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
	AL11910479	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYLAND MANOR	7632 MARYLAND AVENUE HUDSON, FL 34667

(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 Assisted Living Facility A complaint survey, CCR# 2012005330, was conducted on . Maryland Manor assisted living facility had deficiencies found at the time of the visit. A Class II deficiency or an uncorrected Class III deficiency directly related to facility medication practices will require the facility to employ on staff or by contract, a licensed pharmacist pursuant to Section 465.0125, F.S. or registered nurse as determined by the agency. The initial on-site consultant visit shall take place within 7 working days of the identification of a Class I or Class II deficiency and within 14 days of the identification of an uncorrected Class III deficiency.	A 000		
A 052	58A-5.0185(3) FAC Medication - Assistance with Self-Admin (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least , trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. (b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container,	A 052		

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A 052	Continued From page 1	A 052		

and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container.
(c) Staff shall observe the resident take the medication. Any concerns about the resident ' s reaction to the medication shall be reported to the resident ' s health care provider and documented in the resident ' s record.
(d) 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 which coincides with the resident ' s presence in the facility;
2. The medication container may be given to the resident or 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;
(e) Pursuant to Section 429.256(4)(h), F.S., the term " competent resident " means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.
(f) Pursuant to Section 429.256(4)(i), F.S., the

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A 052	Continued From page 2 terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (4) Assistance with self-administration 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 through intermittent positive pressure breathing machines or a . (d) Administration of medications by way of a tube inserted in a cavity of the body. (e) Administration of preparations. (f) Irrigations or debriding agents used in the treatment of a skin condition. (g) , , or preparations. (h) 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 at the request of a competent resident. (i) 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. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to assure all medications were assisted with in the correct manner, that prepared medications were free	A 052		

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from contamination and failed to assure all medications were available as ordered which resulted in 2 (Resident #2 and # 4) of 8 sampled residents suffering negative physical and emotional effects from not receiving medications as ordered. Also 1 (resident #1) of 8 sampled residents was at risk for contamination from improper sanitization practice during medication pass.

Findings include:

1. An email sent from the Department of Elder Affairs to the Agency for Health Care Administration on provided details of a visit made by the ombudsman to the facility on . During this visit resident #2 reported that he did not receive his , from to . On , a record review of resident #2 ' s medication observation records (MORs) for months of , , and 2012 was done. According to the MOR he had 2 mg tablet ordered 3 times a day. To be given at 8am, 12pm and 8pm. The 2012 MOR indicates that resident #2 was not given any dosages of this medication as ordered from to . Due to the facility ' s failure to maintain a copy of the prescription, from the resident ' s provider, it was not possible to determine if this was the correct dosage, amount and time this medication was ordered to be given in of 2012.

On , at 3:30 p.m., an interview was done with resident #2. At this time resident #2 stated that staff informed him that he was missing 12 dosages of and they are unable to give him the medication. He also stated that staff did not try and notify his provider to get refills of this medication. He did not know if local law

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enforcement was called concerning the missing dosages. He did state that due to missing the dosages it caused him to have become very , to where he was unable to go outside without suffering an and According to resident #2 the missed meds caused him to seek hospital for treatment from to . According to the U.S. National Library of Medicine if is suddenly stopped side effects such as , difficulty sleeping, nervousness, and may occur. www.ncbl.nlm.nih.gov

On the same day, at 3:40 p.m., an interview with the administrator was done in regards to resident #2 ' s missing medication. He stated he did not know how the medications came up missing. He thinks it is related to a former employee who was linked to other missing medications. He did state the local law enforcement agency was contacted and a report was done. He was unable to produce a report number, name of law enforcement officer (LEO) who took report or the date that LEO came out to do report. He had no explanation to why resident #2's provider was not notified of missing medications.

2. Resident #4 had orders for several control meds ordered and a review of the medication observation records on had numerous doses missing signatures indicating the doses were not given as ordered: information: *Methadone 10mg tabs (a controlled medication-), give 3 tabs twice daily. The 2012, 2012, 2012 and 2012 medication observation sheets had the medication transcribed and scheduled at 8am and 8:00pm. There were numerous slash marks on each of those months (missed 13 doses, missed 12 doses, missing 7 doses)

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where initials should have been to indicate each dose given. The back of the MOR did not have the required documentation to say whether the medication was not available or not or whether the resident had refused the doses. There were no control sheets available to determine the correct counts of /controlled drugs. The record review revealed no notes to describe what action the facility took if the medication was missing, whether the administrator had been made aware and whether the resident's prescribing physician(s) had been contacted to notify of the resident's status and to reorder the medication.

* 1mg, give 1 every 6 hrs as needed (no indication for use). It was documented as a scheduled medication, therefore when there were slashes or spaces, you could not tell if it was an error or whether the resident did not need it or it wasn't available. There was no copy of the order for comparison but it was written as a scheduled medication on the 2012 MOR.

* 1mg tab, give 4 x daily and was scheduled at 8:00am, 12noon, 5:00pm and 8:00pm. on the 06, 07, and MORs. Again, there were numerous slash marks (in 06 there were 18 doses missing initials, 2012 was missing 7 doses (in the spaces where the med tech initials should have been to indicate the medication had been given) and nothing was marked on the back of the MORs making it impossible to figure out.

* , give 1 tab 3x daily and was scheduled at 8:00am, 2:00pm and 8:00pm. In 2012, 3 doses were marked with slash marks, 2012 had 59doses marked with slash marks and 2012 had 40 doses marked with slash marks.

An interview with Staff A on at

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approximately 10:00am revealed a slash mark means the medication was not given but she acknowledged there was no explanation written as to why the medication was not given, that it could mean it was not available or the resident refused the dose. She said she did not know that you were supposed to write on the back of the MOR to give an explanation as to why the medications were not given. She went on to say she and the other staff and the administrator had been aware that medications for the resident were missing and the administrator moved the controlled meds out of the kitchen cabinet into his office and they started only taking out enough Methadone for a days supply which was kept in the locked kitchen cabinet. She said the Sheriff's office had been called the first 2 times it was noticed the pills were missing but the resident would not complete the paperwork in order for a case to be opened. She said she noticed on when she went to give the resident his am dose of Methadone, that the pills had been replaced with different pills. She immediately grew suspicious of a staff member (who had just gone off duty) and immediately called her boss, Staff A and the administrator was also contacted. The employee was terminated right then she states. She reports there have not been any more missing medications since that date. After the last theft, the staff member stated she did not call the Sheriff's office because she assumed they would ask for the paperwork again which they did after the first 2 times the medications were missing. She said the resident was not willing to do the paperwork because he didn't want to get the former employee in trouble.

A review of Staff D's file revealed she had the required 4 hour medication training on / .

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A 052	Continued From page 7 During an interview with Resident #4 on at 10:15 a.m.: he was missing Methadone pills (which he said he takes for chronic pain) in , , and (but he wasn't sure those were the correct months). He said they come in 3 in a pack. "I told them to buy a lock box for the but they wouldn't do it. I went through hell- I had nightmares, , leg pain, , and daily". They did not offer to take me to the emergency I probably would not have gone. The first 2 times it happened, they (staff) all had the keys. I take 3-10mg Methadone tabs with breakfast and 3 before bed. The first time it happened, the pills were gone and I tried to get an earlier appointment at the pain clinic but was denied, I didn't tell them the pills were stolen because I thought they'd cut me off. The second time it happened, I did tell the doctor they were stolen but they refused to refill. The third time, it was the facility's fault because they did not get a lock box like I suggested. I didn't want to get my doctor involved, he'd cut me off. I called my case manager and he helped me by going to the pain clinic and speaking to the doctor there. I also called the ombudsman. Now its good, only enough are taken out for the day (total of 6 pills are put in a medicine bottle for the days worth) and they keep better track of them. The resident stated he also takes 3x day and 3x day. He went on to say he had numerous physical ailments/chronic pain from a bad motorcycle accident in 1987. I know who stole the Methadone because she begged me for 3 methadone tablets the day she was fired. Staff B recognized the pills (Methadone) were replaced with other pills. I didn't want to tell on her because I didn' t want her to get in trouble. I love this place, it's my home and I think they've got it under control now, no more missing meds since she	A 052		

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A 052	Continued From page 8 was fired. They treat me well here, they are my family. 3. On . . . . , at 12 p.m., staff #D was observed performing a medication pass on residents' #1, #2, and # 3. Prior to preparing medications staff #D washed her hands. While preparing medications for resident #1 staff #D was observed removing the medication from the bubble pack and placing it in her ungloved hand. She then placed the medication in a plastic cup and gave to gave cup to resident #1. She then provide resident #1 with cup of water to take medication with. Staff #D then began to get medications ready for resident #2. At this time staff #D was told to stop what she was doing. It was explained to her that due to cross contamination risks during medication pass, medications are not allowed to handled by hand. Also that hands must sanitized in between medication passes. Staff # D responded that she was unaware that she had contact with bare skin with medications. She also stated that she thought she only had to sanitize hands prior to assisting with medications and not in between each medication pass. According to staff #D's training record she completed 4 hours of training on assisting medications on . . / . . . Class II Pattern	A 052		
A 054	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication	A 054		

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A 054	Continued From page 9 container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider ' s name, the resident ' s name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to transcribe orders correctly on the medication observation records (MORs) and failed to document doses given or held accurately on the MORs for 2 (Residents #1, #4) of 4 residents who's MORs were reviewed, which could cause when trying to determine what the correct order was and whether it was given accurately. The facility also failed to maintain a written medication order issued and signed by the resident ' s health care provider, or a faxed copy of such order for 4	A 054		

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A 054	Continued From page 10 (residents #1, #2, #3 #4) out of 8 sampled residents. Findings include: A record review revealed Resident #1 had an order for: * , take 1 tablet every 8 hours as needed. The strength of the dose (12.5mg tab) was missing and the indication for use was missing. The order was scheduled at 8:00 a.m., 12:00pm, 5:00pm and 8:00pm and then slashes were marked at each of these time slots. Initials were present on 11 doses so far in 2012. There was no documentation on the back of the MOR to give the time the initialed doses were given and what effect the doses had. An interview with Staff A on at approximately 11:45am revealed the slashes were to show the medication was offered but not given. She said the schedule was put on the MOR to show what time the medication could be given but acknowledged that prn or as needed meds should not be scheduled. The ordered dose was not on the MOR and neither was the indication for use. Record review revealed Resident #4 had several errors on the 2012 MORs including: *Methadone, 3 tablets 2x day (strength and supplied dose was missing), each dose had a number above it, with either a 1, 2 or 3. Three doses had slashes in the 8am dose slots possibly indicating not given.(The back of the MOR had no explanation as to what the numbers meant- the MOR was blank on back) * 1mg, take 1 tab 4x day and was scheduled at 8:00 a.m., 12 noon, 5:00 p.m. and 8:00 p.m. 3 doses had slash marks in them with	A 054		

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no explanation on the back. The label on the dispensed package had give 3x day (order was changed on /) but the 2012 MOR did not show the order change.
* , (missing the number of tablets to give each dose), and indication for use. It was scheduled at 8:00am, 12 noon and 8:00pm. The bottle had directions to give 1 tab every 6-8 hours, with no indication for use or direction whether this was to be scheduled or prn. There was no documentation that the physician had been contacted for clarification of the order.
* - take one tablespoon daily as needed (missing indication for use). Slash marks were marked daily but there was no explanation to tell what the marks meant.
*Milk of Magnesia- take 10ml by mouth daily as needed (missing indication for use). Slash marks were drawn daily with initials on and with no explanation on the back of the MOR to indicate what time the resident requested the medication, why it was requested and if it was effective or not.

An interview with Staff A on at approximately 2:00 p.m. revealed she was not aware of the errors identified above. She said she would call the pharmacy and obtain all current orders in order to reconcile the MORs.

On , a record review of, residents #1, #2, #3 #4, revealed that no written or copied medication order issued and signed by the resident ' s health care provider, or a faxed copy of such order was maintained in their records.

On at approximately 12:45 p.m. with the administrator and staff #D was done. During this interview both administrator and staff # D stated that when they got a new prescription they would

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A 054	Continued From page 12 fax it over to their pharmacy to be filled. When the pharmacy would deliver the medications they would give the original prescription to the pharmacy. They both stated that it was not facility's policy to keep a copy of the prescription in residents' records. The both stated they did not know they were required to maintain a copy. Class III Widespread	A 054		
A 055	58A-5.0185(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; or in their or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility shall 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 055		

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A 055	Continued From page 13	A 055		

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 prior to admission as required under Rule 58A-5.0181, F.A.C.
(b) Centrally stored medications must be:
1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and
4. Kept separately from the medications of other residents and properly closed or sealed.
(c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident ' s representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident ' s request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked " discontinued medication. " Such medication may be reused if re-prescribed by the resident ' s health care

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	AL11910479	A. BUILDING _____ B. WING _____	

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provider.
(d) When a resident ' s stay in the facility has ended, the administrator shall 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 shall be considered abandoned and may disposed of in accordance with paragraph (e).
(e) Medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and disposition shall 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.
(f) 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 and interview, the facility failed to keep 8 of 16 residents medications separately from others and included oral medications with and eye drops all together which could cause a potential problem with residents being given other resident's medicines.

Findings include:

An observation of the medication cabinet in the kitchen on at approximately 11:45 a.m. revealed the following medications all in the same box for 8 different residents:
cream,

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A 055	Continued From page 15 inhaler, Triancinalone 0.5% cream, MOM, , Nicotene system patches, Ondanesetron OD, solution, another drops. An interview with the Staff A on at approximately 11:45 a.m. revealed she was not aware that the residents medications could not be stored together. She went on to say the medications were those that the residents did not need but had not been discontinued. Class III Pattern	A 055		
A 056	58A-5.0185(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) No prescription drug shall be kept or administered by the facility, including assistance with self-administration of medication, unless it is properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident ' s name; and 2. Identification of each medicinal drug product in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no person other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are " as needed " or	A 056		

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" as directed, " the health care provider shall be contacted and requested to provide revised instructions. For an " as needed " prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations shall be specified; for example, " as needed for pain, not to exceed 4 tablets per day. " The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, shall be noted in the medication record, or a revised label shall be obtained from the pharmacist.
(d) Any change in directions for use of a medication for which the facility is providing assistance with self-administration or administering medication must be accompanied by a written medication order issued and signed by the resident ' s health care provider, or a faxed copy of such order. The new directions shall promptly be recorded in the resident ' s medication observation record. The facility may then place an " alert " label on the medication container which directs staff to examine the revised directions for use in the MOR, or obtain a revised label from the pharmacist.
(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident ' s medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed copy of a signed order is acceptable.
(f) The facility shall make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
(g) Pursuant to Section 465.0276(5), F.S., and Rule 64F-12.006, F.A.C., sample or

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complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer ' s packaging, which shall also include the practitioner ' s name, the resident ' s name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer ' s labeled package, they shall be kept in a container that bears a label containing the following:
1. Practitioner ' s name;
2. Resident ' s name;
3. Date dispensed;
4. Name and strength of the drug;
5. Directions for use; and
6. Expiration date.
(h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident ' s health care provider shall provide the resident with a written prescription, or a fax copy of such order.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to obtain clarification for 4 (Residents #1,#2, #4, #8) of 8 residents who had medication or treatment orders that were as needed or prn which causes unlicensed staff to use judgement when determining what intended indication for use and frequency in which to give them which could result in medications being given either too frequently or infrequently and did not dispose or return medications belonging to a discharged resident.

Findings include:

Examples of residents with medications ordered without the specific parameters or indication for use include:

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Resident #1 had an order transcribed onto the 2012 medication observation record (MOR) for , take 1 tablet every 8 hours as needed. There was no indication for use and no copy of the order was available. Another medication with the resident's name was for 1%/0.5% with no instructions for use.

Resident #2 had an order transcribed onto the 2012 MOR for Hydroxyine 50mg 3 times a day as needed for . The 2012 MOR has medication scheduled as routine to be given at 8 a.m., 12 p.m. and 8 p.m. The is no documentation that the physician had been contacted for clarification.

Resident #4 had an order transcribed onto the MOR for , and was scheduled at 8:00am, 2:00pm and 8:00pm. The bottle of was labeled 1 tab every 6-8 hours as needed (missing the indication for use and a specific frequency instead of the range given). There was no documentation that the physician had been contacted for clarification. , give 1 tablespoon daily as needed (no indication for use), MOM 10 ml daily as needed (no indication for use).

Resident #8 had several pill packs with Acetamenophen 325mg, take 2 tabs as neeed every 4 hours with no indication for use given. He also had a container with the following label: 0.5mg, take 1-2 tabs (range) every 6 hours prn .

A vial of 1%/0.05% had no label and no name, with an expiration date of / .

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A 056	Continued From page 19 An inhaler of [redacted] for a discharged resident had instructions to use 1-2 puffs 4 x day as needed (no indication for use was given). Class III Pattern	A 056		
A 058	429.42 FS; 58A-5.033 FAC Pharmacy & Dietary; Uncorrected Deficiencies Uncorrected deficiencies: 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. (4) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies.	A 058		

Agency for Health Care Administration

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A 058	Continued From page 20 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 agency personnel pursuant to an inspection of the facility, the agency shall notify the facility in writing that the facility must employ, on staff or by contract, the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse, as determined by the agency. 2. The initial on-site consultant visit shall take place within 7 working days of the identification of a Class I or Class II deficiency and within 14 working days of the identification of an uncorrected Class III deficiency. The facility shall have available for review by the agency a copy of the pharmacist ' s or registered nurse ' s license and a signed and dated recommended corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility shall 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 shall provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility had a class II deficiency in medication so the facility will be required to employ the consultant services of a licensed pharmacist or a licensed registered nurse. Findings include:	A 058		

Agency for Health Care Administration

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A 058	Continued From page 21 A record review on of the medication observation record for residents (#2 and #4) revealed that medication was not properly secured and medications were unaccounted for, causing residents #2 and #4 to miss dosages of required medications. These missed dosages caused negative physical and emotional effects on residents #2 and #4 and resulted in a class II deficiency. The class II deficiency was A0052. Unclassified	A 058		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Maryland Manor
7632 Maryland Avenue
Hudson, FL 34667

Dear Administrator:

Re: **CCR# 2012005330**

This letter reports the findings of a complaint survey that was conducted on , 2012, by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. (Please note **Tag A 052 M.C.D.** .) Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

FAV Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

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