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
	AL11964518	A. BUILDING: _____ B. WING _____	R 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF SARASOTA SENIOR LIVING	1809 18TH STREET SARASOTA, FL 34234

(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 revisit survey was conducted at the Meadows of Sarasota Senior Living on through . This was a follow -up to the relicensure, emergency power plan monitoring, health facility reporting system, visitation form and complaint survey. Deficiencies were identified at the time of the survey. .	{A 000}		
{A 054} SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication	{A 054}		

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{A 054}	Continued From page 1	{A 054}		

is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.
(c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.

This Statute or Rule is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to accurately update the Medication Observation Record (MOR) each time a medication is given for 2 (Resident #2, and #3) out of 4 residents observed.

The findings included:

Policy: Assistance with Self-Administration . . .
Do: Read the label. . .
Document the times the resident took the medication

1. On at 10:15 a.m., during medication pass, Resident #3 was not given - 0.2%-0.5% (for), as scheduled. Medication Technician (MT) Staff A was observed to ask the resident if he had his , in his room. Resident #3 said, "Yes." The MT said, 'OK' and concluded the medication pass. No , were observed being given.

On , during record review of Resident #3, the Medication Observation Record (MOR) revealed that MT Staff A documented the - 0.2%-0.5% as administered between the hours of 7:00 a.m. and 11:00 a.m. and between the hours of 1:00 p.m. and 5:00 p.m. on .

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{A 054}	Continued From page 2 On at 10:20 a.m., during an interview, MT Staff A said that he lets Resident #3 does his own , , , and he always keeps them in his room. On , during record review of Resident #3, the Resident Health Assessment AHCA Form 1823 revealed physical or sensory limitations of legally , wheelchair for mobility, and , , precautions. Section 2 of Form 1823 states Resident #3 needs assistance with self-administration of medications. On , during a tour of Resident #3's room, a bottle of - 0.2%-0.5% was observed in the bathroom. ** Photographic Evidence Obtained ** On at 8:30 a.m. during an interview, Resident #3 said that he takes the , , 3 times a day. He said that he sometimes forgets how many doses he gives himself because he is and sometimes, he loses track of time. Resident #3 said his doctor told him to hold off if he forgets because it is not recommended to double dose. "It's better to skip the dose and start again in the morning." Resident #3 said that he always does his , , on his own and that the MT or any other staff member is in the room with him when he uses them. On at 9:25 a.m. during an interview, the Resident Care Coordinator (RCC) said the protocol is the MT documents in the MAR when the resident administers the , , . The RCC said, "The MT needs to watch him take the drops."	{A 054}		

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{A 054}	Continued From page 3 2. On at 10:50 a.m., during medication pass, Resident #2 was not given Farziga 10 mg as scheduled. Medication Technician (MT) Staff A was observed to document 10 mg (for), as "medication not available", for Resident #2 on the Medication Observation Record (MOR). On , during record review of Resident #2, the Medication Observation Record (MOR) showed that Farziga 10 mg had been documented as administered on , , and . On at 9:30 a.m., during record review of Resident #2, the MOR showed that Farziga 10 mg was documented as not given on , , , and . Yet it was documented given on , , and by a different medication tech. On at 9:38 a.m., during an interview, MT Staff A said that he has marked the Farziga 10 mg as out of stock for a week. He showed me the interior of the med cart, and the Farziga 10 mg was not observed to be in the cart. MT Staff A said that he had no idea why anyone would mark the medication as given because it has been out of stock for a week. On at 10:50 a.m., during medication pass, MT Staff A asked Resident #2 if his cream was in his room. Resident #2 replied, "Yes, I have it there." There was no cream observed to be administered to Resident #2. On , during record review of Resident #2, it was shown that 20% ( ) was marked as given between 7:00 a.m. and 11:00 a.m. on .	{A 054}		

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{A 054}	Continued From page 4 On at 1:00 p.m., during a tour of Resident #2's room, a cream was observed on a nightstand. Resident #2 said that he can't put the cream on himself and a staff member comes by to apply the cream. He said that there really isn't a given time when they come to do it. "It's kind of when they're around." Resident #2 said that he hadn't gotten the cream yet today. ** Photographic Evidence Obtained ** On at 9:55 a.m., during an interview, the Resident Care Coordinator (RCC) the RCC said that the Farziga has been out of stock since the 18th and is working directly with the pharmacy to get another generic option. She stated that they had seen the MOR with the Farziga for Resident #2 being signed off as given on the 21st, 22nd, and 23rd. The Administrator and the Resident Care Coordinator acknowledged all of the errors in the MOR for Resident #2. Class III	{A 054}		