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
	AL11968817	A. BUILDING: _____ B. WING _____	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT TERRACINA GRAND	6855 DAVIS BLVD NAPLES, FL 34104

(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 An unannounced relicensure, emergency power plan, health facility reporting system, generator, and visitation form survey was conducted on . . . .. through . . . . .. at Villa at Terracina Grand, an assisted living facility in Naples, Florida. The following is a description of the deficiencies. .	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	A 052		

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A 052	Continued From page 1 helping the resident by lifting the container to his 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.	A 052		

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A 052	Continued From page 2 (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. (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	A 052		

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A 052	Continued From page 3 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 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 observations, and interviews with staff, the facility failed to ensure that unlicensed staff (Staff D) followed policy and procedures when	A 052		

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A 052	Continued From page 4 they provided assistance with self-administration for 3 (Residents #12, #13, and #14) of 3 residents observed. The findings included: On . . . at 9:31 a.m., Medication Aide Staff D was observed preparing Resident #12's medications. Staff D mixed her two tablets with a spoonful of applesauce. She then spoon-fed the medications to the resident and failed to orally advise what medications were being given. On at 9:37 a.m., Medication Aide Staff D was observed preparing Resident #13's medications. Staff D crushed her two tablets, and then mixed them with a spoonful of applesauce. She failed to orally advise what medications were being given and then spoon-fed the medications to the resident. On at 9:51 a.m., Medication Aide Staff D was observed preparing Resident #14's medications. Staff D crushed her medications, and then mixed them with a spoonful of applesauce. She failed to orally advise what medications were being given and then spoon-fed the medications to the resident. Staff D then walked out of the room to get the resident a glass of water and left the cart unlocked and out of sight. Staff D then spoon-fed the resident the remainder of her medications without first orally advising what was given. Staff D then administered Resident #14's spray in each nostril and did not orally advise what medication was being given. During an interview on at 12:03 p.m., the Director of Health and Wellness confirmed that Medication Aide Staff D did not adhere to policy	A 052		

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A 052	Continued From page 5 and procedures when she did not orally advise (Residents #12, #13, and #14) what medications were given, when she administered the resident's medications, and when she left the cart unlocked and walked away from it. Class III	A 052		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice	A 081		

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A 081	Continued From page 6 training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control,	A 081		

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A 081	Continued From page 7 including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training	A 081		

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A 081	Continued From page 8 within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure employees completed 1 hour of in-service training for Recognizing/Reporting /Neglect, and Elopement Response Training, based on facility policy and procedures as required by Florida Administrative Code within 30 days of employment for 3 (Staff E, F, Resident Care Coordinator) of 5 employee records reviewed. The findings included: Record review for Staff E revealed a hire date of as a resident aide. Staff E's employee record contained documentation of a certificate of completion for 30 minutes of training for Preventing/Recognizing/Reporting , Managing Elopement on and 30 minutes of training for Elopement Protocols in Florida on through Relias an online computer-based	A 081		

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A 081	Continued From page 9 training system. There was no evidence of completion of Preventing/recognizing . . . . . /neglect training and Elopement Response training completed based on facility policy and procedures. Record review for Staff F revealed a hire date of as a Licensed Practical Nurse (LPN). Staff F's employee record contained documentation of a certificate of completion for 30 minutes of training for Preventing/Recognizing/Reporting . . on through Relias an online computer-based training system. There was no evidence of completion of Preventing/recognizing . . . . . /neglect training completed based on facility policy and procedures. During an interview on at 10:35 a.m., the Human Resource Coordinator (HRC) reviewed the employee file for Staff E. She stated she did not see the certificate of completion for the elopement training and training based on the facility policies and procedures, she said "I don't see it." The HRC confirmed the only certificates for the elopement and . . . . . training in Staff E's file are the ones completed through Relias online on the computer which are not based on the facility policies and procedures. During an interview on at 10:41 a.m., the HRC reviewed the employee file for Staff F and confirmed the only documentation of training completed was the Relias training and it was only 30 minutes and was not specific to facility policies and procedures. Review of the Resident Care Coordinator's employee file showed a hire date of . It contained no documentation of completion of the 1-hour in-service for Elopement Response	A 081		

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A 081	Continued From page 10 training. Class III	A 081		