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
	AL11969264	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE ASSISTED LIVING AND MEMORY COTTAG	2595 HARBOR BLVD PORT CHARLOTTE, FL 33952

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A 000	Initial Comments An unannounced emergency power plan monitoring, health facility reporting system, visitation form and complaint survey for #2024010689 , #2023014707, #2023005121, #2024002760, #2023007587,# 2024006335, #2024013818, #2023004578, was conducted on through , at Parkside Assisted living and Memory Cottage, an assisted living facility in Port Charlotte, Florida. Complaint #2024010689 was substantiated at A052, A056. Complaint #2023014707 was not substantiated. Complaint #2023005121 was substantiated without deficient practice Complaint #2024002760 was substantiated at A032. Complaint #2023007587 was not substantiated. Complaint #2024006335 was not substantiated. Complaint #2024013818 was substantiated at A032. Complaint #2023004578 was substantiated without deficient practice. 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	A 032		

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A 032	Continued From page 1 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 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	A 032		

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A 032	Continued From page 2 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. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure that residents deemed as an elopement risk, have identification on their persons that includes their name, the facility's name, address, and telephone number. The facility failed to implement and follow their elopement policy and procedure for identification on their persons for residents deemed as an elopement risk. The findings included: Requested and reviewed facility policy titled: Elopement protocol: Resident Elopement is defined as when a dependent resident in a licensed facility leaves that facility without staff observation or knowledge of their departure. . . . P.A.L.M.C. Protocol for: Memory care residents are not permitted to exit their neighborhood alone. Each Memory Care Resident has an I.D. bracelet on that is checked at every meal time, med pass, and visual checks every 2 hours. Requested and obtained a list of residents deemed as an elopement risk. On at 9:50 a.m., During an interview, the Wellness director	A 032		

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A 032	Continued From page 3 (WD), and Administrator said all 33 residents in the memory unit were deemed as an elopement risk. During Observation on at 10:00 a.m., in the facility's memory care unit, showed that none of the residents in the memory unit had any identification on their person that included their name, the facility's name, address and telephone number. During an interview with the Wellness Director on at 10:05 a.m. he confirmed that all the residents in the memory unit were deemed as an elopement risk, and none of them had any identification on their person that included their name, the facility's name, address and telephone number. During an interview with staff A Medication Technician on at 10:10 a.m., confirmed that all residents in the memory unit were deemed as an elopement risk and did not have any identification on their person that included their name, the facility's name, address and telephone number. During an interview with staff B Medication Technician on at 10:12 a.m., confirmed that all residents in the memory unit were deemed as an elopement risk, and did not have any identification on their person that included their name, the facility's name, address and telephone number. During an interview with staff C Medication Technician on at 10:14 a.m., confirmed that all residents in the memory unit were deemed as an elopement risk and did not have an identification on their person that included their	A 032		

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A 032	Continued From page 4 name and the facility's name, address and telephone number. During an interview with staff D Medication Technician on at 10:18 a.m., confirmed that all residents in the memory unit were deemed as elopement risk and did not have an identification on their person that included their name and the facility's name, address and telephone number. During an interview with administrator on at 8:02 a.m., he said that all residents in the memory unit should have their identification on their person. Second observation on at 8:15 a.m., Only 5 residents were observed having identification on their person. During an interview with the Wellness Director (WD) on at 8:20 a.m., he confirmed that only few residents had their identification on their person. The WD said they were in process on buying the permanent identifications. During an interview with the administrator on at 12:45 p.m. he confirmed that the facility failed to ensure the residents identified as an elopement risk had their identification on their person with their name, the facility's name, address and telephone number. Class III .	A 032		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin	A 052		

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A 052	Continued From page 5 429.256 (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 the dispensing cup of the .	A 052		

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A 052	Continued From page 6 (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 SELF-ADMINISTRATION.	A 052		

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A 052	Continued From page 7 (a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] 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 the facility, with this fact noted in the resident's	A 052		

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A 052	Continued From page 8 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, and interview, the facility failed to ensure staff who assist residents with self-administration of medications do so in accordance with proper procedure for 5 (Residents #13, #14, #15, #16, #17) of 5 medications observations. The findings included: Review of facility policy title: Assisted Living Facility (ALF) Policy for Assistance with Self-Administration of Medications. Purpose: To outline guidelines and procedures for assisting with self-administration of medications in compliance with Florida law, ensuring safe and accurate support in medication management for	A 052		

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A 052	Continued From page 9 ALF. . .Responsibilities . . 2. Permitted Assistance activities: Staff may assist with the following actions: Reminding the resident to take their medications at the appropriate time. . . Opening containers, including pill bottles, packs, and medication organizers. . . Reading medication labels to the resident. 1. On at 8:09 a.m., Med Tech Staff C was observed assisting Resident #14 with medications. Staff C rolled the med cart to where Resident #14 was seated in the dining room. Staff C removed Resident #14's medication from the medication cart and compared them to Resident #14's profile on the computer. Staff C placed the dose of each medication into a cup and handed the cup to the resident. Staff C said, "Here are your pills." Staff C did not inform Resident #14 what medications she was being given. 2. On at 8:23 a.m., Med Tech Staff C was observed assisting Resident #13 with medications. Staff C rolled the med cart to where Resident #13 was seated in the dining room. Staff C removed Resident #13's medication from the medication cart and compared them to Resident #13's profile on the computer. Staff C placed the dose of each medication into a cup and took the cup over to the resident. Staff C said, "Here are your meds." Placing the cup on the table in front of Resident #13 and said, "Could you take you pills for me please." Staff C did not inform Resident #13 what medications she was being given. 3. On at 8:30 a.m., Med Tech Staff C was observed assisting Resident #15 with medications. Staff C rolled the med cart to where Resident #15 was seated in the dining room. Staff C opened the med cart and compared the	A 052		

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A 052	Continued From page 10	A 052		

medications to Resident #15's profile on the computer. Staff C placed the dose for each medication into a cup and placed the cup on the table in front of Resident #15 and said, "Here are your pills." Staff C did not inform Resident #15 what medications she was being given.

4. On at 8:40 a.m., Med Tech Staff C was observed assisting Resident #16 with medications. Staff C rolled the med cart to where Resident #16 was seated in the dining room. Staff C opened the med cart and compared the medications to Resident #16's profile on the computer. Staff C placed the dose for each medication into a cup and placed the cup on the table in front of Resident #16 and said, "Here are your pills." Staff C did not inform Resident #16 what medications he was being given.

5. On at 5:50 a.m., Med Tech Staff C was observed assisting Resident #17 with medications. Staff C rolled the med cart to where Resident #17 was seated in the dining room. Staff C removed Resident #17's medication from the medication cart and compared them to Resident #17's profile on the computer. Staff C placed the dose of each medication into a cup and took the cup over to the resident. Staff C said, "Hello, I have your meds and spray which one do you want to take first?" Resident #17 replied, "This one." Pointing at the cup with the pills. Staff C med tech said, "Okay, here are your meds." Staff C did not inform Resident #17 what medications she was being given.

On at 8:51 a.m., during an interview, Med Tech Staff C said sometimes she does not tell some of the residents what meds they are being given as some don't understand. Med Tech Staff C confirmed she did not tell the residents what

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A 052	Continued From page 11 medications and dosages they were being given. Staff C confirmed they are supposed to tell the residents what medications they are being given. She said, "It's the first time she is on both the med carts." On at 9:40 a.m., during an interview, the HWD confirmed Staff C did not follow protocol and informed the residents what medication they were being given during the med pass. The HWD asked, "Does staff still have to tell the resident what medications they are being given if they don't understand?" Class III .	A 052		
A 056 SS=D	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.	A 056		

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A 056	Continued From page 12 (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; 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.	A 056		

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A 056	Continued From page 13 (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, 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 observation, interview, and record review, the facility failed to provide medications as ordered by the physician and ensure that prescriptions are ordered and or reordered in a timely manner and available for 3 (Resident #14, #15, and #16) of 5 residents reviewed. The findings included: Review of the policy titled: Medication Reordering policy 1. Purpose: Ensure that medications for all residents are reordered in a timely manner to avoid interruptions in treatment and maintain	A 056		

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	AL11969264	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 056	Continued From page 14 continuity of care. 2. Designated staff, such as medication technician or licensed nurse, is responsible for monitoring medication supplies and initiating reorders. . . . The ALF Administrator or healthcare supervisor overseas the reordering. 1. On at 8:09 a.m., Med Tech Staff C was observed assisting Resident #14 with medications. Staff C rolled the med cart to where resident # 14 was seated in the dining room. Staff C removed Resident #14's medication from the medication cart and compared them to Resident #14's profile on the computer. Staff C did not give Resident #14 all medications as ordered as the , 10 mg and , 125 mg were not available in the medication cart. On at 8:18 a.m., Staff C stated the , 10 mg and , 125 mg medications for Resident #14 are not available; she said "They are not in the cart." Staff C stated the Health and Wellness Director is supposed to follow up and make sure the medications are delivered form the pharmacy. On at 8:20 a.m., Staff C Med Tech was observed searching the cabinets and the bottom drawer of the med cart while in the medication room, looking for the 2 medications for Resident #14. Staff C said, "They are not here, there is no additional medications here in this room." Review of the Electronic Medication Administration Record (EMAR) for Resident #14 for the Month of , , and , failed to show Resident #14 received the following medications: : 20 9:00 unavailable. , : cream 5% 5:00 unavailable. Rosuvastatin 20 mg	A 056		

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A 056	Continued From page 15 8:00 unavailable. : , 10 mg , 9:00 unavailable, , sod ER 125 , , , , 9:00 not available, Nitrofuran mono 100 capsules 9:00 unavailable. 2. On at 8:30 a.m., Med Tech Staff C was observed assisting Resident #15 with medications. Staff C rolled the med cart to where Resident #15 was seated in the dining room. Staff C opened the med cart and compared the medications to Resident #15's profile on the computer. Resident #15 did not receive , 300 mg, , 5 mg, 1 gm as ordered as they were not available at the facility to be given. On //24 at 8:32 a.m., Staff C Med tech said, "I'll be honest, Resident #15 does not have all of her medications here to be given to her in the cart, she is missing some, she does not have them." On at 8:34 a.m., Staff C stated she requested a resupply of Resident #15's medications on and the pharmacy has not sent anything." Review of the Electronic Medication Administration Record (EMAR) for Resident #15 for the Month of , , and , failed to show Resident #15 received the following medications: : - 9:00 , 300, , 2.5 mg 9:00, sod cap 100 mg, Sod 1 gm, Torsemide 10 mg, med not available. Pot sol 10% (20 meq/15ml) , ,	A 056		

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A 056	Continued From page 16 , , med not available. D3 2000 u, , - , no staff initials documented to indicate medication was given as ordered by the physician. , : 9:00 , 300 mg not available, /- , - , - , 2.5.mg med unavailable, , no staff initials to indicate medication available or given. sod cap 100 mg - , - 9:00 medication not available. Pot sol 10% (20 meq/15ml) - , , med not available. Sod tab 1 gm , , - , - 9:00 med not available/waiting on pharmacy. no staff initials to indicate the medication was given as per physician orders. Torsemide 10 mg , , - , - 9:00 med not available. , , no staff initials documented to indicate medication given as per physician orders. d 3 2000u 9:00 not available, no staff initials documented to indicate medication given as per physician orders. : 9:00 , 300 mg, , 2.5 mg, 1gm, medication not available, 9;00 1 gm medication not available. 9:00 sol 10% (20 meq/15ml) medication not available. 3. On at 8:40 a.m., Med Tech Staff C was observed assisting Resident #16 with medications. Staff C rolled the med cart to where Resident #16 was seated in the dining room. Staff	A 056		

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A 056	Continued From page 17 C opened the med cart and compared the medications to Resident #16's profile on the computer. Resident #16 did not receive 10 mg as ordered as the medication was not available at the facility to be given. Review of the Electronic Medication Administration Record (EMAR) for Resident #16 for the Month of , , and , failed to show Resident #16 received the following medications: : 10 mg 9:00 , medication not available. On at 8:55 a.m., during an interview, Staff C Med Tech confirmed Residents #14, #15, and #16, did not receive all their medications as some of the meds were not available and not onsite in the cart to be given. She stated there are days when the residents don't have all their meds, and she documents not available on the Electronic Medication Administration Record (EMAR). She states they can reorder them from the EMAR and if they don't come, the Health and Wellness Director (HWD) is to follow up and find out why they did not come in. On at 10:30 a.m., during an interview, the HWD states he reaches out to the doctor if he is waiting on the pharmacy to send medication ordered and or reordered. The HWD confirmed there is no documentation for any of the residents observed for med pass with medications not available or onsite in the facility to indicate he contacted the pharmacy or physician when the medications were not available or onsite. The HWD said, "there is no documentation available." On at 10:50 a.m., during a review of the EMARS with medications documented as not	A 056		

Agency for Health Care Administration

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A 056	Continued From page 18 available for multiple days for the residents, the HWD confirmed some of the medications for Residents #14, #15, and #16 were not onsite at the facility to be given during the med pass. He said, "I will follow up." Class III .	A 056		