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
	AL11970184	A. BUILDING: _____ B. WING _____	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GOLDTON AT VENICE	108 BELLA VERDE BLVD NOKOMIS, FL 34275

(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 survey #2023014323, 2023015502, 2024007069, 2024007274, 2024010440 was conducted on through //24 at The Goldton At Venice, an assisted living facility in Nokomis, Florida. Complaint #2023014323 had two allegations, one was substantiated without deficiencies, one was substantiated at A0032. Complaint #2023015502 was not substantiated. Complaint #2024007069 was substantiated at A0052, and A0030. Complaint #2024007274 had two allegations. One was not substantiated; one was substantiated at A0052. The following is a description of the deficiencies. .	A 000		
A 026 SS=D	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the	A 026		

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A 026	Continued From page 1 facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide an individual and group activities program to meet the diversified needs of each resident. This has the potential to impact all 14 residents that reside in the memory care unit. The findings included: The facility activity calendar posted in the memory care unit for , listed activities scheduled throughout the day on including daily gratitude at 9:30 am, move it Monday at 10:30 am, refresh at 11:30 am, Giant Connect four at 1:30 pm, in motion at 2:00 pm, all about me at 2:30 pm, and Rocky Mountain National Park at 3:30 pm.	A 026		

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A 026	Continued From page 2 The facility activity calendar posted for included devotions at 9:30 a.m., balloon badminton at 10:30 a.m., Word Play at 1:30 p.m., In Motion at 2:00 p.m., All About Me at 2:30 p.m., and outside time at 3:30 p.m. On at 10:00 a.m., during an interview, Resident #19's family member reported no activities occur for the residents in the memory care. It's been brought to the attention of the memory care director numerous times but nothing changes. On at 2:00 p.m., during an interview, Resident #16's private duty aid said, we are supposed to have activities, but the staff just turns the television on. We try to help, and organize activities, but the facility should be providing that. On no individual or group activities were observed on the memory care unit between 9:25 a.m., through 3:30 p.m. On at 10:00 a.m., during an interview, the Activities Assistant said she comes to the memory care for a.m. exercise from 10:00 a.m.-10:30 a.m., and 1:30 p.m. for word bingo, or a activity. She said she is off on Sunday and Monday and thinks the Activities Director does the scheduled activities. She said she is not able to do everything on the calendar because she also has to do activities on the assisted living side of the facility. On at 10:20 a.m., during an interview, the Activities Director said she works Monday through Thursday, and the activity assistant will help with the memory care activities, but, she ends up having to help with resident care.	A 026		

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A 026	Continued From page 3 The Activities Director said, she tries to spend most of her day in memory care on Mondays, and, "yesterday at 10:00 a.m., the scheduled activity did not happen." In the afternoon, there was nothing scheduled. I tell the care staff to use the bins, sensory boxes, arts and crafts. The care staff have access to everything. I don't know if they have been trained to use that stuff. Daily gratitude should have been me yesterday, but I did not go there [to the memory care unit] yesterday. I did not do that or Sit and stretch. On Monday's, I am gone by 1:30 p.m., usually, there is not anyone from my department in the later part of the afternoon on Mondays and Wednesdays. The residents in assisted living have access to Putt Putt, and gardening, there was not an organized group activity. I leave at 1 on Monday and Wednesdays there is no one to cover. On at 1:05 p.m., the Executive Director said we have a schedule of activities that is the same every day. There are different bins for caregivers, and the private duty companions to make sure there is something for people to. We ask the family and caregivers to do activities with them as well. Usually, we try to have one big thing in the morning and another in the afternoon. If the activity staff are not here, it is the care staff responsibility to do activities on the schedule. If the staff are busy with resident care, then the activity is not done. Class III .	A 026		

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A 030	Continued From page 4	A 030		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the	A 030		

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A 030	Continued From page 5 facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State	A 030		

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A 030	Continued From page 6	A 030		

of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when

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A 030	Continued From page 7 prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.	A 030		

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A 030	Continued From page 8 (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida.	A 030		

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A 030	Continued From page 9 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, and interviews, the facility failed to honor resident rights to live in an environment where they can communicate with staff in a language they can understand for 2 (Residents #3 and #19) of 2 residents reviewed. The facility failed to honor a residents' preference to have care provided by female staff. The findings included: On at 9:30 a.m., Resident #3 was observed with two male caregivers in the bathroom attempting to assist Resident #3 use the bathroom, and provide morning personal care. Caregiver Staff F (male) was observed speaking in a foreign language to caregiver Staff	A 030		

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A 030	Continued From page 10 G. Resident #3 continued to yell no, stop it, and Caregiver Staff G (male) explained he was helping her and put her pants and shirt on. Staff F was unable to explain care being given in English to Resident #3. Staff F, Caregiver was observed to provide Resident #3 with breakfast, he was unable to communicate in English if the food was after sitting for over 30 minutes. On at 9:50 a.m., Caregiver F was assisting in the kitchen/dining area. Resident #19's daughter in law was observed to ask for milk for her father-in-law. Caregiver Staff F did not understand what the family member was asking for. Resident #19's family said she was concerned for his wellbeing because the staff member is unable to understand the needs of the residents. On at 1:30 p.m. during an interview Staff F, said his English was "not to good" and he has to ask another employee to translate. He said he forgets what is and is unable to recall any training he has done while working at the facility. On at 9:45 a.m., Male Caregiver Staff G was observed providing toileting care to Resident #3 in the bathroom. The bathroom and bedroom door were left open. Resident #3 could be heard shouting let me go, Resident #3 was observed hitting, kicking and pinching staff while he was holding her . On at 1:05 p.m., The Executive Director (ED) said, Resident #3's care plan is reviewed, and the memory care medication technician is involved with her, and we usually have the women staff take care of her. When Resident #3	A 030		

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A 030	Continued From page 11 is refusing care, they need to step away for a minute. On at 2:30 p.m., Staff B, memory care medication technician (MT) (female) said Resident #3 can be racist, she will be calm with me but gets agitated with other people. Her daughter has mentioned in the past she was abused by a person of color. One was a female, and the one was a black male. We usually have female staff take care of her. . Class III	A 030		
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 12 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 13 This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to determine residents deemed at risk for elopement, have identification on their person that includes their name, the facility's name, address, and telephone number for 9 residents (#2,#5, #12, #13, #14, #15, #16, #17, #18) of 9 residents observed for identification. The facility failed to ensure the Elopement policy and procedures reflect the language indicating residents deemed as an elopement risk have identification on their person that includes their name, the facility's name, address and telephone number. The findings included: Record review of Atlas Senior Living Elopement or Missing Resident policy revealed the policy and procedure did not indicate that residents deemed as an elopement risk were to have identification on their persons that includes their name, and the facility's name, address, and telephone number. On at 9:19 a.m., during a tour of the memory care unit, Observations were made of memory care residents without the required identification on their person that included, their name, the facility's name, address and telephone number. On at 9:57 a.m., during an interview Licensed Practical Nurse (LPN) Staff A said she does not know if there are any residents in the facility that are elopement risk. Staff A said there are three residents, #17, #18, #15, who she considers elopement risk as they are always going to the door of the unit to exit seek. Staff A stated there is nothing posted to indicate which	A 032		

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	AL11970184	A. BUILDING: _____ B. WING _____	09/10/2024

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A 032	Continued From page 14 residents are elopement risk and no residents in the memory care unit wears identification to include their name, the facility's name, address and telephone number. On at 10:10 a.m., during an interview, the Administrator said, all the residents in the memory care unit of the facility are considered an elopement risk. Record review of Resident #2 Health Assessment Form 1823 signed and dated , and indicated Resident #2 was an elopement risk. Review of an incident report dated indicated Resident #2 eloped from the facility and was returned to the memory care unit. On at 10:20 a.m., Observation of Residents # 17, #18, #15, #2, and # 14, all in the memory care unit, were not wearing any identification on their person with their name, the facility's name, address and telephone number. On at 8:10 a.m., observation of Residents #2, and #14 in memory care unit , did not have identification of their name, facility's name, address and telephone number on their person. On at 8:45 a.m., observation of Residents , #5, #15, and #16 in the memory care unit , without identification of their name, facility's name, address and telephone number on their person. On at 9:05 a.m., during an interview, Staff B said there is nothing posted in the memory care unit to inform staff which residents are elopement risk, however she considers Residents # 2, #17, #13, #18 as elopement risk as they like to go to the memory care door to get out. Staff B confirmed none of the residents' wear	A 032		

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A 032	Continued From page 15 identification that includes their names, the facility's name, address and telephone number on their person. On at 9:50 a.m., observation of residents # 12, and #13 were in the memory care unit , without identification on their person with their name, the facility's name, address and telephone number. On at 11:25 a.m., during an interview, the Wellness Director (WD) said there are a few residents in the memory care unit that are elopement risk, Residents # 2, #17, #14, #3, #13, and #15, and the service plans document them as elopement risk. On at 12:03 p.m., the WD confirmed none of the residents that are considered elopement risk wear identification on their person, that includes their name, the facility name, address and telephone number. The WD could not give an explanation as to why, he stated they just never had it. On at 1:32 p.m., during an interview, the Administrator said, all the residents that are considered an elopement risk resides in the memory care unit. The Administrator confirmed the residents that are elopement risk do not wear identification on their person with their name, the facility's name, address and telephone number. Class III	A 032		
A 052 SS=H	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin	A 052		

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A 052	Continued From page 16 429.256 (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 dose of solution, and pouring the prescribed premeasured dose of medication into	A 052		

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A 052	Continued From page 17 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 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	A 052		

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A 052	Continued From page 18 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, 2. The medication container may be given to the resident, a friend, or family member upon leaving	A 052		

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A 052	Continued From page 19 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, record review, and interview, the facility failed to ensure that 2 (Staff A and B) of 2 staff observed who assist residents with self-administration of medications do so in accordance with proper procedure for 7 (Residents #5, #12, #13, #14, #20, #21, #22) of 7 medications observations. The facility failed to follow physician orders when providing assistance with self-administration of medications. The findings included: Atlas Senior Living Assistance with Medications & Treatments updated . Policy Overview: medication assistance and treatment (including	A 052		

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A 052	Continued From page 20	A 052		

,) shall be provided safely and promptly and as prescribed by the resident health care provider ...Policy Detail: prescriber's licensed or permitted by this state to prepare, assist, administer, and documents medications may do so. . . .Medication assistance and administration must follow the prescriber's order.

Atlas Senior Living : Washing Policy: Atlas communities regard washing as the single most important means of preventing the spread of . The community will make every reasonable precaution to protect and safeguard the residents and associates under its care from spreading germs. It is crucial to wash your to limit the transfer of , viruses, and other microbes. . . . Procedure: 1. All associates will follow the community established -washing procedures to prevent the spread of and to other personnel, residents, and visitors. . . . 2. should be washed under the following conditions: c. before preparing or handling medications. . . d. before and after each resident contact. . . p. after removing gloves.

1. On at 8:21 a.m., Medication Technician (Med Tech) Staff B was observed preparing Resident #5's medications. Staff B donned gloves, no hygiene was performed. Staff B removed a syringe filled with from the med cart and said to Resident #5, "I'm going to put some cream on your ." Staff B squeezed the from the syringe onto the of Resident #5's and rubbed it into the skin. Staff B doffed the gloves and proceeded to remove another medication ( ) from the med cart. Staff B donned gloves, and squeezed the medication onto a plastic tray, and took the tray over to Resident #5, and proceeded to lift the bottom of Resident #5's shirt, and wiped the

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A 052	Continued From page 21 cream onto her lower and rubbed it in. No hygiene performed during process and after doffing and before donning gloves. Staff B proceeded to place Resident #5's oral medications into a souffle cup on the top of the med cart. Staff B donned gloves, placed a spoonful of chocolate pudding into a souffle cup, removed the , capsule and opened it pouring the contents in the cup with the chocolate pudding. Staff B placed the other pills into a small plastic package and proceeded to crush them and poured the crush meds into the chocolate pudding along with the contents of the , capsule and stirred the contents together. Staff B walked over to Resident #5 in the wheelchair and said to her, "I have your medications for you," then spooned the mixture of medication into Resident #5's . Staff B did not perform hygiene before or after donning and doffing gloves, did not inform Resident #5 what medications she was being given, and spoon-fed/administered Resident #5 the medications. Staff B proceeded to the next resident. Record review of physician orders for Resident #5 revealed no evidence of a physician order to crush medications. Further review of Resident #5's record, revealed a Health Assessment Form 1823 signed and dated by the health care provider on indicating Resident #5 required assistance with self-administration of medications. 2. On at 8:37 a.m., Medication Technician (Med Tech) Staff B was observed preparing Resident #12's medications. Staff B donned gloves, no hygiene was performed after the last resident. Staff B removed the patch medication, opened the package and walked the	A 052		

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A 052	Continued From page 22 patch to Resident #12 sitting in her wheelchair and said, "Alright I have to put this on your ." Staff B slightly slid the top of her shirt to the side and placed the patch on Resident #12's . Staff B doffed her gloves and donned another pair, removed med cards from the med cart and popped the pills in a small package and proceeded to crush all the medications together, pouring the crushed meds into a souffle cup. Staff B took a spoonful of chocolate pudding and placed it into the cup with the meds and stirred the mixture all together. Staff B doffed the right- glove and donned a new glove and took the cup with the mixture to Resident #12 and spoon-fed the mixture of pills into Resident #12's . Staff B did not perform hygiene after last resident, before, or after donning and doffing gloves, did not inform Resident #12 what medications she was being given, and spooned fed/administered Resident #12 the medications. Staff B proceeded to the next resident. Record review of Resident #12's Health Assessment Form 1823 signed an dated by the health care provider on indicating Resident #12 required assistance with self-administration of medications. 3. On at 8:52 a.m., Medication Technician (Med Tech) Staff B was observed preparing Resident #13's medications. Staff B donned gloves, no hygiene was performed after the last resident. Staff B removed med cards and popped all medications into a package, and proceeded to crush the medications together. Staff B poured the crushed meds into a souffle cup and added a spoonful of chocolate pudding to the cup and stirred the mixture together. Staff B took the cup with mixture over to Resident #13	A 052		

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A 052	Continued From page 23 sitting in a chair in the hallway and said, "I have your meds for you" and spoon fed/administered the medicines into Resident #13's . Staff B did not perform hygiene after the last resident, before or after donning and doffing gloves, and did not inform Resident #13 what medications he was being given, and spoon-fed Resident #13 the medications. Record review of physician orders for Resident #13 revealed no evidence of physician order to crush medications. Further review of Resident #13's record revealed a Health Assessment Form 1823 signed and dated by the health care provider on indicating Resident #13 required assistance with self-administration of medications. On 9//10/24 at 9:16 a.m., during an interview, Staff B said they were told they can wash their or use Base Rub (ABHR), and she prefers to use the ABHR and wear gloves for cleaning between residents when giving meds. Staff B confirmed she did not perform hygiene before, or between residents or before, and or, after removing gloves. On at 9:19 a.m., Staff B confirmed she did not tell the residents what medications they were given and administered the meds as she spoon fed them to the residents. On at 1:05 p.m., during an interview, the Administrator said when assisting with medications, staff are to wash their , read the meds they are giving to the residents, the dosage, and make sure the meds match the EMAR, the resident is the correct resident and hygiene should be done prior to and in between assisting residents with medications, and prior to and after donning and doffing gloves.	A 052		

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A 052	Continued From page 24 4. On at 8:25 a.m., Licensed Practical Nurse (LPN) Staff A was observed assisting Resident #14 with his medications. Staff A was observed when she arrived on the unit. She did not wash or sanitize her . Staff A was observed to remove the residents' medications from bottles which included 10 mg, , 2.5 mg, , 25 mg, Turmeric 450 mg, and B- , with and C. Each medication was placed in a medication cup. Then one pill at a time was removed by Staff A's ungloved, unsanitized and placed in the resident's . Record review for Resident #14 revealed a Health Assessment Form 1823, signed and dated on by the health care provider, indicating Resident #14 required assistance with self-administration of medications. 5. On at 8:32 a.m., LPN Staff A was observed to assist with Resident #20's medication. Staff A, LPN was observed to administer 1 drop to each , and immediately was followed by Refresh , , and instilled 1 drop in each , . Record review for Resident #20 revealed a Health Assessment Form 1823, signed and dated on , by the health care provider, indicating Resident #20 required assistance with self-administration of medications. 6. On at 8:50 a.m., LPN Staff A was observed to remove Resident #21's , 2 tablets, Acidophilus 175 mg, , 81 mg, 10 mg, , 25 mg, 80 mg, 1000 mg. All medications were crushed and mixed together in	A 052		

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A 052	Continued From page 25 pudding. Record review for Resident #21 revealed a Health Assessment Form 1823, signed and dated on , by the health care provider, indicating Resident #21 required assistance with self-administration of medications. Review of the physician orders for , specified "Do Not Crush". The specified the route to be administer , or dissolve under the . 7. On at 3:35 p.m., Resident #22 said the lady [MT Staff D] came in my room on to give me my . She fixed the needle and dialed the pen, then I injected it into my abdomen. I asked her why it was taking so long, usually it was very quick for the medicine to go in. She left and shortly she came , and they started giving me all kinds of sugar objects to offset it. They called the paramedics, and I had to go to the hospital even though I didn't want to. Resident #22 said, the girl dialed the wrong amount on the , . She told me she had not been trained. Record review for Resident #22 revealed a Health Assessment Form 1823, signed and dated on , by the health care provider, indicating Resident #22 required assistance with self-administration of medications. Record review of the physician orders for Resident #22 revealed an order to "inject 10 units once daily DEGL". Record review of the progress note dated at 20:13 (8:13 p.m.), documented by RN MCD, "Resident was given 50 units of her instead of 10 units. Staff member this resident with another resident that gets 50 units	A 052		

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A 052	Continued From page 26 of and failed to do her second checks. Instructed by PCP (primary car provider) to send resident to ER (Emergency Department) for evaluation. . ." On 5:24 p.m., MT Staff D said she was employed months as a MT. MT Staff D said she was told to check the residents before giving . She said she dialed the pen to the units she was supposed to get, handed her the pen, and watched her find a spot and push the button. This was my first job with . She said, the MT training did not include anything about testing or . The training was for the pills. I was thinking about a resident on another floor when I dialed the dosage, and gave it to Resident #22. She was looking at me and said its going for a long time, I went to the electronic medical administration record (emar) and saw the dosage was wrong, so I called another MT. I should have double checked the EMAR. They never came and offered me any additional training. On at 11:20 a.m., during an interview, the Registered Nurse (RN) Memory Care Director (MCD) said all staff are trained to sanitize their between each med pass and before putting gloves on. The staff should be telling the resident what the medications they are taking. When multiple , , are administered, there should be a 5-minute break between the , , . The RN MCD said MT Staff D called me and told me the dose given was incorrect. She found out when she got to the cart. I don't know why an adverse event was not done for that. On at 4:10 p.m., during an interview, the	A 052		

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	AL11970184	A. BUILDING: _____ B. WING _____	09/10/2024

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A 052	Continued From page 27 RN MCD said there was no documentation of retraining of medication technicians following the medication error. On at 4:20 p.m., during an interview, the pharmacy consultant said best practice is not to mix the medications together when they are being crushed. They should be crushed and administered individually. , , need to be administered 5 minutes apart. If is ordered to be administered , it should be dissolved under the , it should not be crushed. The pharmacy consultant verified the medication was ordered and should not have been crushed. Class II .	A 052		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the	A 165		

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A 165	Continued From page 28 resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to	A 165		

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A 165	Continued From page 29 persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to report an adverse event as required within 1 business day after the occurrence of a medication error which required 1 (Resident #22) to be transferred to the hospital for further evaluation and treatment. The facility	A 165		

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A 165	Continued From page 30 failed to provide within 15 days, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. The findings included: Record review for Resident #22 revealed a Health Assessment Form 1823, signed and dated on , by the health care provider, indicating Resident #22 required assistance with self-administration of medications. Record review of the physician orders for Resident #22 revealed an order to "inject 10 units , once daily DEGL". On at 3:35 p.m., Resident #22 said the lady [MT Staff D] came in my room on to give me my . She fixed the needle and dialed the pen, then I injected it into my abdomen. I asked her why it was taking so long, usually it was very quick for the medicine to go in. She left and shortly she came , and they started giving me all kinds of sugar objects to offset it. They called the paramedics, and I had to go to the hospital even though I didn't want to. Resident #22 said, the girl dialed the wrong amount on the , . She told me she had not been trained. On at 11:20 a.m., during an interview, the Memory Care Director (MCD) said I don't know why an adverse event was not done for that. I just looked it up and I am killing myself for not doing one. On at 1:05 p.m., the Executive Director (ED) said the MCD calls me when there is a med error. Resident #22 got 50 units of instead	A 165		

Agency for Health Care Administration

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A 165	Continued From page 31 of 10 units as ordered. It was given by Staff D, Medication Technician. The ED said, I don't recall an adverse event being filed. I am assuming yes there should have been an adverse incident report filed. The MCD would have done that. Class III .	A 165		