

Agency for Health Care Administration

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969303</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/09/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MORNINGSIDE HOUSE OF SARASOTA</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5851 N HONORE AVE<br/>SARASOTA, FL 34231</b>                                 |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                                    | Initial Comments<br><br>An unannounced CHOW, limited nursing services, emergency power plan monitoring, visitation form, and complaint survey for complaint #2024014188 was conducted on at Morningside House Of Sarasota, an assisted living facility in Sarasota, Florida.<br><br>Complaint #2024014188 was substantiated without citation.<br><br>The following is a description of the deficiencies:<br>.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | A 000                                                                          |                                                                                                                          |  |                                                        |
| A 052<br>SS=D                                                            | 429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin<br><br>429.256<br>(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.<br>(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 | A 052                                                                          |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Agency for Health Care Administration

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                          |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969303</b>           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/09/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MORNINGSIDE HOUSE OF SARASOTA</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5851 N HONORE AVE<br/>SARASOTA, FL 34231</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 052                                                                    | Continued From page 1<br><br>resident's medications or dosages change.<br>(c) Placing an oral dosage in the resident's<br>or placing the dosage in another container and<br>helping the resident by lifting the container to his<br>or her<br>(d) Applying , medications.<br>(e) Returning the medication container to proper<br>storage.<br>(f) Keeping a record of when a resident receives<br>assistance with self-administration under this<br>section.<br>(g) Assisting with the use of a , including<br>removing the cap of a , opening the unit<br>dose of solution, and pouring the<br>prescribed premeasured dose of medication into<br>the dispensing cup of the<br>(4) Assistance with self-administration of<br>medication does not include:<br>(a) Mixing, , converting, or<br>medication doses, except for<br>measuring a prescribed amount of liquid<br>medication or breaking a scored tablet or<br>crushing a tablet as prescribed.<br>(b) The preparation of syringes for injection or the<br>administration of medications by any injectable<br>route.<br>(c) Administration of medications by way of a tube<br>inserted in a , of the body.<br>(d) Administration of , preparations.<br>(e) The use of irrigations or debriding agents<br>used in the treatment of a skin condition.<br>(f) Assisting with , or<br>preparations.<br>(g) Assisting with medications ordered by the<br>physician or health care professional with<br>prescriptive authority to be given "as needed,"<br>unless the order is written with specific<br>parameters that preclude independent judgment<br>on the part of the unlicensed person, and the | A 052                                                                                    |                                                                                                                          |                                                        |

Agency for Health Care Administration

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                                                                          |                          |                                                        |
|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969303</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/09/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MORNINGSIDE HOUSE OF SARASOTA</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5851 N HONORE AVE<br/>SARASOTA, FL 34231</b>                                 |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 052                                                                    | <p>Continued From page 2</p> <p>resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.</p> <p>(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.</p> <p>(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.</p> <p>59A-36.008<br/>(3) ASSISTANCE WITH SELF-ADMINISTRATION.<br/>(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.<br/>(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.<br/>(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.<br/>(d) Trained staff must observe the resident take</p> | A 052                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                          |                          |                                                        |
|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969303</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/09/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MORNINGSIDE HOUSE OF SARASOTA</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5851 N HONORE AVE<br/>SARASOTA, FL 34231</b>                                 |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 052                                                                    | <p>Continued From page 3</p> <p>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.</p> <p>(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:</p> <ol style="list-style-type: none"> <li>1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,</li> <li>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,</li> <li>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</li> <li>4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.</li> </ol> <p>(f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S.</p> <p>(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.</p> <p>(h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.</p> <p>This Statute or Rule is not met as evidenced by:</p> | A 052                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                          |                          |                                                        |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969303</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/09/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MORNINGSIDE HOUSE OF SARASOTA</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5851 N HONORE AVE<br/>SARASOTA, FL 34231</b>                                 |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 052                                                                    | <p>Continued From page 4</p> <p>Based on observations, record review, and interview, the facility failed to ensure that staff who assist with self-administration of medication do so in a proper procedure for 2 (Resident #8, and #10) of 3 residents observed.</p> <p>The findings included:</p> <p>On            at 1:03 p.m., Medication Technician (MT) Staff C was observed preparing Resident #8's medications. Staff C crushed Resident #8's            tablet 0.5mg (milligram) and put the medication into a medication cup (med cup). Staff C then put applesauce into the med cup and mixed it with a spoon. Staff C then entered the room with Resident #8's medications and orally advised the resident of the medication given then proceeded to spoon-feed Resident #2 her medication while lying in bed. Staff C then proceeded to administer 1 pre-filled syringe of            solution 100/5ML            to Resident #8. The prescriber's directions were to take 2 syringes of 0.25 ml (for a total of 0.5ml's = 10mg) by            /            , every four hours.</p> <p>On            at 1:13 p.m., MT Staff C was observed preparing Resident #10's medication. Staff C crushed Resident #10's            (            ) tablet 50mg and put the medication into a med cup. Staff C then put applesauce into the med cup and mixed it with a spoon. Staff C then entered the room with Resident #10's medication and after orally advising the resident, proceeded to spoon-feed Resident #10 her medication.</p> <p>During an interview on            at 3:15 p.m., the Executive Director confirmed that unlicensed MT Staff C should not have administered the medications for Residents #8 and #10. The</p> | A 052                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969303</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/09/2025</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**MORNINGSIDE HOUSE OF SARASOTA**

**5851 N HONORE AVE  
SARASOTA, FL 34231**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 052                    | Continued From page 5<br><br>Executive Director confirmed that the medication syringes are pre-filled, and that Resident #8 should have been given 2 syringes of medication.<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A 052               |                                                                                                                          |                          |
| A 053<br>SS=D            | 59A-36.008(4) FAC Medication - Administration<br><br>(4) MEDICATION ADMINISTRATION.<br>(a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label.<br>(b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record.<br>(c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff.<br>(d) A facility that performs clinical laboratory tests for residents, including _____ testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if | A 053               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                          |                          |                                                        |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969303</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/09/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MORNINGSIDE HOUSE OF SARASOTA</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5851 N HONORE AVE<br/>SARASOTA, FL 34231</b>                                 |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 053                                                                    | <p>Continued From page 6</p> <p>facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500.</p> <p>This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview, the facility failed to ensure that unlicensed staff who assist with self administration of medications, follow facility policy and procedures, and physician orders during medication observation for 1 (Resident #8) of 3 residents observed.</p> <p>The findings included:</p> <p>Record review of facility policy titled Policy No. 240, "Administration of Medication", dated . . . , stated:</p> <p>4. Compare eMAR to Resident's medications. Medication label should be read and compared to eMAR a total of three times prior to administration: ensuring right medication for correct resident, right dose, right route, and the right time.</p> <p>6. Observe that all medication is taken as prescribed.</p> <p>Record review on . . . of Medication orders for Resident #8 showed an order for . . . solution (sul sol) 100/5ml. The prescriber's directions were to take 2 syringes of 0.25ml (for a total of 0.5ml's = 10mg) by . . . / . . . every four hours.</p> | A 053                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                          |                          |                                                        |
|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969303</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/09/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MORNINGSIDE HOUSE OF SARASOTA</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5851 N HONORE AVE<br/>SARASOTA, FL 34231</b>                                 |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 053                                                                    | <p>Continued From page 7</p> <p>On            at 1:03 p.m., Medication Technician (MT) Staff C was observed preparing Resident #8's medications. Staff C then proceeded to administer 1 pre-filled syringe of            solution 100/5mL            to Resident #8, instead of 2 syringes as ordered.</p> <p>During an interview on            at 3:15 p.m., the Executive Director confirmed that the medication syringes are pre-filled, and that Resident #8 should have been given 2 syringes of medication. The Executive Director acknowledged Medication Technicians are not to administer medications.</p> <p>Class III</p> | A 053                                                                          |                                                                                                                          |                          |                                                        |