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
	AL11965291	A. BUILDING: _____ B. WING _____	01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SODALIS TALLAHASSEE	2110 Fleischmann Road TALLAHASSEE, FL 32308

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A 000	Initial Comments An unannounced standard biennial survey, including a generator assessment, a review of the comprehensive emergency management plan, and a review of the visitation policy, was completed at Sodalis Tallahassee Assisted Living Facility in Tallahassee, FL on [redacted] - [redacted]. Deficient practice was 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	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, interview, and record review, the facility failed to ensure that staff who assisted residents with self-administration of medications did so in accordance with proper	A 052		

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A 052	Continued From page 4 procedures for 2 of 3 residents observed. (Residents #10 and #11) The findings include: On at approximately 5:48 PM, Staff B, a Medication Technician (MT), was observed assisting Resident #10 with self-administration of medication. Staff B did not orally advise Resident #10 of the medication name or dosage. On at approximately 6:37 PM, Staff B was observed assisting Resident #11 with self-administration of medication. Staff B did not orally advise Resident #11 of the medication name or dosage. Staff B took an , 500 milligram (mg) tablet, an (a medication used to treat) 5 mg tablet, a (medication used to treat) 125 mg capsule, and a (another medication) 5 mg tablet to Resident #11 in a medication cup. Resident #11 then took the medications. The electronic medication record listed these medications as due at 5:00 PM. On at approximately 8:03 PM, Staff B was observed dialing up 30 units of (long-acting (medication used to treat)) on the medication pen and injecting it into the side of Resident #10's upper right arm. On at approximately 6:40 PM, an interview was conducted with Staff B. She stated she has received medication training. She further stated she does not tell the residents the name or the dose of the medication they are receiving, did not know she was supposed to do that, and was not told to do that when she was trained. She also confirmed Resident #11's medications were listed	A 052		

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A 052	Continued From page 5 on the electronic medical record to be given at 5:00 PM. She stated the medications can be given one hour before or after the listed time and confirmed the medications were given late. On at approximately 8:07 PM, a second interview was conducted with Staff B, who stated she was taught in medication training she is not supposed to dial up the amount of or inject the for residents. When asked who taught her to dial up and administer the for the resident, she stated a former MT she shadowed at the facility during her training showed her this. On at approximately 10:00 AM, an interview was conducted with the facility's Executive Director, who stated Resident #10 and Resident #11 did not have a signed waiver to opt out of being orally advised of medication names and dosages. On at approximately 12:23 PM, an interview was conducted with the facility's Director of Wellness (DOW), who stated medications are to be given one hour before or after the time listed on the electronic medication record. She also stated MTs are not supposed to give , MTs have been trained not to give , and she verbally reminded Staff B on that she could not give . She stated if she were not on duty at the facility, the MT would need to call to let her know the resident refused to give their own . She further stated she was not told Resident #10 would not give his own . On , a record review was conducted of Staff B's medication training, which revealed completion of a six-hour Assistance with Self-Administration of Medication course on .	A 052		

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A 052	Continued From page 6 On , a record review was conducted of medication orders for Resident #11, which confirmed the above listed medications are ordered to be given at 5:00 PM. On , a record review for Resident #10 was conducted which revealed the form "Exhibit Y - Informed Consent to Assistance with Medication by Unlicensed Staff" that states, "Assistance with self-administration does not include preparing or administering injections." Class III	A 052		
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	A 056		

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A 056	Continued From page 7 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 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	A 056		

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A 056	Continued From page 8 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. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper labeling of medication for 1 of 3 residents. (Resident #11) The findings include: On at approximately 6:37 PM, a medication observation was conducted with Staff B, a Medication Technician (MT). The observation revealed a medication card for Resident #11 labeled morning, (medication used to treat high . . . . .) 40 milligrams (mg) one tablet by once daily. The electronic medication record listed 40 mg to be given at 5:00 PM. The electronic medication	A 056		

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A 056	Continued From page 9 record did not list . . . . . 40 mg to be given in the morning. Resident #11 did not receive the 5:00 PM dose of . . . . . 40 mg. On . . . . . , a record review was conducted of Resident #11's medication orders, which revealed . . . . . 40 mg was ordered daily at 5:00 PM. On . . . . . at approximately 6:40 PM, and interview was conducted with Staff B. She confirmed the electronic medication record listed 40 mg to be given at 5:00 PM and not in the morning. She also confirmed the 40 mg medication card was labeled morning and there was not an . . . . . medication card labeled for 5:00 PM. On at approximately 12:23 PM, an interview was conducted with the facility's Director of Wellness (DOW), who stated the lead MT on first shift is responsible for checking medications to ensure they are labeled with the correct resident, correct dose, and correct time. She further stated the medication for Resident #11 got missed. She stated the MT would have the responsibility of notifying the pharmacy the resident needed the . . . . . medication for 5:00 PM. Class III	A 056		