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
	AL11968157	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENADES BY	425 S RONALD REAGAN BLVD LONGWOOD, FL 32750

(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 Two complaint investigations #2024007217 and #2024011514 and generator monitoring were conducted on at Serenades by , Longwood. A deficiency was found at the time of the visit.	A 000		
A 052 SS=G	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	A 052		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 052	Continued From page 1	A 052		

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 administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or

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A 052	Continued From page 2 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 resident's record. (e) When a resident who receives assistance with medication is away from the facility and from	A 052		

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A 052	Continued From page 3 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 record review, observation and interview, the facility failed to maintain accurate records for medication for 1 of 2 sampled residents (#2). Findings:	A 052		

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A 052	Continued From page 4 Review of resident #2's record and health assessment confirmed an admission date of and a health assessment dated . Medical history of , short term memory, assistance with daily living to include ambulation, bathing, , self-care, toileting, transferring. Resident#2 required assistance with medication. In further review it revealed a physician order for tablet 50 milligrams 3 times per day, starting on . In a review of resident #2 medication observation record for the months of and , there were no missing medication times for the medication 50 milligrams. In review of resident#2's facility notes shows the following: medication card missing with 18 pills. Law enforcement was contacted, each community was searched, all carts, dumpster, nurses' office and shred box. Licensed Practical Nurse (LPN) A stated it was reported to her that evening when the second shift came in and could not find the medication card. In a review of Law enforcement's report case #2024CJ012694 dated , it was reported by LPN A, that the medication card for for resident #2 was missing. The facility and dumpster were searched, and the medication was not found. In a review of the facility's schedule for the month of and , both LPN A and LPN B are on the schedule and still administer medications to residents. In a review of the facility's medication storage and	A 052		

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A 052	Continued From page 5 disposal policy, it states controlled medications will be counted by each shift to shift by 2 authorized personnel and utilizing the . . . . . count off sheet. One person counting should be the outgoing shift person responsible for the medication cart and the other person counting should be the incoming shift person responsible for the medication cart. In an observation of a medication pass on . . . . . at 11:45am, with LPN C and resident#5, it confirmed the resident receives tablets 50 milligrams 3 times per day. Staff C took out the medication from the lock box in the medication cart and marked the medication on the computer. In an interview with LPN C on at 11:45am, she stated the policy is to sign off on the medication after taken the out of the bubble wrap. She confirmed the medication cart is to be audited after every shift with the incoming shift. In an interview on . . . . . at 11:30am with LPN A, she stated she passed the medication to resident#2 before her shift ended on . She stated she thought she put the medication card . . . into the lock box in the medication cart. She stated after she left her shift, she then received a call from the relieving 2nd shift nurse, LPN B, that the medication card was missing. Nurse (LPN) B stated they searched everywhere for it and the medication card could not be found. She stated the medication was immediately ordered and delivered right away so resident#2 did not miss any medication. Nurse (LPN) A admitted that it was hectic that day and she could have mixed the card up with bingo cards that then got trashed that day. She stated	A 052		

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A 052	Continued From page 6 the nurses had not been auditing the carts after every shift as the policy requires. She stated the facility was thoroughly searched including all rooms, medication carts, trash bins and dumpsters. She stated the wellness director was alerted to the situation right away. She stated all nurses received an in service on auditing carts at the end of every shift. She confirmed she is still employed by the facility and received no suspension. She stated she is still administering medications on her schedule. In an interview on ..... at 11:40am, with resident #2's family POA, he confirmed he was alerted to the missing medication the same day. He stated he was not too concerned as the replacement medication was ordered right away and resident#2 did not miss any dosages. In an interview on at 12:00 pm with the wellness director, she stated the medication card has not been found. She stated she gave all the nurses at the time an in-service on auditing the medication cart after each shift. She stated corporate stated not to suspended or terminate LPN A or LPN B. She stated resident #2 never missed any medication as the physician was notified and he ordered the medication from the pharmacy right away. She confirmed LPN A and LPN B continue to administer medications to the residents. She confirmed all the above statements. Photographic evidence was obtained Class II	A 052		