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 |
|---|---|---|---|
| | AL11964343 | A. BUILDING: _____ B. WING _____ | 03/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SODALIS MERRITT ISLAND | 535 CROCKETT BLVD. MERRITT ISLAND, FL 32953 |

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| A 000 | Initial Comments<br><br>A complaint investigation (#2025002163) and a generator monitoring were conducted on at Sodalis Merritt Island. A deficiency was found at the time of the survey. | A 000 | | |
| A 025 SS=D | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.<br><br>59A-36.007 Resident Care Standards.<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:<br>(a) Monitoring of the quantity and quality of resident diets in accordance with Rule | A 025 | | |

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| A 025 | Continued From page 1<br><br>59A-36.012, F.A.C.<br>(b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interviews and record reviews the facility failed to follow facility policy, by not supervising, monitoring and securing controlled substance medications causing risk to all residents, including resident#1, whose medication was missing from the facility.<br><br>Findings:<br><br>In a review on of Resident#1's Medication Observation Records (MORs) and facility records, it confirmed Residents#1's physician's orders dated , for 120 tablets (2 cards) of , ER 15 mg, 1 tablet 4 x per day for acute , as needed. The review | A 025 | | |

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| A 025 | Continued From page 2<br><br>confirmed on , the facility received delivery from the pharmacy, 2 cards of 15 mg tablets count of 60 each equaled 120 tablets in total. The overnight shift med tech staff A observed the two cards at the nurses station desk at the facility. Staff A then picked the cards up and placed them in the med room on the file cabinet. Later during the night staff, A reports she had opened the door to place a work phone on the charger, and then did not recall if she left the door open or locked. She then left the nurses station to pass medications to other residents. At 6 am, the change of shift, staff E could not locate the 2 cards for resident#1. Resident #1 did not have any omission of medication, and a new order was delivered to the facility that morning.<br><br>In review of resident#1's record it showed an admission date of . A review of the health assessment dated revealed a medical history of , , II, , and , , , , . The resident is ambulatory with a walker, alert and oriented x 3 and needs assistance with medications. The resident need assistance with transferring only.<br><br>In a review of resident#1's MORs for the months of , , , , and , revealed the resident did not miss any medication times for her prescribed medications or 15 mg.<br><br>In review of Brevard County Sheriff's office report, it states on at approximately 9:47 am law enforcement responded to the facility call for a report of lost property. Upon arrival, the director of nursing stated at 7 am medication for a resident was missing. Staff A stated on at 6:am 120, 15mg tablets of | A 025 | | |

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| A 025 | Continued From page 3<br><br>prescribed to resident#1 was delivered to the facility. She stated the medication was not stored properly in the medication room, but was left unattended at the nurse's station, directly outside the medication room. She stated she observed the unattended medication when she charged her phone inside the medication room, so she placed it on the filing cabinet within. She admitted she left the room and medication in an unsecured unlocked area against facility policy. The room remained unlocked throughout the entire shift and staff A left the area to do a med pass in another area of the facility. Staff conducted a search of the facility, but the medication was never found. There are no cameras in the nurse's station or within the medication room.<br><br>In review of the facility policy for medication storage it states medication is to be immediately logged in by the nurse and placed into a medication cart. If a nurse is not available, then the staff are to take pictures of the medications and send them to the nurse by email or text. The medication room is supposed to be locked at all times.<br><br>In a review of the facility medication policy chain of command it states: Delivery of medications from pharmacy, sign manifest, count number of pills on card match manifest. Notify the director of nursing to add to drug count. Place medication in double-locked box med cart. Sign sheet into cart. The change of shift count is to be completed each cart signed off with witness. Med Techs are to take a picture on the manifest and pack and send to nurses on call who will put in system. Med Tech will sign into white binder and lock medication up. | A 025 | | |

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| A 025 | Continued From page 4<br><br>Review of the facility internal investigation- all carts searched, med room searched, all staff contacted on duty.<br>Guardian notified of diversion of , , new script to pharmacy, law enforcement contacted, staff drug tested, specimen removed from med room placed in different location, hinge placed on med room door to self-close, in-service on chain of custody of medication/ to all nursing staff, code to front door changed.<br><br>In an interview on at 11:30am, Resident #1 stated she did not miss any medication due to the incident. She stated she was made aware of the incident right away that day and the facility reordered the medications from the pharmacy right away when they found out the medication was missing. She stated she is self-sufficient and can make her needs known to staff. She stated she does not have any family or guardian, and she takes care of herself financially and otherwise. She stated she receives high quality of care from the facility and does not have any concerns or issues at this time.<br><br>In an interview on at 11:50am Staff F stated the med tech can accept the from the pharmacy, but the medications are to be locked in the med room for the nurse to log in. If a nurse is not available, then we take a picture and email the nurse. She stated she is not sure why staff A did not lock the medications up until a nurse could count them and log them in. She stated the facility and nurses' station was searched but the medication cards were never found.<br><br>In an interview on at 12pm Staff E stated are counted on each shift and | A 025 | | |

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| A 025 | Continued From page 5 | A 025 | | |

audited monthly. She stated the nurse usually logs them in. She stated staff A logged the in for resident #1 but never put the medication in the locked cart. She stated unlicensed staff are not supposed to log in only nurses. She stated the medications have never been found and the facility was searched from top to bottom.

In an interview on at 1pm with the director of nursing (DON) she stated staff A no longer works at the facility and the entire staff involved had an in-service for medication storage and were written up. She stated all staff involved were drug tested and tested negative. She stated she installed locks on the med room and nurses' station that now lock immediately. She stated staff A accepted the medications from the pharmacy and should not have counted them, she should have notified the nurse and locked in the med cart. She stated staff A logged in which she should not have been doing. She stated Resident #1 never missed any doses. She stated it was reported to the police but not the department of children and families as she did not think it was necessary. She stated the unlicensed staff check the now on each shift change and the director of nursing audits monthly. She stated it was a failed chain of custody. She stated the med techs only count medication but cannot add to the count. and always by 2 med techs. She stated staff A did not follow facility policy on counting the medications or storage of medication. She stated she confirms all the above information and has made improvements to prevent this from happening again.

Photographic evidence taken

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| A 025 | Continued From page 6<br>Class III | A 025 | | |