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
	AL11964709	A. BUILDING: _____ B. WING _____	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OPAL AT BLUEWATER BAY	1551 MERCHANTS WAY NICEVILLE, FL 32578

(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 survey for complaints 2025013786, 2025013480, and 2025011414 was conducted on - at The Opal at Bluewater Bay, an assisted living facility in Niceville, FL. At the time of the survey, deficient practice was identified. Class I deficiencies were found at Tags A0030, A0052, and A0055. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. On , Resident #1 was given the wrong medications. Because of this, Resident #1 eventually had to be transferred to a higher level of medical care due to the resident's declining condition. Investigations into the facility's medication administration practices found that staff often pre-poured medications into cups, did not review medications being given with the residents, and left medications out and unattended. There was no documentation to show any retraining occurred after the incident. The Class I noncompliance began on . The facility's Administrator was notified of the Class I noncompliance on at 5:00 pm. The census at the start of the survey was 38. The following is a description of the deficiencies	A 000		

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A 000	Continued From page 1 found at the time of the visit	A 000		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided	A 030		

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A 030	Continued From page 2 pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of	A 030		

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A 030	Continued From page 3 any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise	A 030		

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A 030	Continued From page 4 several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall	A 030		

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A 030	Continued From page 5 show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of	A 030		

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A 030	Continued From page 6 Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based upon interviews, observations, and facility policy reviews, the facility failed to demonstrate and implement their written grievance policy and procedure for complaints and allowing residents and / or resident family representatives to recommend changes to the facility policies and procedures. The facility failed to provide adequate and appropriate health care services to Resident #1 in response to a change in condition, delaying care and treatment, resulting in actual harm to Resident #1 and potential harm for all 38 residents residing in the facility. Cross Reference to A52	A 030		

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A 030	Continued From page 7 The findings include: Grievance policy On at 1:50 pm, upon review of the grievance log and book, there were no grievances observed. An interview was then conducted with the Regional Director of Operations (RDO) concerning the procedures when a resident or family member has a complaint or concern. She stated that they look into it and just resolve it, they do not write it up on grievance form. She further stated, when she spoke with the Executive Director (ED) on the phone, that she stated that there are no grievances. The RDO further stated, "We only write a grievance if we can't resolve the issue". On at 04:30 pm, an interview was conducted with Staff Member B (Medication Tech), who revealed that, when a resident or family member voices a concern or complaint, that she will discuss it with them then and, if she is not able to resolve it then and there, she would refer it to the ED. She further stated that, to her knowledge, there is not a form that they write concerns or complaints on. On at 10:00 AM, an interview was performed with Resident #3. She stated that she has voiced concerns before regarding the staffing and food issues but feels no one ever does anything about it. She confirms there is no form to fill out or write on, they just let the staff know the concerns. On at 3:00 pm, an interview was performed with Resident #2. She voiced concerns about staffing and food issues, stating staffing is	A 030		

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always low on the weekend. She stated that the center works with a nurse or med tech on weekends during the second shift and there is not a lot of choices with the food. She stated that the residents at the center will voice their complaints in the resident council meetings each month, or go to the ED. She confirmed that there is no grievance form to write on. She states she feels that the ED listens and tries to fix things but is unable since "corporate will only allow her to do so much".

On at 2:30 pm, an interview was conducted with Staff Member D, a Licensed Practical Nurse (LPN), who states there has never been a grievance form to write complaints. She tries to make sure grievances are voiced to the correct personnel, such as the cooks in the kitchen if there is a concern about the food. She always makes sure the ED knows of every complaint.

On at 3:30 pm, the Activities Director confirmed that the staff does not do any grievance forms for complaints. She stated that she meets with the residents each month. The residents do voice a lot of concerns about the food and quality of the food that is served but it is never written up on a grievance form.

An interview was conducted with the ED on at 4:30 pm. She revealed that, when a resident or family member comes to her with a concern, they will sit and discuss it until a resolution is made. If it is unable to be resolved, it will be written down. Usually only complaints about a staff member can't be resolved and that is when it is written down in the grievance book.

The grievance policy dated with last

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revision on reveals that, "The resident and / or responsible party will be supplied with a written copy of the state grievance procedure at the time the resident moves in. When a grievance has been submitted, the ED or regional director of operations will follow the grievance procedure per state regulations."

Medication incident .

An interview was conducted on at 4:30 pm with Staff Member B (Medication Technician (Tech)) stating, "pre-pouring medication is the common practice here; I was trained to pre-pour medications into medicine cup with room numbers then take these to the residents. I put them in my basket on the metal cart and go down the hallway with it. No one pushes the medication cart down the hallway, it's too big and there is not enough room on it."

"[On] I grabbed the wrong medicine cup and gave it to [Resident #1]. I didn't realize it until I got to the next room and realized that I had administered the wrong medication. I believe when I turned the corner to go down the hallway, the medicine cups must have shifted, causing them to be out of order. I did not check the medicine cup to make sure it was the right one before I administered the medication to him." She further stated that she was trained to take the smaller rolling cart to administer the medications and to "pre-pour" the medicine into medicine cups with the residents name or room number on them and that it is a "common practice" to administer medication in that way.

On , Resident #1 was monitored for a change in condition after the wrong medication was administered to him at 7:00 pm. At 7:45 pm,

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Resident #1's , was and the . At 8:30 pm, Resident #1's was with a rate at 73. A continued decline was noted in Resident #1's rate, but he was not transferred to acute care setting until 5:55 am on with a rate reported at 60 and Resident #1 being unresponsive to staff.

Staff Member B has been an employee at the center for three years and has been a Medication Tech for almost a year. She further stated she contacted the ED about the incident and received instructions to monitor vital signs every two hours. Prior to leaving her shift at 10:00 pm, she called the ED and gave her an update on Resident #1's vital signs and gave her report to the incoming staff, Staff Member A (Medication Tech).

An interview with Staff Member A (Medication Tech) revealed that Resident #1 became unresponsive, not able to speak clearly and had decrease in grips. Resident #1 presented with -like symptoms and he called to transport resident to the hospital.

After this incident, Staff Member B continued to administer medications to residents in the center and has not completed any re-training or re-education at the time of the survey. Upon review of the staff schedule, Staff Member B worked as a medication tech on thru and is scheduled to work as a medication tech on , , and .

Medication administration observation

On at 12:00 pm, Staff Member C (lead Medication Tech) was observed administering medications while residents were in the dining

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room eating their lunch. Staff Member C was observed removing medication cups from the top drawer of the medication cart with the name of the resident on the medicine cup and administering the medicine to the resident without confirming the resident's name or the medication that was being administered. She repeated this process more than five times while residents were eating.

An interview following this with Staff Member C revealed that medication techs are to follow the facility policy and procedure when administering medication to any resident. She demonstrated the procedure by reviewing the Electronic Medication Administration Record (EMAR) for medications and comparing the order to the medication label on the medicines. She stated, "We perform this task in front of the resident and read the medication to the resident prior to administering."

On at 2:30 pm, Staff member D, LPN, was observed in the hallway with the small metal rolling cart with medicine cups labeled with the residents' names on them. Staff Member D was observed administering medications without reading the list of medications to be administered to the resident.

An interview was conducted with Staff Member D afterwards. She stated that she has been a nurse for 42 years and "we all know that nurses pre-pour medications to administer". She confirmed that pre-pouring medications does occur in the center and she has done that before.

An interview was conducted with the ED on . She stated the center's protocol on medication administration. She stated she was not aware medication administration was not

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A 030	Continued From page 12 being done that way. She further expressed her expectation is that all nurses and med techs follow the policy and procedure by having the EMAR present to read off the medications to the resident, confirming the right resident is getting the right medication. The medication associate competency states, The medication associate will follow safety regulations, assist with medication administration, review the six rights of medication administration which includes the right resident, right medication, right dose, right route, right time, and the right documentation. The medication associate will remove the medication from the container, confirm the medication order and label three times prior to administering the medication and the associate will not pre-pour medication." Class I	A 030		
A 052 SS=J	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,	A 052		

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A 052	Continued From page 13 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. (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.	A 052		

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A 052	Continued From page 14 (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. (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.	A 052		

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A 052	Continued From page 15 (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 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	A 052		

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A 052	Continued From page 16 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 upon record reviews, observations, and interviews, the facility failed to safely administer medication, confirm that the medication is intended for that resident, and orally advising the resident of the medication name and dosage prior to administering medication. On , a medication error occurred where Resident #1 received the wrong medication and had a delay in treatment causing actual harm requiring transfer to a higher level of care. The medication techs and nurses continue to pre-pour medication to administer to residents with the potential for harm of 31 out of 38 residents residing in the facility. The findings include: Medication Incident On at 07:00 pm, Staff Member B (Medication Tech), was administering medications when she administered the wrong medications to Resident #1. After this incident, Resident #1 displayed decreased function, decreased physical function, and a change in and rate which required that Resident #1 be transported to a higher level of care at an acute care hospital 11 hours after the incident occurred.	A 052		

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A 052	Continued From page 17	A 052		

An interview was conducted on at 4:30 pm with Staff Member B (Medication Tech) stating, "pre-pouring medication is the common practice here; I was trained to pre-pour medications into medicine cup with room numbers then take these to the residents. I put them in my basket on the metal cart and go down the hallway with it. No one pushes the medication cart down the hallway, it's too big and there is not enough room on it."

"[On] I grabbed the wrong medicine cup and gave it to [Resident #1]. I didn't realize it until I got to the next room and realized that I had administered the wrong medication. I believe when I turned the corner to go down the hallway, the medicine cups must have shifted, causing them to be out of order. I did not check the medicine cup to make sure it was the right one before I administered the medication to him." She further stated that she was trained to take the smaller rolling cart to administer the medications and to "pre-pour" the medicine into medicine cups with the residents name or room number on them and that it is a "common practice" to administer medication in that way.

On , Resident #1 was monitored for a change in condition after the wrong medication was administered to him at 7:00 pm. At 7:45 pm, Resident #1's , was and the . At 8:30 pm, Resident #1's , was with a rate at 73. A continued decline was noted in Resident #1's rate, but he was not transferred to acute care setting until 5:55 am on with a rate reported at 60 and Resident #1 being unresponsive to staff.

She further stated she contacted the Executive

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A 052	Continued From page 18 Director (ED) about the incident and received instructions to monitor vital signs every two hours. Prior to leaving her shift at 10:00 pm, she called the ED and gave her an update on Resident #1's vital signs and gave her report to the incoming staff, Staff Member A (Medication Tech). Staff Member B has been an employee at the center for three years and has been a Medication Tech for almost a year. Staff Member B stated she completed her six-hour online course training for medication assistance in with two weeks of training in the center with a nurse or another medication tech prior to being certified. She further revealed that she is not familiar with all the medications such as , but is able to recognize medications like , and , . In her training, she stated she learned to go over the medications that she is administering to a resident prior to administering them. An interview with Staff Member A (Medication Tech) revealed that Resident #1 became unresponsive, not able to speak clearly and had decrease in grips. Resident #1 presented with -like symptoms and he called to transport resident to the hospital. After this incident, Staff Member B continued to administer medications to residents in the center and has not completed any re-training or re-education at the time of the survey. Upon review of the staff schedule, Staff Member B worked as a medication tech on thru and is scheduled to work as a medication tech on , , and . Supplementary medication adminstration observations	A 052		

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A 052	Continued From page 19 On at 12:00 pm, Staff Member C (Lead Medication Tech) was observed administering medications while residents were in the dining room eating their lunch. Staff Member C was observed removing medication cups from the top drawer of the medication cart with the name of the resident on the medicine cup and administering the medicine to the resident without confirming the resident's name or the medication that was being administered. She repeated this process more than five times while residents were eating. An interview following this with Staff Member C revealed that medication techs are to follow the facility policy and procedure when administering medication to any resident. She demonstrated the procedure by reviewing the Electronic Medication Administration Record (EMAR) for medications and comparing the order to the medication label on the medicines. She stated, "We perform this task in front of the resident and read the medication to the resident prior to administering." On at 2:30 pm, Nurse D was observed in the hallway with the small metal rolling cart with medicine cups labeled with the residents' names on them. Staff Member D was observed administering medications without reading the list of medications to be administered to the resident. An interview was conducted with Nurse D afterwards. She stated that she has been a nurse for 42 years and "we all know that nurses pre-pour medications to administer". She confirmed that pre-pouring medications does occur in the center and she has done that before. An interview was conducted with the ED on . She stated the center's protocol on	A 052		

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A 052	Continued From page 20 medication administration. She stated she was not aware medication administration was not being done that way. She further expressed her expectation is that all nurses and med techs follow the policy and procedure by having the EMAR present to read off the medications to the resident, confirming the right resident is getting the right medication. The medication associate competency states, The medication associate will follow safety regulations, assist with medication administration, review the six rights of medication administration which includes the right resident, right medication, right dose, right route, right time, and the right documentation. The medication associate will remove the medication from the container, confirm the medication order and label three times prior to administering the medication and the associate will not pre-pour medication." Class I	A 052		
A 055 SS=J	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter	A 055		

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A 055	Continued From page 21 medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other	A 055		

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A 055	Continued From page 22 residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based upon observations, staff interviews, record reviews, and policy reviews, the facility failed to provide a safe and secure place for medication to be stored. This situation allows prescription and non-prescription medications to be easily	A 055		

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A 055	Continued From page 23 obtained by other residents in the facility. Staff was observed removing medications from the nurses station and storing medications loosely in a medication cup for multiple residents, placing them in a basket on a rolling metal cart and rolling down the hallway to administer medications to residents. This situation left the cart and medications unattended several times in the hallway. The findings include: On at 10:30 AM, an interview was performed with Resident #3. She revealed her medications are stored in a basket on an open counter and unlocked, potentially allowing for anyone to have access. She shares the room with her husband. They both administer their own medications. Medications for both individuals were aavailable in the open and not stored in a locked compartment. The front door to their room is capable of locking, but they stated they do not keep their door locked. During the interview, Resident #3 states that she always keeps the medication in easy reach sitting out on the counter by the sink. On at 5:30 PM and at 2:30 pm, Staff Member D, a Licensed Practical Nurse (LPN), was observed placing medications for residents in a medicine cup with the room number on each cup, place the medication cups in a white basket on a metal rolling cart, and take down hallway to administer medications to residents. Several times during these observations, Staff Member D left this cart unattended while she was administering medications to residents.	A 055		

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A 055	Continued From page 24 An interview was conducted on with Staff Member D. She revealed that she often uses the smaller metal rolling cart to take down the hallway to administer medications instead of using the large medicine cart with a secure lock on it. A staff interview was conducted on with Staff Member C (Lead Medication Tech) and the Executive Director, which revealed that the smaller metal rolling cart is only used when they need to grab something quickly and to store , cuffs, stethoscopes and , monitoring equipment. They further stated there is only one staff member (Staff Member D) who uses the cart. Staff Member C stated that all medications are stored in a locked area in the nurses stations, except for the residents who manage their medications, "those are stored in the residents rooms usually in a dresser drawer". Upon review of medication records, there are seven residents who manage their own medications and store their medicines in their room. During observations of the 7 rooms with residents who self-administer and manage their own medications, it was noted that 5 rooms had their medications in easily accessible, visibly seen, and in an unlocked container. Resident room doors have the capability of locking, but only 2 rooms were locked. Upon the review of facility policy of assistance with self-administration of medications, it states that if a resident is allowed to self-administer medication, their medication should be stored in their room in a locked compartment. Class I	A 055		

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A 000	Initial Comments An unannounced complaint survey for complaints 2025013786, 2025013480, and 2025011414 was conducted on - at The Opal at Bluewater Bay, an assisted living facility in Niceville, FL. At the time of the survey, deficient practice was identified. Class I deficiencies were found at Tags A0030, A0052, and A0055. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. On , Resident #1 was given the wrong medications. Because of this, Resident #1 eventually had to be transferred to a higher level of medical care due to the resident's declining condition. Investigations into the facility's medication administration practices found that staff often pre-poured medications into cups, did not review medications being given with the residents, and left medications out and unattended. There was no documentation to show any retraining occurred after the incident. The Class I noncompliance began on . The facility's Administrator was notified of the Class I noncompliance on at 5:00 pm. The census at the start of the survey was 38. The following is a description of the deficiencies	A 000		

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A 000	Continued From page 1 found at the time of the visit	A 000		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided	A 030		

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A 030	Continued From page 2 pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical , (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of	A 030		

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A 030	Continued From page 3 any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise	A 030		

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A 030	Continued From page 4 several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall	A 030		

Agency for Health Care Administration

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A 030	Continued From page 5 show good cause in a court of competent jurisdiction. (I) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of	A 030		

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A 030	Continued From page 6 Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based upon interviews, observations, and facility policy reviews, the facility failed to demonstrate and implement their written grievance policy and procedure for complaints and allowing residents and / or resident family representatives to recommend changes to the facility policies and procedures. The facility failed to provide adequate and appropriate health care services to Resident #1 in response to a change in condition, delaying care and treatment, resulting in actual harm to Resident #1 and potential harm for all 38 residents residing in the facility. Cross Reference to A52	A 030		

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A 030	Continued From page 7 The findings include: Grievance policy On at 1:50 pm, upon review of the grievance log and book, there were no grievances observed. An interview was then conducted with the Regional Director of Operations (RDO) concerning the procedures when a resident or family member has a complaint or concern. She stated that they look into it and just resolve it, they do not write it up on grievance form. She further stated, when she spoke with the Executive Director (ED) on the phone, that she stated that there are no grievances. The RDO further stated, "We only write a grievance if we can't resolve the issue". On at 04:30 pm, an interview was conducted with Staff Member B (Medication Tech), who revealed that, when a resident or family member voices a concern or complaint, that she will discuss it with them then and, if she is not able to resolve it then and there, she would refer it to the ED. She further stated that, to her knowledge, there is not a form that they write concerns or complaints on. On at 10:00 AM, an interview was performed with Resident #3. She stated that she has voiced concerns before regarding the staffing and food issues but feels no one ever does anything about it. She confirms there is no form to fill out or write on, they just let the staff know the concerns. On at 3:00 pm, an interview was performed with Resident #2. She voiced concerns about staffing and food issues, stating staffing is	A 030		

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A 030	Continued From page 8	A 030		

always low on the weekend. She stated that the center works with a nurse or med tech on weekends during the second shift and there is not a lot of choices with the food. She stated that the residents at the center will voice their complaints in the resident council meetings each month, or go to the ED. She confirmed that there is no grievance form to write on. She states she feels that the ED listens and tries to fix things but is unable since "corporate will only allow her to do so much".

On at 2:30 pm, an interview was conducted with Staff Member D, a Licensed Practical Nurse (LPN), who states there has never been a grievance form to write complaints. She tries to make sure grievances are voiced to the correct personnel, such as the cooks in the kitchen if there is a concern about the food. She always makes sure the ED knows of every complaint.

On at 3:30 pm, the Activities Director confirmed that the staff does not do any grievance forms for complaints. She stated that she meets with the residents each month. The residents do voice a lot of concerns about the food and quality of the food that is served but it is never written up on a grievance form.

An interview was conducted with the ED on at 4:30 pm. She revealed that, when a resident or family member comes to her with a concern, they will sit and discuss it until a resolution is made. If it is unable to be resolved, it will be written down. Usually only complaints about a staff member can't be resolved and that is when it is written down in the grievance book.

The grievance policy dated with last

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A 030	Continued From page 9	A 030		

revision on reveals that, "The resident and / or responsible party will be supplied with a written copy of the state grievance procedure at the time the resident moves in. When a grievance has been submitted, the ED or regional director of operations will follow the grievance procedure per state regulations."

Medication incident .

An interview was conducted on at 4:30 pm with Staff Member B (Medication Technician (Tech)) stating, "pre-pouring medication is the common practice here; I was trained to pre-pour medications into medicine cup with room numbers then take these to the residents. I put them in my basket on the metal cart and go down the hallway with it. No one pushes the medication cart down the hallway, it's too big and there is not enough room on it."

"[On] I grabbed the wrong medicine cup and gave it to [Resident #1]. I didn't realize it until I got to the next room and realized that I had administered the wrong medication. I believe when I turned the corner to go down the hallway, the medicine cups must have shifted, causing them to be out of order. I did not check the medicine cup to make sure it was the right one before I administered the medication to him." She further stated that she was trained to take the smaller rolling cart to administer the medications and to "pre-pour" the medicine into medicine cups with the residents name or room number on them and that it is a "common practice" to administer medication in that way.

On , Resident #1 was monitored for a change in condition after the wrong medication was administered to him at 7:00 pm. At 7:45 pm,

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Resident #1's , was and the . At 8:30 pm, Resident #1's was with a rate at 73. A continued decline was noted in Resident #1's rate, but he was not transferred to acute care setting until 5:55 am on with a rate reported at 60 and Resident #1 being unresponsive to staff.

Staff Member B has been an employee at the center for three years and has been a Medication Tech for almost a year. She further stated she contacted the ED about the incident and received instructions to monitor vital signs every two hours. Prior to leaving her shift at 10:00 pm, she called the ED and gave her an update on Resident #1's vital signs and gave her report to the incoming staff, Staff Member A (Medication Tech).

An interview with Staff Member A (Medication Tech) revealed that Resident #1 became unresponsive, not able to speak clearly and had decrease in grips. Resident #1 presented with -like symptoms and he called to transport resident to the hospital.

After this incident, Staff Member B continued to administer medications to residents in the center and has not completed any re-training or re-education at the time of the survey. Upon review of the staff schedule, Staff Member B worked as a medication tech on thru and is scheduled to work as a medication tech on , , and .

Medication administration observation

On at 12:00 pm, Staff Member C (lead Medication Tech) was observed administering medications while residents were in the dining

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A 030	Continued From page 11	A 030		

room eating their lunch. Staff Member C was observed removing medication cups from the top drawer of the medication cart with the name of the resident on the medicine cup and administering the medicine to the resident without confirming the resident's name or the medication that was being administered. She repeated this process more than five times while residents were eating.

An interview following this with Staff Member C revealed that medication techs are to follow the facility policy and procedure when administering medication to any resident. She demonstrated the procedure by reviewing the Electronic Medication Administration Record (EMAR) for medications and comparing the order to the medication label on the medicines. She stated, "We perform this task in front of the resident and read the medication to the resident prior to administering."

On at 2:30 pm, Staff member D, LPN, was observed in the hallway with the small metal rolling cart with medicine cups labeled with the residents' names on them. Staff Member D was observed administering medications without reading the list of medications to be administered to the resident.

An interview was conducted with Staff Member D afterwards. She stated that she has been a nurse for 42 years and "we all know that nurses pre-pour medications to administer". She confirmed that pre-pouring medications does occur in the center and she has done that before.

An interview was conducted with the ED on . She stated the center's protocol on medication administration. She stated she was not aware medication administration was not

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A 030	Continued From page 12 being done that way. She further expressed her expectation is that all nurses and med techs follow the policy and procedure by having the EMAR present to read off the medications to the resident, confirming the right resident is getting the right medication. The medication associate competency states, The medication associate will follow safety regulations, assist with medication administration, review the six rights of medication administration which includes the right resident, right medication, right dose, right route, right time, and the right documentation. The medication associate will remove the medication from the container, confirm the medication order and label three times prior to administering the medication and the associate will not pre-pour medication." Class I	A 030		
A 052 SS=J	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,	A 052		

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A 052	Continued From page 13 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. (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.	A 052		

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A 052	Continued From page 14 (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. (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.	A 052		

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A 052	Continued From page 15 (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 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	A 052		

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A 052	Continued From page 16 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 upon record reviews, observations, and interviews, the facility failed to safely administer medication, confirm that the medication is intended for that resident, and orally advising the resident of the medication name and dosage prior to administering medication. On , a medication error occurred where Resident #1 received the wrong medication and had a delay in treatment causing actual harm requiring transfer to a higher level of care. The medication techs and nurses continue to pre-pour medication to administer to residents with the potential for harm of 31 out of 38 residents residing in the facility. The findings include: Medication Incident On at 07:00 pm, Staff Member B (Medication Tech), was administering medications when she administered the wrong medications to Resident #1. After this incident, Resident #1 displayed decreased function, decreased physical function, and a change in and rate which required that Resident #1 be transported to a higher level of care at an acute care hospital 11 hours after the incident occurred.	A 052		

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An interview was conducted on at 4:30 pm with Staff Member B (Medication Tech) stating, "pre-pouring medication is the common practice here; I was trained to pre-pour medications into medicine cup with room numbers then take these to the residents. I put them in my basket on the metal cart and go down the hallway with it. No one pushes the medication cart down the hallway, it's too big and there is not enough room on it."

"[On] I grabbed the wrong medicine cup and gave it to [Resident #1]. I didn't realize it until I got to the next room and realized that I had administered the wrong medication. I believe when I turned the corner to go down the hallway, the medicine cups must have shifted, causing them to be out of order. I did not check the medicine cup to make sure it was the right one before I administered the medication to him." She further stated that she was trained to take the smaller rolling cart to administer the medications and to "pre-pour" the medicine into medicine cups with the residents name or room number on them and that it is a "common practice" to administer medication in that way.

On , Resident #1 was monitored for a change in condition after the wrong medication was administered to him at 7:00 pm. At 7:45 pm, Resident #1's , was and the . At 8:30 pm, Resident #1's , was with a rate at 73. A continued decline was noted in Resident #1's rate, but he was not transferred to acute care setting until 5:55 am on with a rate reported at 60 and Resident #1 being unresponsive to staff.

She further stated she contacted the Executive

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A 052	Continued From page 18 Director (ED) about the incident and received instructions to monitor vital signs every two hours. Prior to leaving her shift at 10:00 pm, she called the ED and gave her an update on Resident #1's vital signs and gave her report to the incoming staff, Staff Member A (Medication Tech). Staff Member B has been an employee at the center for three years and has been a Medication Tech for almost a year. Staff Member B stated she completed her six-hour online course training for medication assistance in with two weeks of training in the center with a nurse or another medication tech prior to being certified. She further revealed that she is not familiar with all the medications such as , but is able to recognize medications like , and , . In her training, she stated she learned to go over the medications that she is administering to a resident prior to administering them. An interview with Staff Member A (Medication Tech) revealed that Resident #1 became unresponsive, not able to speak clearly and had decrease in grips. Resident #1 presented with -like symptoms and he called to transport resident to the hospital. After this incident, Staff Member B continued to administer medications to residents in the center and has not completed any re-training or re-education at the time of the survey. Upon review of the staff schedule, Staff Member B worked as a medication tech on thru and is scheduled to work as a medication tech on , , and . Supplementary medication adminstration observations	A 052		

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A 052	Continued From page 19 On at 12:00 pm, Staff Member C (Lead Medication Tech) was observed administering medications while residents were in the dining room eating their lunch. Staff Member C was observed removing medication cups from the top drawer of the medication cart with the name of the resident on the medicine cup and administering the medicine to the resident without confirming the resident's name or the medication that was being administered. She repeated this process more than five times while residents were eating. An interview following this with Staff Member C revealed that medication techs are to follow the facility policy and procedure when administering medication to any resident. She demonstrated the procedure by reviewing the Electronic Medication Administration Record (EMAR) for medications and comparing the order to the medication label on the medicines. She stated, "We perform this task in front of the resident and read the medication to the resident prior to administering." On at 2:30 pm, Nurse D was observed in the hallway with the small metal rolling cart with medicine cups labeled with the residents' names on them. Staff Member D was observed administering medications without reading the list of medications to be administered to the resident. An interview was conducted with Nurse D afterwards. She stated that she has been a nurse for 42 years and "we all know that nurses pre-pour medications to administer". She confirmed that pre-pouring medications does occur in the center and she has done that before. An interview was conducted with the ED on . She stated the center's protocol on	A 052		

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A 052	Continued From page 20 medication administration. She stated she was not aware medication administration was not being done that way. She further expressed her expectation is that all nurses and med techs follow the policy and procedure by having the EMAR present to read off the medications to the resident, confirming the right resident is getting the right medication. The medication associate competency states, The medication associate will follow safety regulations, assist with medication administration, review the six rights of medication administration which includes the right resident, right medication, right dose, right route, right time, and the right documentation. The medication associate will remove the medication from the container, confirm the medication order and label three times prior to administering the medication and the associate will not pre-pour medication." Class I	A 052		
A 055 SS=J	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter	A 055		

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A 055	Continued From page 21 medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other	A 055		

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A 055	Continued From page 22 residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based upon observations, staff interviews, record reviews, and policy reviews, the facility failed to provide a safe and secure place for medication to be stored. This situation allows prescription and non-prescription medications to be easily	A 055		

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A 055	Continued From page 23 obtained by other residents in the facility. Staff was observed removing medications from the nurses station and storing medications loosely in a medication cup for multiple residents, placing them in a basket on a rolling metal cart and rolling down the hallway to administer medications to residents. This situation left the cart and medications unattended several times in the hallway. The findings include: On at 10:30 AM, an interview was performed with Resident #3. She revealed her medications are stored in a basket on an open counter and unlocked, potentially allowing for anyone to have access. She shares the room with her husband. They both administer their own medications. Medications for both individuals were aavailable in the open and not stored in a locked compartment. The front door to their room is capable of locking, but they stated they do not keep their door locked. During the interview, Resident #3 states that she always keeps the medication in easy reach sitting out on the counter by the sink. On at 5:30 PM and at 2:30 pm, Staff Member D, a Licensed Practical Nurse (LPN), was observed placing medications for residents in a medicine cup with the room number on each cup, place the medication cups in a white basket on a metal rolling cart, and take down hallway to administer medications to residents. Several times during these observations, Staff Member D left this cart unattended while she was administering medications to residents.	A 055		

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A 055	Continued From page 24 An interview was conducted on with Staff Member D. She revealed that she often uses the smaller metal rolling cart to take down the hallway to administer medications instead of using the large medicine cart with a secure lock on it. A staff interview was conducted on with Staff Member C (Lead Medication Tech) and the Executive Director, which revealed that the smaller metal rolling cart is only used when they need to grab something quickly and to store , cuffs, stethoscopes and , monitoring equipment. They further stated there is only one staff member (Staff Member D) who uses the cart. Staff Member C stated that all medications are stored in a locked area in the nurses stations, except for the residents who manage their medications, "those are stored in the residents rooms usually in a dresser drawer". Upon review of medication records, there are seven residents who manage their own medications and store their medicines in their room. During observations of the 7 rooms with residents who self-administer and manage their own medications, it was noted that 5 rooms had their medications in easily accessible, visibly seen, and in an unlocked container. Resident room doors have the capability of locking, but only 2 rooms were locked. Upon the review of facility policy of assistance with self-administration of medications, it states that if a resident is allowed to self-administer medication, their medication should be stored in their room in a locked compartment. Class I	A 055		

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