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
	AL11968987	A. BUILDING: _____ B. WING _____	R 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

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{A 000}	Initial Comments A revisit to the relicensure survey at Premier Assisted Living Facility, LLC was conducted on . Deficiencies were found not to be corrected at the time of the survey.	{A 000}		
{A 052}	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.	{A 052}		

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{A 052}	Continued From page 1 (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or 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.	{A 052}		

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{A 052}	Continued From page 2 (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must 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	{A 052}		

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{A 052}	Continued From page 3 enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow physician orders for 1 of 3 sampled residents (Resident #4) observed receiving assistance with their medications from unlicensed personnel. Findings Included:	{A 052}		

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{A 052}	Continued From page 4 On at 12:00pm an observation was made of Staff B, an unlicensed medication technician, assisting Resident #4 with medication. During the observation, Staff B went to Resident #4's room and told him she was there to assist him with his . Staff B the went through the process of obtaining Resident #4's level. Resident #4's reading was observed to be 270 at the time. Staff B then opened a drawer of the medication cart, and brought forth a plastic container with Resident #4's and supplies. Upon closer observation of the lid of the plastic container, a written note attached, which read: 0 - 120: 9 121 - 200: 13 201 - 250: 17 251 - 300: 21 301 - 350: 25. Staff B was observed retrieving the resident's , , dialing it to 21 units, and handing the pen to Resident #4. Resident #4 was observed injecting himself with the , Staff B dialed to the dose of 21 units, and injecting himself with the . In an interview with the Staff B at 12:10pm on , she stated that they were using the written to Resident #4's dose, and that they did not have a from the pharmacy. She said she checked the medication dosing instructions in the medication assistance record, and in the computer, and there was no for Resident #4's . She confirmed the order only said "clarify directions."	{A 052}		

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{A 052}	Continued From page 5 In an interview with the Administrator at 12:30 on , she stated she checked the orders they had in the computer for Resident #4's instructions, and verified what Staff B previously stated, that there was no listed, only "clarify directions". The Administrator then checked the Resident #4's medical record and found his only medication orders were dated . She stated the medication technicians should not have been using the -written , and the should have been in the medication assistance record in the computer. She stated that the medication technicians should have known not to use the -written label and should have asked about the note that said "clarify instructions" in the computer. She stated she understood that meant that their previous tag 0056 for medication labeling and orders would not be corrected. A review of Resident #4's record revealed medication orders dated which included his . The was to be given before each meal, and had a based on the resident's level (reading). The written orders for in his record did not match the previously observed on a handwritten note attached to the resident's plastic container and stored on the medication cart. The orders Resident #4's record read: Less than 90 - no 90 - 120: 4 units 121 - 200: 8 units 201 - 250: 12 units 251 - 300: 16 units 301 - 350: 20 units Photographic evidence obtained.	{A 052}		

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{A 052}	Continued From page 6 Class III Based on observation, interview, and record review, the facility failed to to follow physician orders for 1 of 3 sampled residents (Resident #4) observed receiving assistance with their medications. Findings Included: On at 12:00pm an observation was made of Staff B, an unlicensed medication technician, assisting Resident #4 with medication. During the observation, Staff B went to Resident #4's room and told him she was there to assist him with his . Staff B the went through the process of obtaining Resident #4's level. Resident #4's reading was observed to be 270 at the time. Staff B then opened a drawer of the medication cart, and brought forth a plastic container with Resident #4's and supplies. Upon closer observation of the lid of the plastic container, a written note attached, which read: 0 - 120: 9 121 - 200: 13 201 - 250: 17 251 - 300: 21 301 - 350: 25.	{A 052}		

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{A 052}	Continued From page 7 Staff B was observed retrieving the resident's , , dialing it to 21 units, and handing the pen to Resident #4. Resident #4 was observed injecting himself with the , Staff B dialed to the dose of 21 units, and injecting himself with the . In an interview with the Staff B at 12:10pm on , she stated that they were using the written to . Resident #4's dose, and that they did not have a from the pharmacy. She said she checked the medication dosing instructions in the medication assistance record, and in the computer, and there was no for Resident #4's . She confirmed the order only said "clarify directions." In an interview with the Administrator at 12:30 on , she stated she checked the orders they had in the computer for Resident #4's instructions, and verified what Staff B previously stated, that there was no listed, only "clarify directions". The Administrator then checked the Resident #4's medical record and found his only medication orders were dated . She stated the medication technicians should not have been using the -written , and the should have been in the medication assistance record in the computer. She stated that the medication technicians should have known not to use the -written label and should have asked about the note that said "clarify instructions" in the computer. She stated she understood that meant that their previous tag 0056 for medication labeling and orders would not be corrected.	{A 052}		

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{A 052}	Continued From page 8 A review of Resident #4's record revealed medication orders dated which included his . The was to be given before each meal, and had a based on the resident's level (reading). The written orders for in his record did not match the previously observed on a handwritten note attached to the resident's plastic container and stored on the medication cart. The orders Resident #4's record read: Less than 90 - no 90 - 120: 4 units 121 - 200: 8 units 201 - 250: 12 units 251 - 300: 16 units 301 - 350: 20 units Photographic evidence obtained. Class III Based on observation, interview, and record review, the facility failed to to follow physician orders for 1 of 3 sampled residents (Resident #4) observed receiving assistance with their medications. Findings Included:	{A 052}		

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