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
	AL11968599	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS RESIDENCE	700 E WELCH RD APOPKA, FL 32712

(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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	CZ814		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 4 sampled staff (C) had a new level 2 background screening after having had a break in service from a position that required level 2 screening for more than 90 days. Findings: A review of caregiver C's personnel record revealed an employment agreement that was effective on . The caregiver's most recent eligible background screening was . Review of the caregiver's employment application revealed only this facility was listed under former employers from to . Review of the facility's background clearinghouse on at 10 am revealed the caregiver's employment end date at this facility was .	CZ814		

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CZ814	Continued From page 2 On at 2:28 PM, the co-owner said caregiver C stopped working in for medical reasons. The co-owner then said the caregiver did work a couple of days since then and before her rehire. A request was made to review the caregiver's timesheets for those couple of days. The assistant administrator provided what she identified as those timesheets then left with the paper. On at 2:43 PM, caregiver C said she did not work anywhere since . On at 2:54 PM, caregiver C called the AHCA surveyor and said after checking her records she determined her last days worked at the facility were , , and . On at 3:20 PM, the assistant administrator was told what the caregiver said about the last three days she worked, and a request was made to see the timesheet again. The assistant administrator said after she and the co-owner reviewed it further, they determined the timesheet was wrong and there was no documentation of the caregiver working beyond those dates. Unclassified	CZ814		
CZ821 SS=D	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider	CZ821		

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CZ821	Continued From page 3 type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form	CZ821		

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CZ821	Continued From page 4 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPo	CZ821		

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CZ821	Continued From page 5 rtal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may	CZ821		

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CZ821	Continued From page 6 contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit a preliminary report within 1 business day and a full report within 15 calendar days to the Agency for Healthcare Administration (AHCA) after law enforcement responded to the facility over a dispute over medication for 1 of 1 sampled resident (#15.) Findings: Review of resident #15's record revealed a facility admission date of and discharge date of . On at 1:49 PM, resident #15's family member said the facility did not return all the resident's medications when she moved out. The family member said when they first asked the co-owner for them, the co-owner said the caregivers were having a huddle in the medication room so the co-owner could not retrieve the medications. The family member said they asked for them again on the day they removed the resident's belongings, and the co-owner said she could not find them. The family member said law enforcement went to the facility and asked the co-owner for them. A facility note indicated that all medications on and a pill box were given to the resident's family. The family member contacted the local sheriff's office to report that the resident did not receive the remainder of , 6 mg tablets.	CZ821		

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CZ821	Continued From page 7 On at 11:46 AM, in response to a request to see the preliminary and final reports submitted to AHCA when law enforcement responded over the medications, the administrator said AHCA was not informed because the police did not write a report. On at 3:30 PM, the administrator said the resident's family member alleged the facility stole the resident's medications, hence the reason for law enforcement responding to the facility. A call for service summary report indicated that on at 4:37:01 PM, law enforcement responded to the facility due to a dispute between relatives of prior resident and assisted living staff over medication. Staff advised medication may have been disposed of or used but it was not there. Unclassified	CZ821		
A 000	Initial Comments A complaint investigation (2025002191) was conducted at Wellsprings Residence on and . The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to	A 025		

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A 025	Continued From page 8 such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian,	A 025		

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A 025	Continued From page 9 health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility gave medications that were not prescribed by a health care provider to 1 of 12 sampled residents (#15.) Findings: Review of resident #15's record revealed a facility admission date of and discharge date of . A health assessment form (1823) revealed the resident's medical history included , and she needed assistance with self-administration of medications. On at 1:49 PM, resident #15's family member said the facility gave the resident and D that was not prescribed by a health care provider and gave the resident the wrong dose of , . The family member said the resident experienced stress as a result of this. A , health care provider's medication list indicated that from to the resident should have received , 12 mg at bedtime and from to present 16 mg at bedtime. Review of the residents' , and	A 025		

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A 025	Continued From page 10 medication observation records (MOR) revealed the resident was given the following medications with the prescriber listed as doctor G: to - , 6 mg every morning to - , 16 mg every bedtime to - one tablet every day to - D one capsule every day On at 11:01 AM, the pharmacy technician said the and D were filled based on the medication list, not a doctor's order, sent from the facility. A pharmacy medication profile indicated that the resident was prescribed , 6 mg every morning and 8 mg at bedtime, one tablet every day, and D3 2,000 units daily. The prescribing health care provider was doctor G. On at 11:14 AM, medical assistant F at doctor G's office said resident #15 was never doctor G's patient. On at 1:38 PM, the findings were discussed with the facility's administrator and with the co-owner. Specifically, there was no valid order for the , 6 mg every morning and 16 mg at bedtime from to and no valid orders for the and D. The co-owner's response was, "what we have is what we got. Whatever's written down." On at 4:39 PM, Doctor G said he never saw resident #15 and never prescribed medication for her. Class III	A 025		

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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 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	A 052		

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A 052	Continued From page 12 prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008	A 052		

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A 052	Continued From page 13 (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 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	A 052		

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(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 052	Continued From page 14 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. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the unlicensed staff (B) who assisted 5 of 5 sampled residents with medications orally advised the resident of the medication name and dosage (#3, 6, 7, 8, 9.) Findings: On at 9:09 am, resident #3 stated the facility does my meds. I don't know the name of the staff, but I know it's not the nurse. They don't tell me what I'm taking and I'm fine with that. I go to the room out there (referring to the medication	A 052		

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	AL11968599	A. BUILDING: _____ B. WING _____	03/26/2025

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WELLSPRINGS RESIDENCE	700 E WELCH RD APOPKA, FL 32712

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A 052	Continued From page 15 room) to get my medicine, and they just me a medicine cup. On at 11:25 AM, unlicensed caregiver B said she assisted residents with medications. She said when she did, she told each resident what kind of medication they were taking and the dosage. On at 12:30 PM, the facility's co-owner, who was a registered nurse, wrote the name of residents #3, 6, 7, 8, and 9 on the bottom of a souffle cup. She then pre-poured the following medications for each one then secured them inside the medication room: Resident #3- 25 mg and 1 mg Resident #6- 25 mg and 25 mg Resident #7- 25 mg and 500 mg Resident #8- 25 mg and 500 mg Resident #9- 250 mg On at 1:20 PM, unlicensed caregiver B carried a tray with all their pre-poured souffle cups. She approached resident #6 and said, "I got your meds." She then handed the liquid medication mixture to the resident, who took it without help. The co-owner was present. On at 1:22 PM, caregiver B said to resident #7, "here you go." The resident took the medications without help. The co-owner, who had been present, walked outside, retrieved the mail then returned inside and sat in a chair approximately 10 away.	A 052		

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A 052	Continued From page 16 On at 1:24 PM, caregiver B said to resident #8, "I have your one o'clock med. That's your one o'clock med." The resident took them without help. The co-owner remained in the chair she sat in when she came inside. On at 1:26 PM, caregiver B said to resident #3, "have a seat. Here you go. You got your spray." The resident took the pills and administered the spray without help. This took place in the resident's room and the co-owner was not present. On at 1:27 PM, caregiver B said to resident #9, "I bring you your meds." The co-owner entered the room. The caregiver lifted the souffle cup to reveal it had the resident's name on it. She then handed a cup of medication liquid to the resident. The co-owner left the room. The resident put the liquid in his without help. On at 2:05 pm, the observations were discussed with the co-owner. The co-owner said the caregiver did not have to because the co-owner poured them, and the caregiver only took them to and watched each resident take them. The co-owner then said also because she was present each time. The agency for healthcare administration (AHCA) surveyor reminded her of the times she was either not present or walked away. She responded by saying she was on the phone the entire time with the administrator and told him every time the caregiver gave a medication so he could verify she was in fact present. On at 9:44 AM, resident #9 when asked if staff told him the name and dosage of his	A 052		

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A 052	Continued From page 17 medications replied, "they just give it to me and expect me to take it. They don't usually tell me." On at 10:34 AM, caregiver B said she did not tell each resident the name and dosage of their medications because she did not pour them, the co-owner did. On at 3:30 PM, the co-owner said none of the residents had a waiver indicating they did not want the name and dosage of their medications told to them. The AHCA surveyor asked the co-owner why she did not give the medications since she prepared them or why the unlicensed caregivers were not allowed to prepare them. The administrator, who was on speaker phone, spoke up and said the caregivers were not allowed to prepare them because the facility was under such scrutiny by AHCA so the facility was trying to do the process in a way in which a nurse could do. He then said the co-owner did not do the entire process herself because as a nurse she was allowed to delegate the task of handing out the medications to the caregivers at her discretion. He said that the process was more efficient for the facility. Reviews of resident #3's, 6's, 7's, 8's and 9's record revealed they all needed assistance with self-administration of medications. Class III	A 052		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage	A 055		

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A 055	Continued From page 18 residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by	A 055		

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A 055	Continued From page 19 being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.	A 055		

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A 055	Continued From page 20 (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow its policy regarding destruction of medications for 3 of 3 sampled residents (#11, 12, 13.) Findings: Review of resident #11's record revealed a facility note that indicated the resident in a hospice inpatient unit. The family refused the remainder of the resident's medications, so they were destroyed/discarded per policy. Review of resident #12's record revealed a facility note that indicated the resident , on while in the hospital. A note indicated the family refused the remaining medications, so they were destroyed/discarded. Review of resident #13's record revealed a facility note that indicated the resident was transferred from the hospital to a hospice inpatient unit. A note indicated the family refused the remaining medications, so they were destroyed/discarded. The facility's undated policy "medications left behind by a resident," indicated if a resident the prescription medications were to be destroyed. The designated staff person and another adult witness who was not a resident returns the medication to the dispensing	A 055		

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A 055	Continued From page 21 pharmacy for disposal or disposes of the medication in a medical waste receptacle. The designated staff person and witness will document destruction on the centrally stored medication record. There was no centrally stored medication record to indicate the facility followed its policy when resident #11's, 12's, and 13's medications were destroyed/discarded. On at 11:01 AM, the pharmacy technician said the pharmacy never destroyed medications with or for the facility. On at 1:35 PM, the findings were discussed with both the co-owner and the administrator. No additional documentation regarding this was provided. Class III	A 055		