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 _____	R 03/18/2026

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 revisit survey, including a generator assessment, was completed at The Opal of Bluewater Bay, an Assisted Living Facility in Niceville, Florida, on . At the time of the survey, although some citations were found corrected, some previously cited deficiencies remain uncorrected.	{A 000}		
{A 052} SS=E	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her .	{A 052}		

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{A 052}	Continued From page 1 (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 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	{A 052}		

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{A 052}	Continued From page 2 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 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.	{A 052}		

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{A 052}	Continued From page 3 (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 observations, interviews, and records review, the facility failed to ensure that medications were administrated appropriately and in a safe manner for 2 out 6 residents observed (Resident #1 and #2), failed to ensure that 1 out	{A 052}		

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{A 052}	Continued From page 4 of 1 medication cart were locked and supervised, and 1 of 1 staff failed to comply with control standards. The findings include: On at approximately 9:10 AM, an observation of medication administration was conducted with Staff A, Executive Director (ED) (who is also a licensed practical nurse (LPN)). Medication administration was observed for Resident #1. The ED did not perform hygiene prior to pulling medications. Of the 5 medications removed from bubble packs or pill bottles, all five were handled directly with bare , and transferred into a medication cup at the medication cart. Upon entering the Resident #1 room, the ED did not perform hygiene. The computer screen remained open with the Resident #1's information and the medication cart was unlocked with her keys attached to the lock while she was away from the cart. A pill bottle and an inhaler for different residents were sitting on top of the medication cart. The ED rested the medication cup on the table and proceeded taking the pills out of the cup one by one with her bare and set them on the contaminated side table as she named the medication to be taken. Resident #1 refused one of the medications. Staff A removed the pill with her bare . She did not perform hygiene after resident care. She discarded the unwanted pill in the open side garbage attached to the medication cart. On at approximately 9:23 AM, an observation of medication administration was conducted with the ED for Resident #2. The ED did not perform hygiene prior to pulling medications. Of the 7 medications removed from	{A 052}		

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bubble packs or pill bottles, all seven were handled directly with bare and transferred into a medication cup at the medication cart. She donned gloves to crush the medications and realizes that one of the medications cannot be crushed. She set the crushed medications in the top drawer on the medication cart and started the process all over. With her gloves, she placed the pills on her writing paper , to open the capsules into the crush bag. She removed her gloves and performed hygiene. She proceeded to make a phone call with her personal cell phone that was sitting on top of the medication cart. The inhaler from a different patient was still sitting on top of the cart. She took the crushed medications and the uncrushable one in apple sauce and the bubble pack medications to the resident's room. The medication cart was unlocked and unattended as she did this. She did not perform hygiene upon entrance. She did don gloves. The resident only took some of her medications and refused the remaining. The ED explained she will call the resident's son to come over, and she will administer the rest of the medication in his presence later. She placed the reminder of the medications in apple sauce in the top drawer of the medication cart, with no name or date. She did not perform hygiene after resident care. She pushed the medication cart to the nurse's station. The medication in apple sauce remained stored on the top drawer of the medication cart until 10:20 AM when the son arrived at the facility.

On at approximately 10:35 AM, the ED was observed checking Resident #3's level using a . The ED did not perform hygiene prior to the task. She donned gloves, performed the prick,

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{A 052}	Continued From page 6 removed gloves and did not perform hygiene after resident care. On at approximately 10:40 AM, the ED was observed checking Resident #4's ⌄ level using a ⌄ After performing hygiene and donning gloves, she entered the room, leaving the medication cart unlocked and unattended, her keys sitting on top of the medication cart. On at approximately 12:25 PM, an observation of medication administration was conducted with Staff C, Medication Technician (MT). Medication administration was observed for Resident #5. Staff C, MT did not perform hygiene prior to pulling medications. She donned gloves, removed the medication from the bubble pack and transferred it into a medication cup. Upon entering the Resident #5 room, Staff C did not perform hygiene. The computer screen remained open with Resident #5's information and the medication cart was unlocked. (Photographic evidence obtained) On at approximately 12:30 PM, an observation of medication administration was conducted with Staff C, MT. Medication administration was observed for Resident #6. Staff C, MT did not perform hygiene prior to pulling medications. She donned gloves, removed the medication from the bubble pack and transferred it into a medication cup. She entered Resident #5 room, leaving the medication cart unlocked and unattended, computer screen open with the resident's information. She did not perform hygiene after the completion of the medication administration. On at approximately 12:52 PM, an	{A 052}		

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{A 052}	Continued From page 7 interview was conducted with Staff C, MT. She explained that she performs hygiene during medication pass only when moving between the 2 hallways; however, she stated that within each hallway she changes gloves between residents but does not perform hygiene between patient care. She added that she prefers just wearing gloves because the sanitizer dries her . She recalled leaving the medication cart open and unattended during her medication administration pass, with the computer screen open displaying Resident #5 and #6's information, while she administrated medication in the resident's room. She stated that this was her fault and acknowledged that she is not supposed to leave the medication cart open and unattended. She further acknowledged that the facility has ambulatory residents with , creating safety concern when the medication cart is left unlocked and unattended. She stated that she did not intend to do it but acknowledged that it occurred. She also acknowledged that she failed to perform hygiene when changing gloves between residents. She stated that she is aware that hygiene is required between residents and when changing gloves to prevent transmission and cross contamination. She confirmed that she received education on proper hygiene practices during her six-hour training and acknowledged the control requirement. On at approximately 1:14 PM, an interview was conducted with the ED. She explained that in her role she conducts audits and evaluates competency skills for both medication technicians and nursing staff. She added that she is responsible for the compliance and accountability of care delivered to the residents. She stated that she expects the staff to perform	{A 052}		

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{A 052}	Continued From page 8	{A 052}		

hygiene between residents and keep the medication carts locked. Regarding the medication administration performed earlier, she acknowledged that she failed to perform hygiene and handled medications with her bare prior to administering to the resident. She stated that she understood that hygiene should be performed after each resident contact and after removal of gloves, and that gloves are required for control and prevention. She further stated that she left the medication card unlocked and unattended with medication placed on top of the cart. She acknowledged that the resident population includes ambulatory residents with memory and recognized that leaving the medication card unsecured posed a safety risk. She acknowledged the control breach and risk for cross contamination and stating that her actions were incorrect and this is not the standards of practice expected by the facility. Regarding Resident #1, she stated that when the resident only consumed half of the medication crushed in applesauce, she stored the remaining unlabeled portion in the top drawer of the medication card while waiting for the Resident's son to arrive. She believed this practice was acceptable because she was the only person who had access to the medication card keys and the card was kept locked at the nurse's station. She explained that all medications had been crushed together and, because the resident took only half, she did not think she could discard the reminder.

The facility Medication Associate Competency Appraisal form conducted by the Executive Director was reviewed. This form is used to assess and ensure competency and compliance for medication administration. It includes employees to wash /sanitizer between

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{A 052}	Continued From page 9 residents, employees to wash after gloves worn. The Medication cart is always visible to the staff or locked, keys in employee possession, do not touch medications with . If medication is contaminated, destroy appropriately. Assistance with Self-Administration of Medication policy dated was reviewed which states that all medications, including over the counter, are to be kept in locked storage at all times. CLASS III	{A 052}		
{A 055} SS=D	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 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	{A 055}		

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{A 055}	Continued From page 10 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 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	{A 055}		

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{A 055}	Continued From page 11 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 on observation, interview and, review of facility policy, the facility failed to ensure medications were stored in a safe and secure manner for 1 out 5 residents assessed for self-administration of medications. (Resident #9) The findings include: On at approximately 12:30 PM, the medications belonging to Resident #9 were observed stored in an unlocked kitchen cabinet within the resident's room. There was no evidence that the facility ensured medications were stored in a locked, secure manner in	{A 055}		

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{A 055}	Continued From page 12 accordance with the facility and state requirements. On at approximately 12:30 PM, an interview was conducted with Resident #9. She stated that her daughter brings her medications and she stores them in the kitchen cabinet on the shelf. She further indicated that she never had a lock on her cabinet since her admission in On at approximately 1:14 PM, an interview was conducted with Staff A, Executive Director. She explained that she is responsible for ensuring and verifying the locked cabinets for residents that self-administer medications. She acknowledged that medications for residents who self-administer should be secured. She explained that the medications for Resident #9 were supposed to be kept in a locked cabinet in the kitchen and stated that this was likely an oversight and the enforcement of proper storage was not implemented for Resident #9, as the cabinet should have been secured. A review of the resident's record revealed documentation indicating the resident was approved to self-administer medications. Assistance with Self-Administration of Medication policy dated was reviewed. It states, "All medications, including over the counter, are to be kept in locked storage at all times. If a resident is allowed to self-administer medication, their medications should be stored in their room, in the locked compartment." CLASS III	{A 055}		