued From page 11 have documentation of participation in a 6-hour assistance with self-administration of medication training in her file. She said she did not know what happened to it, but she knows she took it. Class III	A 084		