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
	AL11967856	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	5601 N HONORE AVE SARASOTA, FL 34243

(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 emergency power plan monitoring and complaint #2023001532 survey was conducted on at Desot Palms Assisted Living Community, an assisted living facility in Sarasota, Florida. Complaint #2023001532 was substantiated The following is description of the deficiencies:	A 000		
A 056 SS=H	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;	A 056		

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
	AL11967856	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	5601 N HONORE AVE SARASOTA, FL 34243

(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 056	Continued From page 1 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 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,	A 056		

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
	AL11967856	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	5601 N HONORE AVE SARASOTA, FL 34243

(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 056	Continued From page 2 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 record review, and interviews, the facility failed to provide physician ordered medication and ensure that medications for residents were filled or refilled within a timely manner for 5 (Residents #1, #2, #3, #4, and #5) of 8 residents reviewed. Depending on the medication, skipping a dose or multiple doses can have a major impact on your health as many medications won't be effective if you don't take them when and the way they are supposed to, especially if you miss multiple doses. It can lead to discomfort, complications, withdrawal, an increase in flare-ups, and/or resistance to in the future. The findings included: Review of the Medication Labeling and Orders policy and procedure on indicated that the facility will make every reasonable effort to ensure	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967856	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	5601 N HONORE AVE SARASOTA, FL 34243

(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 056	Continued From page 3 that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. Review of the Medication Administration Record (MAR) for and , failed to show documentation that Resident #1 received Nystantin / Suspension 100000 UNIT/ML (indicated for) on (at 0900 and 1400); (at 1400); (at 2000); and (at 0900 and 2000); (at 1800); (at 0600 and 1800). It failed to show that she received Viscous HCl / Solution 2% (indicated for without) on (at 1800); (at 1200); (at 0600, 1200, and 1800); (at 0600 and 1200); and (at 1200). It failed to show that she received Mintox Maximum Strength Oral Suspension 400-400-40 MG/5ML (indicated for without) on (at 0600 and 1200); (at 0600 and 1200); and on (at 0600 and 1200). It failed to show that she received HCl Oral Tablet 50 MG (indicated for) on (at 0800 and 1400). It failed to show that she received Flucanazole Oral Tablet 200 MG (indicated for other for 3 days) on and . The medications were marked as unavailable. Resident #1 , on . Review of the MAR for and , failed to show documentation that Resident #2 received Levothyroxin Tab 112 MCG (indicated for) on and . It failed to show he received External Patch 4% (indicated for) on ; ; ; ; ; ; and	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967856	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	5601 N HONORE AVE SARASOTA, FL 34243

(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 056	Continued From page 4 . It failed to show he received Tablet 15 MG (indicated for ,) on ; and - . It failed to show he received , Oral Tablet 325 MG (indicated for ,) on (at 1400 and 2000); (at 0200, 0800, and 1400); and on (at 0800, 1400, and 2000). It failed to show he received Hydorocodone- , Oral Tablet 5-325 MG (indicated for ,) on (at 1400 and 2000); - (at 0200, 0800, 1400, and 2000); and on (at 0200 and 0800). The medications were marked unavailable. Review of the MAR for and , failed to show documentation that Resident #3 received Duloxotine Cap 30 MG (indicated for ,) on /24; and on - . It failed to show that she received Amoxycillin Oral Tablet 500 MG (indicated for dental , ,) on - ; and on - . It failed to show she received her Spray 50 MCG (indicated for) on ; /24; - ; ; and on . It failed to show she received her Tab 20 MG (indicated for clots) on - ; ; and on . It failed to show that she received her HCl Oral Tablet 50 MG (Indicated for bedtime) on /24. The medications were marked as unavailable. Review of the MAR for and , failed to show documentation that Resident #4 received Tab 1000 MCG (indicated for deficiency) on (at 0900 and 2100); (at 2100) (at 2100); (at 0900 and 2100); (at 0900 and 2100); (at 0900); (at 2100); and on (at 0900). It failed to show Tab 50 MG (indicated for ,) was received on -	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967856	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	5601 N HONORE AVE SARASOTA, FL 34243

(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 056	Continued From page 5 (at 0800 and 2000). It failed to show that she received Tab 40 MG (indicated for) on ; - . It failed to show she received Cap 300 MG (indicated for) on - (at 0800 and 2000). It failed to show she received Levothyroxin Tab 125 MCG (indicated for) on - . It failed to show she received Tab 500 MG (indicated for) on - . The medications were marked as unavailable. Review of the MAR for and failed to show that Resident #5 received Amoxycillin-Pot Oral Tablet 875-125 MG (indicated for) on (at 1700) and on (at 0800). It failed to show that she received her Tab 0.25 MG (indicated for) on and on . The medications were marked as unavailable. During an interview on at 3:53 p.m., Resident #5 stated that she had been doing her own medications for years and after two weeks after moving into the facility, she decided to let them supervise her self-administration. She gave them her medications, but when it came time for bedtime, her medication was unavailable. During an interview on at 4:10 p.m., Resident #4 stated that she had been complaining to her family about not receiving her medications. The family member then spoke to the facility on her behalf, and they started to have her sign off on receiving her medications. During an interview on at 1:21 p.m., The Director of Health and Wellness stated that they are still in the adjustment phase of using Apta Pharmacy and acknowledged there have been	A 056		

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
	AL11967856	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	5601 N HONORE AVE SARASOTA, FL 34243

(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 056	Continued From page 6 some mistakes. They have been delayed and sometimes their fax machine has not been working. We are now taking screenshots on our cellphones to send to them and using WhatsApp to communicate together. She stated that the average wait time for arrival for medications is typically the next day. During an interview on ..... at 5:30 p.m., The Administrator acknowledged the findings of multiple medications not being available for multiple residents over a long period of time and questioned why she hadn't noticed that in the audits she has been doing. Class II	A 056		