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
	AL11969654	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARINA ISLE ASSISTED LIVING	530 N PALMETTO AVE SANFORD, FL 32771

(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 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document	A 078		

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A 078	Continued From page 1 observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure staff were appropriately licensed to perform a task when unlicensed caregivers assisted 2 of 8 sampled residents (5, 6) with . Findings: On at 9:59 AM, resident #5 said he dialed his , to the prescribed units then staff administered it to him. He could not recall staff names and how often he took them. On at 10:01 AM, resident #6 said the staff	A 078		

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A 078	Continued From page 2 put the needle on then dialed the , to the prescribed units. He then injected himself. Review of both resident #5's and #6's records revealed a medical history of , and both needed assistance with self-administration of medications. On at 11:32 AM, the unlicensed caregiver coordinator said she assisted resident #5 with by giving him verbal prompts to make sure the needle was on correctly. She asked the resident to tell her what the label said. She asked him if he dialed to the right units. She verified he dialed to the correct dosage. The resident then injected himself. On at 12:35 PM, unlicensed caregiver B was observed assisting resident #5 with a . The caregiver first put a needle on the prefilled , then dialed it to the prescribed 5 units. She then handed the pen to the resident and instructed him to inject himself. The resident injected it in the inner crease of his left , which was not a site recommended for injecting . The caregiver said, "Push down till you hear it click." The caregiver removed the needle from the pen. She then said, "he can't see well." On at 1:55 PM, the administrator said she though resident #5 was independent with managing his . She said none of the staff told her otherwise. On at 2:29 PM, unlicensed caregiver D said she assisted both residents #5 and #6 with by putting the needle on the prefilled pen, dialing the prescribed units, then instructing the resident to press hard when injecting himself to	A 078		

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A 078	Continued From page 3 ensure he received all the doses. On at 2:31 PM, unlicensed caregiver E said she assisted both residents #5 and #6 with by telling the resident how many units to dial on the pen and making sure he pressed down hard on the injection button. Class III	A 078		
A 000	Initial Comments A complaint investigation (2025008133) and a generator monitoring were conducted at Marina Isle Assisted Living on . 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 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	A 025		

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A 025	Continued From page 4 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, 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 reviews and interviews, the facility failed to follow a health care provider's order for 2 of 8 sampled residents (5 & 9).	A 025		

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A 025	Continued From page 5 Findings: Review of resident #9's, health assessment form (1823) revealed the resident needed assistance with self-administration of medications. The resident's medical history included . Review of the medication observation record (MOR) revealed , , , were not signed as given from to . The medication had an order of on the MOR. On at 2:10pm the findings were discussed with the administrator. On at 3:58pm the resident coordinator said there may be conflicting order dates for the , , there should be a new order, which the family may have, and she cannot explain why the medication is not signed as given from . 2. Review of resident #5's record revealed a medical history of , , and type 2. On a health care provider ordered to monitor levels twice each day. One morning fasting and one post-prandial after lunch. Monitor , daily two hours after morning medications. Review of the residents' , and vital signs log revealed the following: was not monitored at all or only	A 025		

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A 025	Continued From page 6 one time on , , , , , , , , . , was not monitored on , , , , , , , , , . On at 1:32 PM, the findings were discussed with the caregiver coordinator, who did not provide additional documentation. Class III	A 025		
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.	A 052		

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A 052	Continued From page 7 (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 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	A 052		

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A 052	Continued From page 8 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 (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	A 052		

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A 052	Continued From page 9 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 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	A 052		

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A 052	Continued From page 10 interview, the facility failed to ensure the unlicensed caregivers (A & C) who assisted 2 of 4 sampled residents (#4 &#9) with medications followed the correct procedures and failed to report medication refusals to a health care provider for 1 of 8 sampled resident (3). Findings: 1. Review of resident #9's health assessment form (1823) revealed the resident needed assistance with self administration of medication. The residents' medical history included , ( ), , ( ), , and . The record did not contain a written waiver to opt out of being orally advised of the medication name and dosage. On at 9:39 AM, unlicensed caregiver C was observed giving resident #9 medications. The caregiver did not orally advise the resident of the name and dosage of each medication. On at 9:48 AM, unlicensed caregiver C said she normally does say the name and dosage of each medication to the resident, but she did not do it this time. The caregiver said she did not know if the resident had a written waiver to opt out of being orally advised of the medication name and dosage. On at 12:12 PM resident #9 said the staff normally tells her the name of the medications when they give it to her. 2. Review of resident #3's 1823 revealed resident needed assistance with medication self-administration. The residents' medical history	A 052		

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A 052	Continued From page 11 included , ( ), Sleep , , , ( ), ( ), ( ), , , , (HLD) The medication observation record (MOR) revealed resident #3 refused the following medications: Jardiance on , , and . Cranberry on . 9 AM on , , and 8 PM . on and . D3 on and . On at 11:55 AM the findings were discussed with the caregiver coordinator, who confirmed the findings and said the resident had a procedure in and may have been informed to stop some of her , medications. On at 1:32 PM the caregiver coordinator said resident #3 had a procedure in , if the facility would have received paperwork about medications it would be to hold the medications and not a refusal. There was no additional documentation provided. There was no documentation on either the MORs or the resident's record to indicate the refusals were reported to a health care provider, administrator, or director of nursing. The refusal of medication policy, effective	A 052		

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A 052	Continued From page 12 , indicated refusal of medications must be documented by the end of med pass, additional notification must be made to the administrator and director of nursing, documentation of notification shall be documented in the resident record. 3. Review of resident #4's 1823 revealed the resident needed assistance with self-administration of medications. On at 9:35 AM, unlicensed caregiver B was seen popping resident #4's pills into a cup while standing at the medication cart outside of the resident's room. Without being asked, the caregiver said "we already read them off. I just had to get everything." She put the medication packages in the cart then took only the pills to the resident. The caregiver said she did not take the packages to where the resident was and prepared them in his presence because "I don't know. I never take them in the room." On at 9:55 AM, the resident said the caregiver did not tell him the name and dosage of each medication before bringing them to him, as the caregiver said she did. The resident then said none of the staff did, "they just give me a cup full of medications, and I take them." Class III	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS.	A 054		

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A 054	Continued From page 13 (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 [redacted] 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 is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [redacted], 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 record review and interview, the facility failed to ensure medication observation records (MORs) for 3 of 8 sampled residents (3, 4, 9) were updated each time a medication was given. Findings:	A 054		

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A 054	Continued From page 14 1. Review of resident #4's health assessment form (1823,) dated , revealed he needed assistance with self-administration of medications. Review of the residents' and MORs revealed his weekly Trulicity was not signed as given at all during and . The was not signed on and on . On at 11:26 AM, the caregiver coordinator said the resident came to the office weekly on Tuesday and asked for the Trulicity, which was stored in the refrigerator. The caregiver coordinator said the MORs were not signed because she only removed it from the fridge and handed it to the resident, who self-administered it. The caregiver coordinator said she would check why the other two medications were not signed, but she did not provide any further explanation. 2. Resident 9's health assessment form (1823) revealed resident needed assistance with self-administration of medications. Review of the and MOR's revealed the following omissions: Dorzol/timol on . Cal protect and , , , on . 3. Resident 3's 1823 revealed resident needed assistance with self-administration of medications. Review of the , MOR revealed an omission for	A 054		

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	AL11969654	A. BUILDING: _____ B. WING _____	08/07/2025

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A 054	Continued From page 15 on . There was no documentation to indicate why the medications were not signed as given. On at 3:53pm the findings were discussed with the caregiver coordinator who confirmed the findings and said there is no documentation to explain the omissions in the MOR's. Class III	A 054		
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	A 056		

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A 056	Continued From page 16 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. (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	A 056		

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A 056	Continued From page 17 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, 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 record review and interview, the facility failed to make every reasonable effort to ensure that prescriptions for 4 of 8 sampled residents (1, 3, 4, 9) who received assistance with self-administration of medication were refilled in a timely manner. Findings: 1. Review of resident #1's record revealed a medical history of , , and type 2. An 1823 indicated she needed assistance with self-administration of medications. On at 9:14 AM, unlicensed caregiver A	A 056		

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A 056	Continued From page 18	A 056		

was observed giving resident #1 medication. The caregiver said the resident did not have the , and .

Review of the resident's MOR revealed the , and were not given on and .

There was no documentation to indicate the facility made any effort to ensure the prescriptions were refilled before they ran out.

On at 1:32 PM, the findings were discussed with the caregiver coordinator.

On at 2:54 PM, the administrator said the pharmacy would deliver the that day.

2. Review of resident #4's record revealed a medical history of , , , , type 2, , , and 1823, dated , indicated he needed assistance with self-administration of medications.

Review of the residents' and MORs revealed the following medications were not given:

on , ,
on ,
on
Jardiance on ,
on , , , , , ,
on , ,

There was no documentation to indicate the facility made any effort to ensure the prescriptions

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A 056	Continued From page 19 were refilled before they ran out. On at 11:26 AM, the findings were discussed with the care coordinator, who said she would check on it. On at 12 PM, the care coordinator provided only documentation to indicate the and were waiting on pharmacy to deliver. 3. Review of resident #9's health assessment form (1823) revealed resident needed assistance with self-administration of medications. Review of the , , and MOR's revealed on , , , , , and , , on , , , , , , , , , had a yellow color code indicating medications not given. 4. Review of resident #3's 1823 revealed resident needed assistance with self-administration of medications. Review of and MOR's revealed on on , D3 on , and on , , had a yellow color code indicating medications not given. There was no documentation to indicate the facility made any effort to obtain refills before they ran out. On at 3:53pm the findings were discussed with the caregiver coordinator who confirmed the findings.	A 056		

Agency for Health Care Administration

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A 056	Continued From page 20 The medication refill policy, effective date , indicated 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. Class III	A 056		