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 |
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| | AL11964707 | A. BUILDING: _____ B. WING _____ | 04/28/2025 |

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| INDIGO PALMS | 570 NATIONAL HEALTH CARE DRIVE DAYTONA BEACH, FL 32114 |

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| A 000 | Initial Comments<br><br>A complaint investigation (complaint numbers 2024014442, 2024015242, 2024015632, 2024016803 and 2025002411) was conducted at Indigo Palms from to . The facility had deficiencies at the time of the survey. | A 000 | | |
| A 031 | 59A-36.007(6) FAC Resident Care - Third Party Services<br><br>(6) THIRD PARTY SERVICES.<br>(a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided.<br>(b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs.<br>(c) The administrator or designee must ensure that:<br>1. Care coordination includes documented communications about the resident's condition | A 031 | | |

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| A 031 | Continued From page 1<br><br>and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility;<br>2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and<br>3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition.<br>4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3.<br>(d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on a review of resident records and interviews with staff, the facility failed to document efforts to coordinate with third party providers for | A 031 | | |

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| A 031 | Continued From page 2<br><br>2 of 5 residents whose medication records were reviewed (Resident 3 and 4).<br><br>The findings include:<br><br>1. Record review for Resident 3 revealed he was admitted on . An AHCA form 1823 (Resident Health Assessment) dated noted diagnoses including , , high , , left , / . Resident 3 was noted with reduced mobility, and . He required assistance with activities of daily living and with the self-administration of his medication.<br><br>Review of the electronic medication observation records (eMOR) for Resident 3 revealed a physician's order dated for Plus 8. milligram (mg) tablets, take 1 twice daily. Of the 45 opportunities between to , all doses were initialed and circled (which indicated the resident did not receive the medication) except 1 of 2 doses on , which did not include any signature. Corresponding administration notes reflect the medication was not received due to "physically unable to take" or "resident refused". Photographic evidence was obtained.<br><br>Resident 3 had an order for 50 mg three times a day dated . Of the 67 dosing opportunities between to , all were circled but 12 doses: 2 with no signature on and , and only 10 doses signed as given. Administration notes reflected the medication was not received due to "physically unable to take" or "resident refused." Photographic evidence was obtained. | A 031 | | |

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| A 031 | Continued From page 3<br><br>2. Review of Resident 4's record and eMOR found she had physician's orders to receive the following:<br><br>325 milligrams (mg) daily, ordered . The administration record revealed the signature boxes on the eMOR were circled and initialed by staff. Explanations noted Resident 4 had refused all doses on , , 2, 3, 4, 5, 14, 15, 16 and 17, 2025. Photographic evidence obtained.<br><br>The eMOR for spray 50 micrograms, instill 1 spray in each nostril twice daily (ordered ) revealed the signature boxes were circled on , (9:00 am and 6:00 pm dose), , (9:00 am), , and 11 (6:00 pm), , and 13 (both doses) and , (9:00 am). Administration notes either reported the resident refused or was physically unable to take the medication. Photographic evidence obtained.<br><br>, , spray ( spray to treat ) 0.06%, instill two sprays in each nostril twice daily 9:00 am and 6:00 pm was ordered on . The , eMOR reflected 22 out of 24 doses thus far in were noted with resident refusal or that she was physically unable to take the medication. Photographic evidence obtained.<br><br>An order for a , 5% , daily 12 hours on and 12 hours off dated . For 18 of 23 days in , , administration notes either reported the resident refused or was physically unable to take the medication. Photographic evidence was obtained.<br><br>Record review for Resident 4 revealed an 1823 | A 031 | | |

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| A 031 | Continued From page 4<br><br>dated that noted diagnoses including , , , , , and iron deficiency. She had short term memory problems and required assistance with the self-administration of her medications. A note on the form instructs: 'Needs to be watched to make sure she takes all meds.' Photographic evidence was obtained. Further review of the record found no documentation correspondence that the physician had been made aware of the multiple medication omissions.<br><br>An interview was conducted with the Medication Technician Supervisor (MTS) on at 12:00 pm. She was asked about the omissions on the MORs for Residents 3 and 4. She explained that Resident 3's family member brought in his medications and took him out to his personal primary doctor. This family member did not want Resident 3 taking the because it made him less lucid. The medication was in the facility, but family wanted it discontinued. The MTS acknowledged their records did it reflect any correspondence with the physician about missed medications.<br><br>The MTS continued, explaining Resident 4 refused all sprays. She refused the because she said it gave her . The MTS said the was expensive and likely not covered by insurance; family probably refused to pay for it. She assumed the resident's doctor knew this. The MTS acknowledged in situations when medications were not being given as ordered, the record should reflect communication with the prescribers.<br><br>During an interview with the Clinical Director on | A 031 | | |

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| A 031 | Continued From page 5<br>at 4:46 pm, she acknowledged the findings.<br><br>Class III | A 031 | | |
| A 052 | 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 resident's medications or dosages change.<br>(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<br>(d) Applying , medications.<br>(e) Returning the medication container to proper storage. | A 052 | | |

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| A 052 | Continued From page 6<br><br>(f) Keeping a record of when a resident receives assistance with self-administration under this section.<br>(g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the .<br>(4) Assistance with self-administration of medication does not include:<br>(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.<br>(b) The preparation of syringes for injection or the administration of medications by any injectable route.<br>(c) Administration of medications by way of a tube inserted in a of the body.<br>(d) Administration of preparations.<br>(e) The use of irrigations or debriding agents used in the treatment of a skin condition.<br>(f) Assisting with , , or preparations.<br>(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.<br>(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. | A 052 | | |

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| A 052 | Continued From page 7<br><br>(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.<br><br>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 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.<br>(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to | A 052 | | |

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| A 052 | Continued From page 8<br><br>enable the resident to take medication as prescribed:<br>1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,<br>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,<br>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<br>4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.<br>(f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S.<br>(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.<br>(h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observations, resident record reviews and interviews with staff, the facility failed to provide appropriate assistance with the self-administration of medication by failing to orally advise 2 of 3 residents observed (Residents 13 and 15) of the name and dose of the medication they were taking. | A 052 | | |

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| A 052 | Continued From page 9<br><br>The findings include:<br><br>An observation of Employee H, Medication Technician (MT) was conducted on at 12:08 pm. She was at the medication cart and Resident 13 was next to her in the hallway. After reviewing Resident 13's electronic medication observation record (eMOR), Employee H dispensed 1 40 milligram (mg) tablet into a small cup. Without advising the resident of the name and dose of the medication, she poured the pill into Resident 13's and handed him a cup of water. He took his medication independently and returned the cup to Employee H.<br><br>Record review for Resident 13 revealed a Resident Health Assessment (AHCA form 1823) dated . The assessment noted Resident 13 was alert and oriented and required assistance with self-administration of medication. Photographic evidence was obtained. The record contained no written waiver to opt out of being orally advised of his medication names and dosages.<br><br>On at 12:17 PM, Employee H reviewed the eMOR for Resident 15, and retrieved and dispensed the following medications into a small cup: 1 , 300 mg tablet, 1 , , , 25 mg tablet, and 1 Pregabalin 25 mg tablet. Employee H spoke with the resident as he took his medications, but did not advised him of the names or dosages of these medications.<br><br>Record review for Resident 15 revealed an AHCA form 1823 dated . His assessment indicated he was alert and oriented x 4 and required assistance with self-administration of medications. Photographic evidence was | A 052 | | |

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| A 052 | Continued From page 10<br><br>obtained. Further review of the record found there was no written waiver to opt out of being advised of his medication names and dosages.<br><br>During an interview with Employee K on at 3:25 pm, she confirmed she was a MT. She was asked if she told residents what they were receiving when she assisted them with their medications. She replied, no, she did that only if the resident asked. Then she would tell them what the pill was.<br><br>During an interview with Employee H, she was asked if she typically advised residents of what medications she was providing them. She responded that if residents ask her, she will tell them. She explained she didn't have to tell resident with . She was advised of the requirement to orally advise residents of what they were taking, unless there was an opt-out waiver. Employee H was not aware of the requirements but expressed understanding.<br><br>In an interview with the Clinical Director(CD) on at 4:15 pm, she explained staff's medication training was done by their contract pharmacy. She was asked if there were any residents who had executed opt-out waivers, but she was not aware of what an opt-out waiver was. The CD was advised of the observations and that interviewed staff were unaware of the requirement to advise residents of their medications when assisting with self-administration of medications. The CD expressed unawareness of both this requirement and of the opt-out option. She left the room and returned with a handbook, dated , on providing assistance with self-administration of medications which was used for all MT inservices training. She reviewed the manual in my | A 052 | | |

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| A 052 | Continued From page 11<br><br>presence and confirmed there was no education that staff were required to tell residents what they were taking. She concluded that the training was "faulty". The CD was unaware of the opt-out option for residents who did not wish to have staff tell them what medications they were taking. Photographic evidence obtained.<br><br>Review of the facility policy #703 titled "Medication Assistance with Self-Administration" found it did not include the requirement that staff orally advise residents of the names and doses of the medications they were taking.<br><br>Class III | A 052 | | |