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
	AL11969854	A. BUILDING: _____ B. WING _____	R 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER WINGS ALF LLC	12275 SW 187 TERR MIAMI, FL 33177

(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 058 SS=D	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency.	A 058		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 058	Continued From page 1 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to correct two Class III deficiencies cited under a re-licensure survey regarding assistance with self-administration of medications and unlocked medications. Staff B (Caregiver) failed to orally advise Resident #1 of the name and dosage. Therefore, the facility is required to contract the services of a licensed pharmacist or registered nurse and a licensed dietitian who will provide at least quarterly consultation until the Agency for Health Care Administration determines that these services are no longer needed.	A 058		

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A 058	Continued From page 2 Findings: A record review showed the facility was cited on for staff not orally advising a resident of the name and dosage of medications and unlocked medications. Observation on at 6:04 AM Staff B failed to orally advise Resident #2 of the name and dosage of the medication (, 50 MG). Observation on at 6:50 AM Staff B failed to orally advise Resident #2 of the names and dosage of the medications (, 40 MG, , 300 MG, , 25 MG). Interviewed on at 7:48 AM the Owner acknowledged that a nursing consultant or pharmacist had to be hired. The Owner wanted to know if one should be hired immediately. Class III	A 058		
A 078 SS=G	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.	A 078		

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A 078	Continued From page 3 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing	A 078		

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A 078	Continued From page 4 agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure two (Staff B & Staff C Caregivers) out of five sampled employees were capable of immediately performing . ( ) techniques consistent with their level of education, training, preparation, and experience after Resident #1 found unresponsive for an unknown time. Resident #1 was later transported to the hospital by emergency medical services ( ) and pronounced . Findings: A review of Resident #1's progress notes dated documented that the resident was found unresponsive at 6:20 AM and was started. A review of the records dated documented their dispatch at 6:45 AM and was initiated by the facility staff at 6:45 AM more than 25 minutes after Resident #1 was found unresponsive. A review of Resident #1's hospital records dated showed the resident was brought to the emergency room for .	A 078		

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A 078	Continued From page 5 Interviewed on at 11:30 AM when asked about the emergency response when a resident is found unresponsive, the Administrator stated, "first start , call 911 and in between call the owner. Interviewed on at 11:19 AM the Owner stated that he was not in the facility when Resident #1 was found unresponsive. The Owner stated that Staff B found the resident unresponsive. The Owner stated further, "She (Staff B) called me and told me that he was not responding. Please come." The Owner stated that Staff B was nervous. When asked what Staff B was doing while she was talking with him, the Owner stated that he did not know. When asked what Staff C was doing, the Owner stated that she was with the other residents. The Owner stated that he called 911 when he got to the facility using the facility's telephone. The Owner stated that rescue arrived three minutes after he arrived and that Resident #1 was still alive. Interviewed on at 1:32 PM when asked if she worked on , Staff C stated that she did. Staff C stated that the last time she saw Resident #1 was between 11:00 PM-11:30 PM and that he was awake and . Staff C stated that around 5:45 AM-6:00 AM, Resident #1 had difficulty breathing. Staff C stated that she started and Staff B was there. Interviewed on at 12:07 PM Staff B stated the last time she saw the resident was that he was asleep and breathing at 12:00 AM ( ). When asked what time he was found unresponsive, Staff B thought it was around 6:00 AM but she could not	A 078		

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A 078	Continued From page 6 remember. Staff B stated that she called the Owner first. Staff B stated that the Owner was not there. Staff B stated that the Owner came to the facility and that he was the one to call 911. A review of the personnel records showed training for Staff B on and Staff C on . A review of the resident's records showed three Residents (#2, #4, #5) wished to be and remained in the facility and are at risk. The Cleveland Clinic states start immediately to give the person the best chance of survival. According to the American Red Cross: "If the person does not respond, is not breathing, is only gasping, or has a life-threatening , or another life-threatening condition, immediately call 911. Get equipment and give care based on the condition found according to your level of training." According to the American Association, "For healthcare providers and those trained: conventional using , and -to- breathing at a ratio of 30:2 , -to-breaths." Class II	A 078		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as	A 165		

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A 165	Continued From page 7 part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse	A 165		

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A 165	Continued From page 8 incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and	A 165		

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A 165	Continued From page 9 are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to file an adverse incident report for one (Resident #1) out of five sampled resident who was found unresponsive and was transported to hospital and pronounced . The facility failed to file an adverse incident report within one business day of the occurrence through the agency's online portal and within 15 days a completed report. Findings: A review of the admissions and discharged log showed Resident #1 was discharged on as it was documented, ", ." A review of Resident #1's progress notes dated revealed the resident was found unresponsive at 6:20 AM and 911 was called and resident was transported to the hospital. A review of the adverse incident reporting systems database found no reports of an incident which involved Resident #1 being found unresponsive and later pronounced at the hospital. Interviewed on at 6:38 AM when asked why an adverse incident was not filed, the Owner stated, "it was a regular thing."	A 165		

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A 165	Continued From page 10 Interviewed on at 11:30 AM when asked if an adverse incident was filed regarding Resident #1, the Administrator stated, "It does not need an adverse incident. He just , . It was noted in his records. His family knew." Class III	A 165		
A 182 SS=D	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Staff B & D (Caregivers) were capable of the implementation of the emergency plan. Findings: Observation on at 6:15 AM when asked to start the dual fuel generator (Hybrid II XP12000 EH), Staff B was unable to find the key on the key ring to start the generator. Observation on at 6:25 AM Staff D was unable to start the generator after the set of keys were handed to her.	A 182		

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A 182	Continued From page 11 Observation on at 6:35 AM the Owner grabbed a key from the key box to start the generator. Interviewed on at 7:48 AM the Owner stated that she (Staff B) knew how to start the generator and she did not have the key. The Owner stated further that the fuel had to get into the line. A review of Staff B's personnel records showed understanding facility's generator emergency environmental control plan training. A review of Staff D's personnel records showed understanding of the facility's generator emergency environmental control plan training on . Class III	A 182		
{A 000}	Initial Comments A revisit survey was conducted at Silver Wings ALF LLC. from through . Deficiencies were identified at the time of the survey. A Class I deficiency was found at Tag A0025. 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	{A 000}		

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{A 000}	Continued From page 12 Resident #1 was found unresponsive and the facility staff failed to immediately call 911 for a higher level of care. The Class I noncompliance began on . The facility's Administrator was notified of the Class I noncompliance on at 11:30 AM. The following is a description of the deficiencies found at the time of the visit to include supervision, unlocked medications and medication error, employee unable to implement the emergency plan and not filing an adverse incident after Resident #1 was found unresponsive and later pronounced at the hospital.	{A 000}		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making . , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or	A 025		

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A 025	Continued From page 13 is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 025		

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A 025	Continued From page 14 failed to ensure Staff B and Staff C (Caregivers) provided personal supervision and daily observation of activities while on premises and awareness of the general health, and safety for one (Resident #1) out of five sampled residents found unresponsive and no immediate call to 911 for more than 45 minutes. Resident #1 was pronounced at the hospital after transport by emergency medical services. The facility failed to provide supervision for more than seven hours for Resident #1, including repositioning the resident every two hours with to the right and heel, including to the right . Findings: A review of the emergency medical services ( ) records dated documented rescue was dispatched for Resident #1's at 6:45 AM, which was more than 45 minutes after the resident was found unresponsive by Staff B. The records revealed: "[Rescue] responded to a male that was in . According to the staff at the assisted living facility, the patient was last seen alive around 11:00 PM last night. The staff were making their morning round when they noticed the patient was unresponsive. The staff stated that couldn't feel a . The staff removed the patient from the bed and laid him on the floor. The staff started to perform . {Rescue] arrived and noticed the resident with no . [Rescue] placed the patient on a monitor and initial rhythm was as . [Rescue] started performing efforts. Establishing an , Patient intubated, medication was also administered. Continuous performed enroute to the hospital."	A 025		

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	AL11969854	A. BUILDING: _____ B. WING _____	R 04/21/2026

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A 025	Continued From page 15 A review of Resident #1's hospital records dated revealed: "presents via rescue from assisted living facility (ALF) at 11:00 PM last night rescue responded to a call at 6:50 AM. The patient was found unresponsive with no , no vital signs. They proceeded to intubate the patient and received a total of 7 cycles of , , and did a bicarb in advanced in transport to the emergency room on arrival the patient was unresponsive, intubated Accu-Chek was 106. The patient had no , show straight line The patient was coded for 15 minutes at 7:37 AM the patient was reassessed and had no activity on window monitoring. No spontaneous breathing. The patient pronounced expired." Interviewed on at 11:30 AM The Administrator stated that Resident #1 was found unresponsive between 5:00 AM-5:30 AM. The Administrator stated that she missed the call from the facility and did not see the missed call until 6:00 AM. The Administrator stated that she was not aware that there was an issue with Resident #1 being found unresponsive. However, there was no documentation that Staff C made a 911 call. Interviewed on at 11:19 AM the Owner stated that he was not in the facility when Resident #1 was found unresponsive. The Owner stated that Staff B found the resident unresponsive. The Owner stated further, "She (Staff B) called me and told me that he was not responding. Please come." The Owner stated that Staff B was nervous. When asked what Staff B was doing while she was talking with him, the Owner stated that he does not know. When asked what Staff C was doing, the Owner stated	A 025		

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A 025	Continued From page 16 that she was with the other residents. The Owner stated that he called 911 when he got to the facility using the facility's telephone. The Owner stated that rescue arrived three minutes after he arrived and that Resident #1 was still alive. When asked what time he called 911 on the facility's phone, the Owner stated that he did not know. A review of the staff schedule dated showed Staff C on schedule from 7:00 AM to 7:00 PM, and Staff B from 7:00 PM-7:00 AM on . However, Staff C stated that she was in the facility when the resident was found unresponsive. Interviewed on at 1:32 PM when asked if she worked on , Staff C stated that she did. Staff C stated that the last time she saw Resident #1 was between 11:00 PM-11:30 PM and that he was awake and . Staff C stated that around 5:45 AM-6:00 AM, Resident #1 had difficulty breathing. Staff C stated that she started and Staff B was there. Staff C stated that she called 911 but could not remember what time. Staff B stated that there were four residents in the facility. Staff B stated that she was the first person to do . Staff B stated that Staff C called the Owner. Interviewed on at 12:07 PM Staff B stated the last time she saw Resident #1 he was asleep and breathing at 12:00 AM ( ). When asked what time he was found unresponsive, Staff B thought it was around 6:00 AM but she could not remember. Staff B stated that she called the Owner first. Staff B stated that the Owner was not there. Staff B stated that the Owner came to the facility and that he was the one to call 911. Staff B stated that the Owner arrived within 10 minutes when she called him.	A 025		

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A 025	Continued From page 17 Staff B stated that while she was one the phone, the Owner coached her in doing . Staff B stated that she did not do right away when she found the resident unresponsive. Staff B stated that the resident was warm when she touched him. Staff B stated that Resident #1 had color that was normal. Staff B stated that his , was low. She stated that she did 30 , and two breaths and could not remember for how long. Staff B stated that the owner replaced her when he arrived. When asked if there was an employee working with her when the resident was found unresponsive, Staff B stated that Resident #C was there. When asked what she was doing, Staff B stated that she helped her to take Resident #1 from the bed to the floor and that she could not remember what else she did. Staff B stated that Staff C could have been taking care of the residents or making breakfast. A review of Resident #1's progress notes dated documented that the last time staff saw Resident #1 alive was at 11:00 PM on and that the resident was found not breathing and moving on at 6:20 AM and 911 was called and instructions were provided to start , ( ) process. According to the American Red Cross: "If the person does not respond, is not breathing, is only gasping, or has a life-threatening or another life-threatening condition, immediately call 911. Get equipment and give care based on the condition found according to your level of training." 2) A review of Resident #1's home health records for	A 025		

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A 025	Continued From page 18 care dated revealed Resident #1 must be repositioned every two hours due to several including to the right , but the last time the resident was seen alive was at 11:00 PM on . Interviewed on at 12:07 PM Staff B (Caregiver) stated that the last time the resident was checked on was 12:00 AM. Staff B stated that she did not see the resident until 6:00 AM on . When asked if she repositioned Resident #1 every two hours as required by the instructions from home health due to several , Staff B stated that the resident had a to the , heel and . Staff B stated, "No, he did not have that criteria. He would rotate himself because he could do it himself. I did not know he had any order to move. Interviewed on at 9:36 AM the home health nurse stated that Resident #1 had care to the right , right heel and right and the instructions were to treat the with normal solution, , dry and reposition the resident every two hours. However, according to the staff, Resident #1 was last seen at 11:00 PM on and was found unresponsive at 6:30 AM. Interviewed on at 1:32 PM when asked how often the residents are checked throughout the shift, Staff C stated every 40 minutes to an hour. Staff C stated that she does not know if checking residents every hour was the policy, but she did it because it was humanity. Staff C stated that she checks residents during the day but at night she did not do it because she did not want to wake up the residents. When asked if she was aware Resident #1 had , Staff C stated that he had a to the ,	A 025		

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A 025	Continued From page 19	A 025		

and that she moved him during the day but not at night. Staff C stated that she was aware he had to be turned but they never did it at night. Staff C stated that she did not have the understanding that she had to move him at night.

Interviewed on at 11:30 AM when asked if the resident had care, the Administrator stated, "Yes." When asked the location of the , the Administrator stated that she did not recall. When asked about the repositioning of the resident every two hours, the Administrator stated that she did not recall. When asked if rounds were done throughout the shifts, the Administrator stated that during the day and not at night unless the patient calls out. The Administrator stated further, "We don't check on them when they are sleeping. "I don't recall the repositioning. During the day, I am sure rounds are done, but during the night, I don't know."

A review of Resident #1's health assessment dated showed diagnoses of , and . The physical status showed dependent with activities of daily living and limited walking. The status showed awake, alert and oriented times three and forgetful. The nursing notes showed care. The resident had precautions. The activities of daily living showed assistance with ambulation, bathing, , eating, self-care, toileting and transferring.

According to the Cleveland Clinic, " people who are older, immobile or bedridden are most at risk for . These , occur when there's prolonged pressure on your skin. Friction, moisture and (pulling on skin) also lead to , there are different

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A 025	Continued From page 20 stages of . The most serious (stages 3 and 4) increase your risk of life-threatening : A shallow with pink or red develops. You may lose skin loss, and ." Class I	A 025		
{A 052} SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (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 21 (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 22 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 23 (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Staff B (Caregiver) orally advised one (Resident #2) out of four sampled residents who needed assistance with self-administration of medication of the	{A 052}		

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{A 052}	Continued From page 24 names and dosage of each medication. Findings: Observation on at 6:04 AM Staff B offered , 50 MG to Resident #2 without naming the medication and dosage. Observation on at 6:50 AM Staff B Employee offered medications to Resident #2 without naming the medications (, 40 MG, , 300 MG, , 25 MG) and dosage. A review of Resident #2's health assessment dated showed the resident needed assistance with self-administration of medication. A review of Resident #2's record found no medication waiver to opt out of being orally advised of the name and dosage of each medication. Interviewed on at 7:48 AM the Owner stated, "I don't want them to have a waiver. I want the employee to know." The Owner stated further that Resident #2 does not have a medication waiver. A review of Staff B's personnel records showed six hours of assistance with self-administration of medication training on . Uncorrected Class III	{A 052}		
{A 055} SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL.	{A 055}		

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{A 055}	Continued From page 25 (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 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	{A 055}		

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{A 055}	Continued From page 26 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 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	{A 055}		

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{A 055}	Continued From page 27 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, record review and interview, the facility failed to maintain a locked medication cabinet or closet. Findings: Observation on at 6:02 AM medication cabinet unlocked and agency staff left alone in kitchen while Staff B and Staff C (Caregivers) assist residents. A review of the facility's medication policy revealed medications will be locked in a cabinet. Interviewed on at 7:48 AM, the Owner insisted that there was a lock for the cabinet. Uncorrected Class III	{A 055}		