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
	AL11969409	A. BUILDING: _____ B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS SENIOR LIVING AT SARASOTA	5750 HONORE AVENUE SARASOTA, FL 34233

(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, visitation form, and complaint survey for #2023008868, #2023009899, and #2024000395 was conducted on through at Angels Senior Living at Sarasota, an assisted living facility in Sarasota, Florida. Complaint #2023008868 was unsubstantiated. Complaint #2023009899 was substantiated at A032. Complaint #2024000395 was unsubstantiated. The following is a description of the deficiencies.	A 000		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at	A 032		

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A 032	Continued From page 1 risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S.	A 032		

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A 032	Continued From page 2 This Statute or Rule is not met as evidenced by: Based on interview, record review, and policy and procedures the facility failed to develop a policy for elopement that included a policy for at least two elopement drills annually in which all direct care staff were required to participate. The facility failed to ensure three Direct care staff members participated in elopement drills annually. The facility failed to ensure that resident demonstration elopement tendencies were reassessed for risk of elopement. The facility failed to ensure one (Resident #12) of three residents surveyed for elopement was reassessed to be at risk after eloping from the facility. Findings Included: 1. The policy "Elopement Policy Synopsis" was provided by the Administrator as the facility's policy and procedure for elopement. The policy does not mention the requirement to have two elopement drills annually and that all direct care staff must participate in the elopement drills annually. In reviewing the elopement drills completed by the facility in 2023, three staff members were not documented as participating in any of the elopement drills on [redacted], or [redacted]. Caregiver, Staff E's Date of Hire (DOH) was on [redacted]. On [redacted] at 9:30 a.m. Staff E was observed providing care to residents on the memory care unit. Staff E is not documented as participating in any of the elopement drills preformed in 2023.	A 032		

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A 032	Continued From page 3 Medication Technician, Staff H's DOH was on . Staff H is not listed as participating in any of the four elopement drills preformed in 2023. Caregiver, Staff F's DOH was . Staff F is not listed as participating in any of the four elopement drills completed by the facility in 2023. On at 1:00 p.m., the Administrator verified there was no documentation that Staff E, Staff H, or Staff F participated in any of the elopement drills completed in 2023. 2. The Policy "Elopement Policy Synopsis" contained no documentation of how the facility would make a daily effort to identify residents at risk for elopement. On at 1:19 p.m. Resident #12 eloped from the facility's memory care unit and was found outside a away from the facility. Review of Resident #12's last completed Health Assessment Form-1823 dated . . . . . shows Resident #12 was not designated as at risk for elopement. The current list of residents at risk for elopement provided by the Administrator did not include Resident #12. On . . . . . at 1:30 p.m., the Administrator verified she did not have documentation Resident #12 had been assessed as an elopement risk after he had eloped from the facility on . Class III	A 032		

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A 052	Continued From page 4	A 052		
A 052 SS=E	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. (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	A 052		

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A 052	Continued From page 5 dose of [illegible] solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the [illegible]. (4) Assistance with self-administration of medication does not include: (a) Mixing, [illegible], converting, or [illegible] 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 [illegible] of the body. (d) Administration of [illegible] preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with [illegible], or [illegible] 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. (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.	A 052		

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A 052	Continued From page 6 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 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,	A 052		

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A 052	Continued From page 7 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, record review, and interviews with staff, the facility failed to ensure that unlicensed staff followed policy and used safe and sanitary procedures when assisting residents with self-administration of medication for 2 (Residents #6 and #7) of 3 residents observed. Facility staff also failed to advise residents of the medication and dosage for 3 (Residents #6, #7, and #15) of 3 residents observed. The findings included:	A 052		

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A 052	Continued From page 8 1. On at 9:55 a.m., Medication Technician (Med Tech) Staff A was observed preparing the medications for Resident #18's by popping them into a med cup. Staff A entered the resident's room and told the resident she had their medicine but failed to accurately advise them of the specific medications or proper dosage. She then observed the resident take the medications. 2. On at 10:22 a.m., Med Tech Staff A was observed preparing Resident #7's medications at the medication cart. Staff A placed all of the prescribed tablets and capsule into a medication cup. Staff A then opened the drawer and pulled out the resident's bottle of Oral Solution USP 10% (supplement intended to treat low levels) prescribed to take 15 milliliters by every day with instructions, "must be diluted prior to use". Staff A poured an accurate dose of 15 milliliters of the Oral Solution USP 10% (solution) into a small medication cup. She also filled a separate cup with water, without diluting the solution with water. Staff A then entered Resident #7's room and gave the resident the cup of tablets, the medication cup filled with the solution, and a glass of water. Staff A failed to advise the resident of their medications or dosage. Staff A observed the resident take the tablets, followed by the undiluted solution, and then drink the water. 3. On at 10:40 a.m., Med Tech Staff A was observed preparing Resident #6's medications. She popped medication tablets into a small medication cup, along with 2 gummy bear supplements into a separate medication cup. Staff A then retrieved a small pouch of Oral Powder (supplement). She filled a	A 052		

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A 052	Continued From page 9 small plastic cup with water and attempted to open the Oral Powder by tearing the top of the pouch with her . . . . . She was unable to open the pouch with her , so she tore it open with her . . . . . Staff A poured the powder into the glass of water to dissolve. Staff A then entered Resident #6's room and handed the resident the medications without advising the resident what medication or dosage they were receiving. During an interview on at 10:50 a.m., the Regional Health and Wellness Director confirmed that they should be telling the residents of their medication and dosage, they should be diluting a medication that is ordered to be diluted, and staff should be using a scissor (which is provided on their cart) to open the pouch. During an interview on at 12:38 p.m., the Executive Director confirmed that Staff A did not follow the proper policies and procedures during the medication passes as indicated in their Medication Information policy.	A 052		