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
	AL11969122	A. BUILDING: _____ B. WING _____	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT DANIA BEACH	150 STIRLING RD DANIA BEACH, FL 33004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Complaint (#2025007705) survey was conducted on at The Residence at Dania Beach. The facility had deficiencies identified related to the Complaint at the time of the survey.	A 000		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including 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	A 052		

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

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

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A 052	Continued From page 3 facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that staff followed the appropriate steps when assisting resident with their self-administration of prescribed medication, by failing to orally advise the residents the name and dosage of the medication for 20 out of 20	A 052		

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A 052	Continued From page 4 sampled residents (Resident #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19 and 20). The findings included: The following observations occurred during the medication pass observed in the AM and PM medications. 1) During medication pass on the surveyor observed Staff B (Medication Technician), assisting with self-administration of medication. Staff B did not orally advise Resident #1 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 2) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #2 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 3) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #3 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 4) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #4 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 5) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not	A 052		

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A 052	Continued From page 5 orally advise Resident #5 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 6) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #6 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 7) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #7 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 8) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #8 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 9) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #9 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 10) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #10 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 11) During medication pass on the	A 052		

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A 052	Continued From page 6 surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #11 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 12) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #12 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 13) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #13 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 14) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #14 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 15) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #15 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 16) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #16 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed.	A 052		

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A 052	Continued From page 7 17) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #17 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 18) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #18 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 19) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #19 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. 20) During medication pass on the surveyor observed Staff B, assisting with self-administration of medication. Staff B did not orally advise Resident #20 of the name and dosage of the medication or verbally prompt the resident to take medication as prescribed. During an interview on at approximately 2:00 PM, the Administrator was informed to provide medication waiver forms signed and dated for Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19 and 20). During an interview on at 4:35 PM, the acting Administrator stated she does not have the waivers in the residents file at this time. No additional documentation was provided.	A 052		

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A 052	Continued From page 8 Class III	A 052		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist.	A 056		

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A 056	Continued From page 9 (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name,	A 056		

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A 056	Continued From page 10 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, it was determined that, the facility failed to ensure staff followed physican orders for prescribed medications, for 6 of 6 sampled residents (Resident #1, 10, 11, 12, 15, 17 and #20). The staff also failed to ensure that they compared the medication labels and MORs to ensure the accuracy of the current orders. The findings included: A Medication Observation Record (MOR) must include the name of the resident, the name of each medication prescribed, the strength and direction of use. 1) An observation on at approximately 8:06 AM, during medication pass, Staff B (Medication Technician) was observed pulling out a prepackaged pouch containing medication and putting them into a medication cup for the following medications for Resident #1: a) , tablet 81 milligrams (mg), chew and swallow,1 tablet in the morning at 8:00 AM b) tablet 37.5 mg, take 1 tablet by daily with food in the morning at 8:00 AM	A 056		

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A 056	Continued From page 11 Record review of the facility's Medication Record (Pharmacy A) and Medication Record (Pharmacy 2 and third party) dated through revealed Resident #1 medication , 81 mg parameters (direction of use) was to chew the tablet during the medication pass, Staff B did not instructed resident to chew tablet. Further review revealed tablet 37.5 mg direction of use was to take the tablet with food. Staff B did not ask Resident#1 if had breakfast. During an interview on at approximately 8:07 AM surveyor asked Resident #1 if he had breakfast and he stated no because he was in a hurry, he stated he goes to a Third Party activity program for the day and he did not have time to eat breakfast. During an interview on at approximately 8:10 AM Staff B was asked why he was not following medication parameters (direction of use) Staff stated he was not aware of the medication parameters at the time of medication pass. 2) An observation on at approximately 8:36AM, during medication pass, Staff B was observed putting medication into a medication cup for the following medications for Resident #17: a) tablet 100 mg, take 2 tablets by daily in the morning at 8:00 AM, because of surveyor's intervention the resident received 2 tablets instead of 1 tablet at the time of medication pass. Staff was preparing to give only 1 tablet instead of 2 per the MOR and medication label. During an interview on at	A 056		

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A 056	Continued From page 12 approximately 8:38 AM Staff B was asked why he was not following medication parameters. Staff B stated he was not aware at the time of medication pass. 3) An observation on at approximately 9:45 AM, during medication pass, Staff C was observed putting medication into a medication cup for the following medications for Resident #20: a) Levothyroxin tablet 25 micrograms (mcg), take 1 tablet by every morning on an empty meal at 8:00 AM During an interview on at approximately 9:46 AM surveyor asked Resident #20 if she had breakfast and she stated yes. During an interview on at approximately 9:48 AM Staff C was asked why she was not following medication parameters. At this time, she acknowledged she should be aware of the medication parameters before giving the medication to Resident #20. 4) An observation on at approximately 9:55 AM, during medication pass, Staff C (Medication Technician Supervisor) was observed putting medication into a medication cup for the following medications for Resident #10: a) , tablet 20 mg, take 1 tablet by once daily-half hour to one hour before morning meal at 8:00 AM During an interview on at approximately 9:57 AM surveyor asked Resident #10 if he had breakfast and he stated yes. He just finished breakfast about 10 minutes ago. During an interview on at	A 056		

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A 056	Continued From page 13 approximately 9:59 AM Staff C was asked why she was not following medication parameters. At this time, she acknowledged she should be aware of the medication parameters before given the medication to Resident #10. 5)An observation on at approximately10:03 AM during medication pass, Staff C was observed putting medication into a medication cup for the following medications for Resident #11: a) , , Cap 100 mg, take 1 capsule by three times daily at 8:00 AM, 12:00 PM and 5:00 PM During an interview on at approximately 10:05 AM Staff C was asked why she was using a bubble pack (medication packaging) with a blue sticker indicating bedtime during a morning pass. She stated she only has one bubble pack to conduct all three med passes at this time. 6) An observation on at approximately 10:12 AM during medication pass, Staff C was observed putting medication into a medication cup for the following medications for Resident #12: a) tablet 20 mg, take 1 tablet by daily with food in the morning at 8:00 AM b) , tablet 100 mg, take 1 tablet by daily with food in the morning at 8:00 AM c) , , tablet 150 mg, take 2 tablets by every morning at 8:00 AM, because of surveyor's intervention the resident received 2 tablets instead of 1 tablet at the time of medication pass. The staff had only placed 1 tablet in the cup for the resident. During an interview on at	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT DANIA BEACH	150 STIRLING RD DANIA BEACH, FL 33004

(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 056	Continued From page 14 approximately 10:14 AM surveyor asked Resident #12 if he had breakfast and he stated no. During an interview on at approximately 10:15 AM Staff C was asked why she was not following medication parameters. Staff C stated she was not aware of medication parameters at the time of medication pass. Staff C was reminded that because of the surveyor's intervening she put two tablets for , , tablet 150 mg instead of one in the medication cup. At this time, she acknowledged she did not follow the medication parameters at the time of medication pass. 7) An observation on at approximately 10:19 AM during medication pass, Staff C was observed putting medication into a medication cup for the following medications for Resident #15: a) , Cap 20 mg, take 1 capsule by every morning - 30 minutes before breakfast at 8:00 AM During an interview on at approximately 10:20 AM surveyor asked Resident #15 if she had breakfast and she stated over an hour ago. During an interview on at approximately 10:21 AM Staff C was asked why she did not follow medications parameters indicating give medication at 8:00 AM and 30 minutes before breakfast. At this time, Staff C acknowledged the findings. During an interview on at approximately 4:20 PM surveyor met with the Administrator, and she was informed of the concerns regarding unlicensed personal	A 056		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT DANIA BEACH	150 STIRLING RD DANIA BEACH, FL 33004

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A 056	Continued From page 15 (Medication Technicians) not following medication direction of use at the time of medication pass. She acknowledged the findings. Class III	A 056		