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 _____	R 03/24/2025

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

(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 Parkside Assisted Living and Memory Cottage LLC, an assisted living facility in Port Charlotte, Florida. The follow-up was in response to the emergency power plan monitoring, health facility reporting system, visitation form and complaint survey completed on , and the revisit survey by desk review completed on . The following is a description of the deficiencies at the time of the survey. .	{A 000}		
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 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	A 052		

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A 052	Continued From page 1 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 ˬ 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 ˬ 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 ˬ 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	A 052		

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A 052	Continued From page 2 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 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	A 052		

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A 052	Continued From page 3 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 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.	A 052		

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A 052	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on record review, 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 #14, #25, #26, #27, and #28) of 5 medication observations. The findings included: Review of facility policy title: Policy for Assistance with Self-Administration of Medications. Purpose: To establish guidelines for assisting residents with the self-administration of medications in compliance with Florida law and to ensure resident safety while promoting independence. . .Procedures . . 2. Permitted Assistance: Staff may assist with self-administration of medications by: Reminding the resident to take their medications at the prescribed time. Bringing the ,medication container to the resident. Reading the medication label to the resident.. Opening medication containers (excluding medication that requires special preparation such as injections)." 1. On at 8:20 a.m., Med Tech Staff E was observed assisting Resident #25 with medications. Staff E rolled the med cart to where Resident #25 was seated in the dining room. Staff E removed Resident #25's medication from the medication cart and placed the dose of each medication into a cup and handed the cup to Resident #25. Staff E did not perform hygiene prior to or after assisting Resident #25 with medications. Staff E proceeded to the next resident. 2. On at 8:30 a.m., Med Tech Staff E was	A 052		

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A 052	Continued From page 5 observed assisting Resident #14 with medications. Staff E rolled the med cart to where Resident #14 was seated in the dining room. Staff E removed Resident #14's medication from the medication cart and placed the dose of each medication into a cup and handed the cup to Resident #14. Staff E did not perform hygiene prior to or after assisting Resident #14 with medications. Staff E proceeded to the next resident. 3. On at 8:45 a.m., Med Tech Staff E was observed assisting Resident #26 with medications. Staff E rolled the med cart to where Resident #26 was seated in the dining room. Staff E removed Resident #26's medication from the medication cart and placed the dose of each medication into a cup and handed the cup to Resident #26. Staff E did not perform hygiene prior to or after assisting Resident #26 with medications. Staff E proceeded to the next resident. 4. On at 8:55 a.m., Med Tech Staff E was observed assisting Resident #27 with medications. Staff E rolled the med cart to where Resident #27 was seated in the dining room. Staff E opened the med cart and compared the medications to Resident #27's profile on the computer. Staff E placed the dose for each medication into a cup, crushed the medications and added vanilla pudding to the cup stirring the mixture. Staff E said to Resident #27, "I have some pudding for you." Staff E spoon fed the mixture with the medications into Resident #27's . Staff E did not inform Resident #27 what medications he was being given. Staff E did not perform hygiene before or after assisting Resident #27 with medications. Staff E administered Resident #27 medications. Staff E	A 052		

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A 052	Continued From page 6 proceeded to the next resident. 5. On at 9:05 a.m., Med Tech Staff E was observed assisting Resident #28 with medications. Staff E rolled the med cart to where Resident #28 was seated in the dining room. Staff E removed Resident #28's medication from the medication cart and compared them to Resident #28's profile on the computer. Staff E placed the dose for each medication into a cup, crushed the medications and added vanilla pudding to the cup stirring the mixture. Staff E spoon fed the mixture with the medications into Resident #28's . Staff E did not perform hygiene before or after assisting Resident #28 with medications. Staff E administered Resident #28 medications. Staff E proceeded to the next resident. On at 9:15 a.m., during an interview, Med Tech Staff E confirmed she did not perform hygiene before, between and after assisting Residents #14, #25, #26, #27, and #28 with medications. Staff E stated, "I spoon feed the resident the medications as there are some resident that when you give them the meds they won't take them. Staff E confirmed administering the medications to Resident #27 and #28 and not assisting them with the meds. Staff E stated, "I know I'm not supposed to spoon feed the residents." On at 9:20 a.m., during an interview, the Health and Wellness Coordinator (HWC) said the med techs should have Base Rub (ABHR) on the carts for hygiene use before, in between and after giving resident the medications. The HWC stated, "the med techs are allowed to administer medications as long as they are prescribed by the physician, and the med techs can spoon feed residents the medications	A 052		

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A 052	Continued From page 7 when they are crushed. The HWC stated, "I worked at Windsor and all the med techs there spoon fed and administered medications and I was never cited for it during my surveys." The HWC said she did not know med techs could not spoon feed resident medications or administer medications to residents. The HWC confirmed Staff E did follow proper procedure when assisting with the med pass. On at 9:28 a.m., during an interview the Administrator said the HWC is responsible for the Med Techs, and the process when assisting with medications for med techs includes washing their , comparing the meds with the resident profile, telling the residents what meds they are being given and what they are for and assisting to . The Administrator stated, "med techs cannot spoon feed resident medications that is administering, and med techs are not allowed to administer medications." 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:	{A 056}		

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{A 056}	Continued From page 8 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. (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	{A 056}		

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{A 056}	Continued From page 9	{A 056}		

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.
(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 7 (Residents #1,

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{A 056}	Continued From page 10 #14, #16, #25, #26, #27, and #28), of 7 residents reviewed. The findings included: 1. On at 8:26 a.m., during an interview, Med Tech Staff E said Resident #1 is missing her B, it is not in the cart. Review of the Medication Administration Record for Resident #1 for the Month of and failed to show Resident #1 received the following physician ordered medications: , 0.5 mg marked as waiting on refill on - , prescription expired, gave last one on . Ferosul 325 mg marked as waiting on pharmacy , prescription expired waiting on refills on - , , - . Marked on hold with no reason why on ; , , , - , , marked as prescription expired waiting on refills. D3 50,000 units-caps marked reorder on , refill on , waiting on pharmacy on C 1000 mg marked as waiting on pharmacy, waiting for refills on , , , , , , , , , , , , , and , . , 10 mg, no staff initials documented to indicate if medication was given on for 7:00 p.m.	{A 056}		

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{A 056}	Continued From page 11	{A 056}		

, 5 mg, no staff initials documented to indicate if medication was given on .

600 mg marked as waiting for recycle meds on .

10 mg marked as not in the cart, waiting on refills on , , , .

50 mg marked as waiting on refills, waiting on pharmacy , .

2. Review of the Medication Administration Record for Resident #14 for the Month of , and failed to show Resident #14 received the following physician ordered medications:

, 500 mg waiting on pharmacy on .

gel 1% waiting on pharmacy on , , and waiting for refill on .

3. Review of the Medication Administration Record for Resident #16 for the Month of , and failed to show Resident #16 received the following physician ordered medications:

, 81 milligrams (mg), on , waiting on pharmacy, resupply ordered, waiting on delivery, and . Marked on hold with no reason why.

Boost original-5688 waiting on refills on .

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{A 056}	Continued From page 12 , 125 mg, waiting on refills on , and . 10 mg, marked as waiting on refill on , resupply ordered on , on hold with no reason why, on . 4. Review of the Medication Administration Record for Resident #25 for the Month of , and failed to show Resident #25 received the following physician ordered medications: Trulance 3 mg marked as waiting on medication on . 5. Review of the Medication Administration Record for Resident #26 for the Month of , and failed to show Resident #26 received the following physician ordered medications: Brenzavvy 20 mg marked as Guardian does not provide this medication, waiting on POA to provide on . Dapagliflozl 10 mg request resupply on , , 25 mg request resupply on request resupply. , 50 mg no staff initials documented to indicate if medication was given on ; and is marked as waiting on pharmacy. 6. Review of the Medication Administration	{A 056}		

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{A 056}	Continued From page 13 Record for Resident #27 for the Month of and failed to show Resident #27 received the following physician ordered medications: , 81 mg marked as waiting arrival on . , . 5 mg meds not in cart on . . 5 mg meds not in cart on , no staff initials documented to indicate if medication was given on and for 5:00 p.m. 40 mg meds not in cart on . 7. Review of the Medication Administration Record for Resident #28 for the Month of and failed to show Resident #28 received the following physician ordered medications: 150 mcg marked as waiting on order on . On at 10:25 a.m., during an interview, the Executive Director confirmed some of the physician ordered medications for Residents #1, #14, #16, #25, #26, #27, #28 were not administered as they were waiting on the pharmacy. Class III .	{A 056}		