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 _____	R 01/07/2025

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 revisit survey was conducted on at The Goldton At Venice, an assisted living facility, in Nokomis, Florida. The follow-up was in response to the emergency power plan monitoring and complaint survey that was conducted on through . The following is the description of the deficiencies found at the time of the visit.	{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 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	{A 032}		

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{A 032}	Continued From page 1 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. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents deemed as an elopement risk, had identification on their person that included their name, the	{A 032}		

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{A 032}	Continued From page 2	{A 032}		

facility's name, address, and telephone number for 10 (Residents #2,#3, #13, #14, #6,#17,#20,#23, #25, #26) out of 11 residents reviewed and deemed as an elopement risk.

The findings included:

Atlas Senior Living Elopement or Missing Resident policy . Policy: Residents identified as being at risk for Elopement shall have wristbands on identifying the name of the community, address, and telephone number, QR code bracelets have been distributed for all residents at risk for elopement, placement and use of them verified daily by staff.

On at 8:19 a.m., during a tour of the memory care unit, observation of only 1 (Resident #21) out of 11 residents residing in the memory unit, wearing identification on their person, which included their name, the facility's name, address, and telephone number.

Medication assistance was observed on from 8:00 a.m. to 8:45 a.m. Staff L responsible for assisting residents with self administration of their medications failed to check on residents to ensure they had their identification bracelets on.

On at 8:57 a.m., during an interview Caregiver Staff B said that all 11 residents were supposed to have their identification on their person, but they take it off.

Requested and obtained a list of all residents deemed as elopement risk. All 11 residents residing in the facility's memory care unit were listed deemed as an elopement risk.

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{A 032}	Continued From page 3 On at 10:10 a.m., during an interview, the Administrator said, all the residents who resided in the facility's memory care unit are considered an elopement risk and are all supposed to have identification on their person as required. The Administrator stated that staff are responsible to check on their bracelet during morning med pass and ensure it is on. On at 10:30 a.m., during an interview, the Wellness Director confirmed that all residents in the memory unit were deemed as an elopement risk, and subsequently were to have their identification on their person at all times. He added that during morning med pass staff are to check on the residents and if they did not have it on they were to add it immediately. On at 2:32 p.m., during an interview, the Administrator confirmed 10 out of 11 residents that were deemed as an elopement risk did not have 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 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	{A 052}		

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{A 052}	Continued From page 4 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 . (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.	{A 052}		

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{A 052}	Continued From page 5 (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) 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	{A 052}		

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{A 052}	Continued From page 6 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 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	{A 052}		

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{A 052}	Continued From page 7 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 reviewed, and interview, the facility failed to ensure that facility's staff follow proper procedure when assisting residents with self-administration of medications for 3 (Residents #16, #21,#23) out of 3 medications observations. The findings included: Atlas Senior Living Assistance with Medications & Treatments updated . Policy Detail: the individual assisting or administering medications must verify the resident's identity before giving them their medications. Record review for Resident #23 revealed a Health Assessment Form 1823 signed and dated by the health care provider on , indicated Resident #23 required assistance with self-administration of medications. 1. On at 8:00 a.m., Medication Technician (Med Tech) Staff L was observed preparing	{A 052}		

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{A 052}	Continued From page 8 Resident #23's medications. Staff L proceeded to place Resident #23's oral medications into a souffle cup on the top of the med cart and observed mixing medications with a spoonful of chocolate pudding. Staff L walked over to Resident #23 sitting in the wheelchair and said to her, "I have your medications for you, please open your " then spooned the mixture of medication into Resident #23's . Staff L did not inform Resident #23 what medications she was being given, and spoon-fed/administered Resident #23 the medications. During the observation Staff L said she is not a licensed nurse. Record review of Resident #16's Health Assessment Form 1823 signed and dated by the health care provider on /24, indicated Resident #16 required assistance with self-administration of medications. 2. On at 8:25 a.m., Medication Technician (Med Tech) Staff L was observed preparing Resident #16's medications. Staff L checked orders and observed placing all medications belonged to Resident #16 in a souffle cup. Staff L crushed medications for Resident #16. Staff L proceeded to place Resident #16's oral medications into a souffle cup on the top of the medication cart and observed mixing medications with a spoonful of chocolate pudding. Staff L walked over to Resident #16 sitting in the wheelchair and said to her, "Here is your medications. Can you please open your ?" then spooned the mixture of medication into Resident #16's . Staff L did not inform Resident #16 what medications she was being given, and spoon-fed/administered Resident #16 the medications. During the observation Staff L said she is not a licensed nurse.	{A 052}		

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{A 052}	Continued From page 9 Record review of Resident #21 Health Assessment Form 1823 signed and dated by the health care provider on , indicated Resident #21 required assistance with self-administration of medications. 3. On at 8:45 a.m., Medication Technician (Med Tech) Staff L was observed preparing Resident #21's medications. Staff L checked orders and was observed placing medications that belonged to Resident #21 in a souffle cup. Staff L walked over to Resident #21 in the wheelchair and said to her, "Here is your medications. Can you please open your ?" then placed the liquid medication into Resident #21's . Staff L did not inform Resident #21 what medications she was being given, and administered Resident #21 the medication. During the observation Staff L said she is not a licensed nurse. Staff L proceeded to the next resident. On at 8:55 a.m., during an interview, Staff L confirmed she did not tell the residents what medications they were given and administered the medications as she spoon fed them to the residents. Staff L acknowledged that the facility did not have medication waivers and she was supposed to tell the residents the names of the medications with the dosages. On at 10:45 a.m., During an interview, the Wellness Director (WD) acknowledged that staff L did not follow proper procedure when assisting Resident #16, #21, #23 with self administration of their medications. The Wellness director acknowledged staff L was not a licensed nurse	{A 052}		

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{A 052}	Continued From page 10 and should not administer medications to Resident #16, #21, #23. The WD acknowledged that the facility did not have medication waivers and staff L was supposed to tell residents the names of the medications with the dosages. On at 2:05 p.m., during an interview, the Administrator acknowledged that staff L did not follow proper procedure when assisting Resident #16, #21, #23 with self administration of their medications. The Administrator acknowledged staff L was not a licensed nurse and should not administer medications to Resident #16, #21, #23. The Administrator acknowledged that the facility did not have medication waivers and staff L was supposed to tell the residents the names of the medications with the dosages. . Class III .	{A 052}		