STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922141	R 06/22/2015
NAME OF PROVIDER OR SUPPLIER **RENAISSANCE RETIREMENT CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **300 WEST AIRPORT BLVD. SANFORD, FL 32771**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

Conducted revisit to Complaint Investigation CCR#2015003086 in conjunction with the revisit to Complaint Investigation CCR# 2014007505, Complaint Inspection CCR#2015003086 and review of the Directed Plan of Care (DPOC) corrections. Renaissance Retirement Center had deficiencies that remained uncorrected at the time of the visit.

0025 Resident Care - Supervision

THE FOLLOWING DEFICIENCY REMAINED UNCORRECTED:
Based on record review and interview the facility failed to ensure the physician orders were followed for 1 of 8 sampled residents (#15).

Findings:

Resident record review revealed resident #15 had an Assisted Living Facility Health Assessment form (1823) dated that indicated diagnoses of and

Review of physician orders dated indicated (for lipids) 10 milligrams (mg) one tablet at bedtime and ProAir HFA aerosol (bronchodilator) 2 puffs by mouth twice daily at 8:30 AM and 5 PM.

Review of Medication Observation Record for 2015 revealed:
on at 7:40 PM, the medication was not available, the pharmacy was notified, and the facility was awaiting delivery from the pharmacy.

ProAir HFA aerosol on at 8:22 AM and 3:42 PM the medication was not available, the pharmacy was notified, and the facility was awaiting delivery from the pharmacy.

The facility did not follow physician orders for resident #15 for the and Pro-Air inhaler.

In an interview with Resident #15 on at approximately 4 PM who stated he ran out of his inhaler medication a few days ago.

In an interview with the Resident Care Coordinator on at approximately 4 PM she was not aware the medications were not given.

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	AL11922141	R 06/22/2015
NAME OF PROVIDER OR SUPPLIER **RENAISSANCE RETIREMENT CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **300 WEST AIRPORT BLVD.** **SANFORD, FL 32771**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Class III

0056 Medication - Labeling and Orders

THE FOLLOWING DEFICIENCY REMAINED UNCORRECTED:
Based on medication review and interview the facility did not make every reasonable effort to ensure that prescriptions were refilled in a timely manner for 1 of 8 sampled residents who received assistance with self-administration of medications (#15).

Findings:

In an interview with Resident #15 on at approximately 2 PM who stated he ran out of his inhaler medication a few days ago.

Resident record review revealed resident #15 had an Assisted Living Facility Health Assessment form (1823) dated that indicated diagnoses of and and needed assistance with self-administration of medications.

Review of physician orders dated indicated (for lipids) 10 milligrams (mg) one tablet at bedtime and ProAir HFA aerosol (bronchodilator) 2 puffs by mouth twice daily at 8:30 AM and 5 PM.

Review of Medication Observation Record for 2015 revealed:
on at 7:40 PM, the medication was not available, the pharmacy was notified, and the facility was awaiting delivery from the pharmacy.
ProAir HFA aerosol on at 8:22 AM and 3:42 PM the medication was not available, the pharmacy was notified, and the facility was awaiting delivery from the pharmacy.

The facility did not have resident #15's medication refilled in a timely manner.

In an interview with the Resident Care Coordinator on at approximately 4 PM she was not aware the medications were not given.

Class III

AH Form Approved

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11922141	A. Building B. Wing	6/22/2015

Name of Facility	Street Address, City, State, Zip Code
RENAISSANCE RETIREMENT CENTER	300 WEST AIRPORT BLVD. SANFORD, FL 32771

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix A0054 Reg. # 58A-5.0185(5) FAC LSC	0054	ID Prefix A0163 Reg. # 429.49 FS LSC	06/22/2015 0163	ID Prefix Reg. # LSC	ZZZZ
ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ
ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ
ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ
ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ

Reviewed By State Agency	Reviewed By L. Henry for S. Decenir	Date: 7/29/15	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on:			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES NO

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Renaissance Retirement Center
300 West Airport Blvd.
Sanford, FL 32771

RE: Revisit to CCR#2014004285

Dear Administrator:

This letter reports the findings of a **third** State Licensure complaint investigation Revisit Survey conducted on 22, 2015 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than 2015.**

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 surveyor(s). Should you have any questions please call Lorraine Henry at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
YOSF

Orlando Field Office
400 W. Robinson St., Suite S-309
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Phone:(407) 420-2502; Fax:(407) 245-0998
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STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,
Petitioner,

vs.

CASE NOS. 2014011689
2014011713
2015003501
2015003503

NIC 5 RENAISSANCE RETIREMENT LEASING, LLC,
D/B/A RENAISSANCE RETIREMENT CENTER,
Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Agency for Health Care Administration ('Agency'), by and through the undersigned counsel, and files this Administrative Complaint against NIC 5 Renaissance Retirement Leasing, LLC, d/b/a Renaissance Retirement Center ('Respondent'), an assisted living facility ('ALF') licensed to operate in the State of Florida, pursuant to Sections 120.569, and 120.57, Fla. Stats. (2014), and alleges:

NATURE OF THE ACTION

This is an action to impose **$19,500** in fines for:

Case #2014011689 - 1 unclassified deficiency for $500 (Count I); and

Case #2014011713 - 3 uncorrected class II deficiencies for $2,500, $2,500 & $1,000 (Counts II –) & 1 uncorrected class III deficiency for $500 (Count V); and

Case #2015003501- 2 repeat uncorrected class II deficiencies for $5,000 each (Counts VI - VII), one uncorrected class II deficiency for $1,000 (Count VIII) & 1 twice uncorrected class III deficiency for $1,000 (Count XIV); and

Case #20150003503 – 1 uncorrected class III deficiency for $500 (Count X).

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to Sections 20.42, 120.60 and Chapters 408, Part II, and 429, Part I, Fla. Stats. (2014).

2. Venue lies pursuant to Florida Administrative Code ('F.A.C.') Rule 28-106.207.

PARTIES

3. The Agency is the regulatory authority responsible for licensure of ALFs, specialty licenses and enforcement of all applicable state statutes and rules governing ALFs pursuant to Chapters 408, Part II, and 429, Part I, Fla. Stats., and Chapter 58A-5, F.A.C.

4. Respondent operates a 115 bed ALF at 300 West Airport Blvd., Sanford, FL 32771, license # 5815.

5. Respondent was at all times material hereto a licensed ALF under the licensing authority of the Agency, and was required to comply with all applicable rules and statutes.

COUNT I – $500 UNCLASSIFIED FINE
(Case #2014011689 - Tag AZ821: Reporting Requirements; Electronic Submission)

6. The Agency re-alleges and incorporates paragraphs 1-5 as if fully set forth herein.

7. On 27 , 2014, the Agency began a complaint inspection (CCR #2014007505) which was conducted in conjunction to the revisit for a prior complaint (CCR #2014004285).

8. a. Based on a review of records and interview the facility failed to ensure an adverse incident report was submitted within one business day when law enforcement conducted an investigation at the facility for 2 of 17 sampled residents, #13 & 14.

b. Resident #13. Sanford Police Department Report #20141272334 dated at 5:22 PM revealed that this male on at about 9 AM had stored $70 in the top desk drawer in his living then he left for the day. When he arrived back to retrieve the money he

discovered that unknown person(s) by unknown means had removed it. On at about 9 AM he had stored $100 in the top desk drawer in his living He went to have lunch and when he returned to deposit the money in the bank the money had been removed by unknown person(s).

c. Resident #14. Sanford Police Department Report #20141261677 dated at 1:30 PM revealed she advised on that she discovered $400 had been removed from the safe in her unknown means without her permission.

d. On at about 5 PM the administrator stated the adverse incident reports were not completed as required.

9. Florida laws state regarding reporting requirements and records maintenance:

429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.—

...

(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States 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 incident, and the status of the facility's investigation of the incident.

(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States 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.

...

Section 429.23, Fla. Stat. (2014)

59A-35.110 Reporting Requirements; Electronic Submission.

....

(2) Electronic submission of information.

(a) The following required information must be reported through the Agency's Internet site at http://www.ahca.myflorida.com/reporting/index.shtml:

...

2. Assisted living facilities:

a. Adverse incident reports required pursuant to Sections 429.23(3) and (4), F.S. and Rule 58A-5.0241, F.A.C.

...

Rule 59A-35.110, F.A.C.

58A-5.024 Records.
The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request.

...

Rule 58A-5.024, F.A.C.

10. The Respondent was cited for an unclassified deficiency, defined in subsection (3):

408.813 Administrative fines; violations.—As a penalty for any violation of this part, authorizing statutes, or applicable rules, the agency may impose an administrative fine.

...

(2) Violations of this part, authorizing statutes, or applicable rules shall be classified according to the nature of the violation and the gravity of its probable effect on clients. ... Violations shall be classified on the written notice as follows:

...

(b) Class "II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. The agency shall impose an administrative fine as provided by law for a cited class II violation. A fine shall be levied notwithstanding the correction of the violation.

(c) Class "III" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients, other than class I or class II violations. The agency shall impose an administrative fine as provided in this section for a cited class III violation. A citation for a class III violation must specify the time within which the violation is required to be corrected. If a class III violation is corrected within the time specified, a fine may not be imposed.

...

(3) The agency may impose an administrative fine for a violation that is not designated as a class I, class II, class III, or class violation. Unless otherwise specified by law, the amount of the fine may not exceed $500 for each violation. Unclassified violations include:

(a) Violating any term or condition of a license.
(b) Violating any provision of this part, authorizing statutes, or applicable rules.
(c) Exceeding licensed capacity.
(d) Providing services beyond the scope of the license.
(e) Violating a moratorium imposed pursuant to s. 408.814.

Section 408.813, Fla. Stat. (2014)

11. The fine for unclassified deficiency is determined as stated in subsection (3) in ¶ 10.

WHEREFORE, the Agency intends to impose a $500 fine.

COUNT II – $2,500 UNCORRECTED CLASS II FINE
(**Case #2014011713** - Tag A0025: Resident Care - Supervision)

12. The Agency re-alleges and incorporates paragraphs 1-5 as if fully set forth herein.

1st Survey – (paragraphs 13-16)

13. On 21 , 2014, the Agency began a complaint investigation (CCR #2014004285).

14. On 19 , 2014, the Respondent was served with an Administrative Complaint (AC) alleging a violation of ID Prefix Tag A0025, a class II violation involving inadequate supervision of residents. Included with the AC was an Election of Rights (EOR) form. See Exhibits 1 (AC) and 2 (EOR) attached to the Final Order regarding AHCA Case No. 2014008122, attached hereto as **Ex. A**.

15. The Respondent elected 'Option 1', thereby admitting to the facts alleged and agreeing to pay the entire $1,000 fine within 30 days of the date on the Final Order, 20 , 2014. **Ex. A**.

16. A class II violation is defined in subsection (2) (b) in ¶ 10.

2nd Survey (paragraphs 17 –22)

17. On , 2014, the Agency started a follow up to the , 2014, complaint investigation.

18. a. Based on a review of Medication Observation Records (MOR), other records and interviews, the facility did not ensure that one of 20 sampled residents, female Resident #9, received care and services appropriate to meet her needs, including following physician orders for medications which resulted in her suffering needlessly in pain.

b. Resident #9.

1) On at about 11 AM she stated the facility ran out of her pain medications so she did not receive all of them as she should have. Because of this she was in a lot of pain.

2) Her health assessment, AHCA Form 1823 ("health assessment Form") dated

showed diagnoses that included , scoliosis, stiff man

and . The Form noted that she required assistance with the self-administration of medications. An order dated noted: 5 mg take 3 half tablets (7.5 mg) three times daily.

3) The sign out sheet, used to note the count, when, and the amount of the given, revealed that on at 6:26 AM she was only given 2 halves and 16 pills were available. On at 6:30 AM only one half pill was given. The amount available at the facility was noted to be 11 half pills. On at 9 PM only 2 halves were given. The amount available at the facility was thirty half pills.

4) The Electronic MOR for and noted that she received 5 mg three halves (7.5 mg).

5) On at about 3 PM the administrator reviewed the MORs and the sign out sheet and confirmed that she did not get her medications as ordered.

19. Florida law states as regards the personal supervision required for ALF residents:

58A-5.0182 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 58A-5.020, 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; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
(e) 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.
...
Rule 58A-5.0182, F.A.C.

20. In sum, the facility failed to provide the required care and services, and personal supervision appropriate for Resident #9, to wit, the facility was unaware of her physical and emotional well-being in that it failed to provide her pain relieving medication as ordered.

21. Respondent was cited again for this class II violation, defined in ¶ 10.

22. The fine is for a class II violation is determined per subsections (2) (b) & (3):

> **429.19 Violations; imposition of administrative fines; grounds.—**
> (1) In addition to the requirements of part II of chapter 408, the agency shall impose an administrative fine in the manner provided in chapter 120 for the violation of any provision of this part, part II of chapter 408, and applicable rules by an assisted living facility, for the actions of any person subject to level 2 background screening under s. 408.809, for the actions of any facility employee, or for an intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.
> (2) Each violation of this part and adopted rules shall be classified according to the nature of the violation and the gravity of its probable effect on facility residents. The agency shall indicate the classification on the written notice of the violation as follows:
> ...
> (b) Class "II" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation.
> (c) Class "III" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class III violation in an amount not less than $500 and not exceeding $1,000 for each violation.
> ...
> (3) For purposes of this section, in determining if a penalty is to be imposed and in fixing the amount of the fine, the agency shall consider the following factors:
> (a) The gravity of the violation, including the probability that ..... or serious physical or emotional harm to a resident will result or has resulted, the severity of the action or potential harm, and the extent to which the provisions of the applicable laws or rules were violated.
> (b) Actions taken by the owner or administrator to correct violations.
> (c) Any previous violations.
> (d) The financial benefit to the facility of committing or continuing the violation.
> (e) The licensed capacity of the facility.
> (4) Each day of continuing violation after the date fixed for termination of the violation, as ordered by the agency, constitutes an additional, separate, and distinct violation.
> (5) Any action taken to correct a violation shall be documented in writing by the owner or administrator of the facility and verified through followup visits by agency personnel. The agency may impose a fine and, in the case of an owner-operated facility, revoke or deny a facility's license when a facility administrator fraudulently misrepresents action taken to correct a violation.
> ...

Section 429.19, Fla. Stat. (2014)

WHEREFORE, the Agency intends to impose a $2,500 fine.

COUNT III – $2,500 UNCORRECTED CLASS II FINE
(**Case #2014011713** - Tag A0163: Records – Resident; Penalties for Alteration)

23. The Agency re-alleges and incorporates paragraphs 1-5 as if fully set forth herein.

1st Survey – (paragraphs 24 – 27)

24. On 21 2014, the Agency began a complaint investigation (CCR #2014004285).

25. On 19 2014, Respondent was served with an Administrative Complaint (AC) alleging a violation of ID Prefix Tag A0163, a class II violation involving improper alteration of resident records. Included with the AC was an Election of Rights (EOR) form. See Exhibits 1 (AC) and 2 (EOR) attached to the Final Order regarding AHCA Case No. 2014008122, attached hereto as **Ex. A**.

26. Respondent elected 'Option 1', thereby admitting to the facts alleged and agreeing to pay the entire $1,000 fine within 30 days of the date on the Final Order, 20 2014. **Ex. A**.

27. A class II violation is defined in ¶ 10.

2nd Survey (paragraphs 28 – 33)

28. On 2014, the Agency started a follow up to the 2014, complaint investigation.

29. a. Based on a review of records and interviews the facility failed to ensure staff did not falsify MORs for 3 of 20 sampled residents, #9, 15 & 19.

b. The Agency received information that staff had falsified MORs, i. e., staff assisting with medications were using Staff 'I's password to document medications as given.

c. Resident #15.

1) The Electronic MOR for 2014, revealed that Staff 'I' signed that she gave (for pain) 50 mg three times a day at 5:00 PM on

2) The sign out sheet (to note the count, when and the amount of

medication given) for revealed Staff 'J' signed that she gave mg at 8:00 PM. There was no documentation that indicated was signed out on the sign out sheet for 5:00 or 8:00 PM by Staff 'I'. A review of the physician's order on the MOR dated showed 50 mg three times a day.

3) On at 2:30 PM the administrator stated her initials were on the MORs but she had not authorized staff to use her password for charting medications.

d. Resident #19.

1) The Electronic MOR noted that on the administrator's initials were in the space as giving the resident her 0.5 mg at 9:00 PM. A review of the sign out sheet revealed that Staff 'J' had signed the sheet at 8 PM as giving the medications.

2) On at about 5 PM Staff 'J' when interviewed stated she had received training regarding providing assistance with medication at another facility. She explained she was asked by the administrator to provide medications to the residents because of staff shortage. The administrator gave her the administrator's password to use because she had not completed the on the job medication training at the facility and had not been provided a password yet. She stated when you logged on under someone else's password that person's initials would be on the Electronic MOR. That was why the administrator's initials were on the MOR when she actually gave the medications. The password must have later changed and she had to go work at the front desk one night because she could no longer log in. She was not given her own password until around

3) The administrator dated revealed that Staff 'J' was at the front desk and she did not have the med cart log in password and she could not pass medication.

4) On at about 4 PM the administrator stated a former med tech was giving out her password to other staff to use. She stated she never authorized any staff to use her password.

e. Resident #9.

1) Her records revealed an order dated for 5 mg. take 3 halves (7.5 mg) three times daily.

2) The sign out sheet regarding the given, revealed that on at 6:26 AM she was only given 2 halves. On at 6:30 AM, only on half pill was given. On at 9:00 PM only 2 halves were given. The MOR for and noted that the resident received 5 mg three halves (7.5 mg) when she did not.

3) On at about 3 PM the administrator reviewed the MORs and the sign out sheet and confirmed that the resident did not get her medications although the MOR was marked as given.

30. Florida law states regarding falsifying ALF medical records:

> **429.49 Resident records; penalties for alteration.**—
> (1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.
> (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges.
>
> Section 429.49, Fla. Stat. (2014)

31. In sum, medical records for Residents #9, 15 & 19 were falsified as described above.

32. Respondent was cited again for this class II violation, defined in ¶ 10.

33. The fine for a class II violation is determined as set forth in ¶ 22.

WHEREFORE, the Agency intends to impose a $2,500 fine.

COUNT – $1,000 CLASS II FINE
(**Case #2014011713** - Tag A0056: Medication – Labeling & Orders)

34. The Agency re-alleges and incorporates paragraphs 1-5 as if fully set forth herein.

35. On , 2014, the Agency started a follow up to the , 2014, complaint investigation.

36. a. The Agency learned based on a review of medications and interviews that the facility did not make every reasonable effort to ensure that prescriptions were filled or refilled in a timely manner for 3 of 20 sampled residents, #1, 3 & 9, who received assistance with self-administration of medications, which resulted in Resident #9 suffering needlessly in pain.

b. Resident #1.

1) Her health assessment Form dated showed diagnoses that included malaise and fatigue, and The Form noted she required assistance with her medications.

2) Her medication orders revealed the following:

50 milligrams (mg.) 1 daily order dated
40 mg. 1 daily order dated
500 mg. 1 twice daily order dated

3) Her MORs revealed that the medications 50 mg, 40 mg, and 500 mg were not given on &

4) The facility's notes documented the following:

at 10:30 AM - "Med tech call physician's office for second time today. Dr. (name mentioned) is on vacation and unable to write refill orders for (used for high (used for high and (used for for the resident. Dr. (name mentioned) covering doctor was out sick. Nurse assured med-tech script will be in tomorrow."

at 9:40 AM - "Pharmacy stating there is a billing issue. This nurse and using the name of pharmacy listed to send med as requested. Yesterday per ED staff at Pharmacy stating meds should be in facility today."

at 3 PM - "Med-tech waiting for Pharmacy to deliver medicine by 5 PM issue is being resolved and in process of being taken care of."

at 8 PM - "Meds have come in tonight."

at 11 AM - and for resident is being held due to the fact that Dr. (name mentioned) office has not faxed us an updated prescription. Awaiting fax from nurse."

at 2:30 PM - "Resident between 4:30 AM and 5:30 AM. Resident was found by med tech when doing Med Pass."

at 5:45 AM - "Incident report written by Med Tech trainee - Performed Med pass at 5:45 AM came into found resident on wheelchair head back. Went to lift head was stiff called staff (names noted) to check vitals."

5) During an interview with the administrator, she was informed there was no documentation that the facility had tried to contact the health care provider office from - 8/1 to make a reasonable effort to obtain the medications. She stated the staff was to call 10 days in advance to reorder the refills and if they were having a problem getting the order they were to notify her and someone could maybe go to get a hard copy of the prescription from the health care provider's office. She could not give an explanation as to why the staff did not call to check the status of the refills.

c. Resident #3.

1) On at about 10:30 AM he stated the facility was not timely refilling his medications and he would miss getting them. His family member obtained an order from his doctor and he was now doing his own medications to ensure that he received them timely.

2) His health assessment Form dated showed diagnoses including and The Form also noted he required assistance with his medications. On he obtained a health care provider's order to self-administer his own medications.

3) The MOR noted he did not receive these medications:

On - Biscadyl 5 mg. - awaiting refill prescription from Physician

On , and - Biscadyl 5 mg. - Pharmacy Notified, Awaiting delivery from Pharmacy

at 8:08 AM and at 6:58 PM - 0.4 mg- Pharmacy Notified, Awaiting delivery from Pharmacy.

4) There was no documentation to show that the facility made a reasonable effort to obtain his medications.

5) On at about 2 PM the administrator could not explain how he received his Biscadyl 5 mg. on 10/3 - 10/7, 10/9 & but not get the medication the other days - 10/1, 10/2, 10/8, & She confirmed he did not receive his medication refills timely.

d. Resident #9.

1) On at about 11 AM she stated that the facility ran out of her pain medications and she did not receive all of them as she should have. She said that because of this she was in a lot of pain.

2) Her health assessment Form dated showed diagnoses including scoliosis, stiff man and The Form 1823 noted she required assistance with the self-administration of medications. The record revealed an order dated for 5 mg - take three halves (7.5 mg) three times daily.

3) The sign out sheet revealed that on at 6:18 PM she received 3 halves and there were none left. The sign out sheet showed that she did not get any medications on The next dosage was given on at 6:26 AM was only 2 halves and not 3 halves as ordered. On 10/7 at 10 **(AM or PM?)** she was given 3 halves and there were none left. She did not receive any medication on 10/8. The next dosage was given on 10/9 but only 2 halves were given. The amount available at the facility was noted to be thirty half pills.

NOTE: 10:00 AM or PM?-I reviewed my deficiency statement and 10 PM is on the statement donot know why it's not on here

5) The MORs for and 10/9 noted that she received 5 mg three halves (7.5 mg). The facility had no documentation that it made a reasonable effort to obtain her pain medication.

6) On at about 3 PM the administrator reviewed the MORs and the sign out sheet and confirmed she did not have her medication timely refilled.

37. Florida law regarding a facility's requirement to refill resident prescriptions states:

58A-5.0185 Medication Practices.
Pursuant to Sections 429.255 and 429.256, F.S., and this rule, licensed facilities may assist with the self-administration or administration of medications to residents in a facility. ...
...
(7) MEDICATION LABELING AND ORDERS.
...
(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
...
Rule 58A-5.1085, F.A.C.

38. In sum, Respondent failed to show that it made every reasonable effort to ensure that refills for timely filled/refilled for 3 residents as described above, such that at least one resident suffered in pain needlessly.

39. Respondent was cited for a class II violation, defined in ¶ 10.

40. The fine for a class II violation is set forth in ¶ 22.

WHEREFORE, the Agency intends to impose a $1,000 fine.

COUNT V – $500 UNCORRECTED CLASS III FINE
(**Case #201401713** - Tag A0054: Medication - Records)

41. The Agency re-alleges and incorporates paragraphs 1-5 as if fully set forth herein.

1st Survey – (paragraphs 42 - 46)

42. On 21 2014, the Agency began a complaint investigation (CCR #2014004285).

43. a. The Agency learned based on a review of records and interviews that the facility failed to ensure staff maintained an accurate, daily MOR for sampled Residents #1 & 33.

b. Resident #1.

1) In an interview with the administrator on at 3:30 PM she stated Staff 'D' had falsified this resident's MOR and did not give to the resident but charted it as given.

2) The resident's health assessment Form dated revealed a diagnosis of and that the resident needed assistance with the self-administration of medications.

3) The Medication Incident and Error Reports dated at 8 PM revealed that discrepancies with the MOR and the med pack were noticed on when reviewing the med cart. 100 milligrams (mg) one tablet by mouth once a day for 7 days was ordered. Staff 'D' acknowledged she assisted Resident #1 with medications - her initials were on the MOR and 'D' stated she gave the medication. The regional nurse noticed the medication was fully packaged and none of the medication was given. The pack was copied on at 1:15 PM, written on the copy was, "no pills given" and The date the medication was filled on the label revealed The was restarted. Type of error revealed, "Falsifying documents, med error."

4) The physician's order dated revealed 100 mg one daily for 7 days.

5) The 2014, MOR revealed 100 mg one daily for 7 days was charted as given on and at 8 PM.

c. Resident #3.

1) The 2014, MOR revealed muscle relaxant) 5 mg take 3 half tablets three times a day and MPAP ER (for pain) 625 mg 2 tablets every 8 hours. They were not charted as given on at 10 PM.

2) On at 3:30 PM the administrator stated she was unaware the MOR for this resident was not up to date.

44. Florida law regarding medication practices concerning records states:

58A-5.0185 Medication Practices.
Pursuant to Sections 429.255 and 429.256, F.S., and this rule, licensed facilities may assist with the self-administration or administration of medications to residents in a facility. …

...

(5) MEDICATION RECORDS.

...

(b) The facility must maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record 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 medication observation record must be immediately updated each time the medication is offered or administered.

...

Rule 58A-5.0185, F.A.C.

45. Respondent was cited for a Class III violation, defined in subsection (2) c) ¶ 10.

46. The Agency notified Respondent by letter dated 26 . 2014, that it had 30 days to correct all deficiencies, to wit, by on or about 26 2014.

2nd survey (paragraphs 47 - 52)

47. On , 2014, the Agency started a follow up to the . 2014, complaint investigation.

48. a. The Agency learned based on review of records and interview that the facility failed to ensure accurate MOR and sign out sheets were maintained for sampled Residents #1 & 15.

b. The Agency received information that staff were assisting with medications and using Staff 'I's password to document medications as given.

c. Resident #15.

1) The . 2014, MOR revealed Staff 'I' signed that she gave (for pain) 50 mg three times a day at 5:00 PM on .

2) The sign out sheet revealed Staff 'J' signed that she gave 50 mg at 8 PM. There was no documentation that indicated was signed out on the sign out sheet for 5 PM by Staff 'I'.

3) The physician order on the MOR dated . . . . . revealed Tramadol 50 mg three times a day.

4) The . . . . . sign out sheet for bottle #3 of 50 mg revealed on . . . . there were 177 tablets of . . remaining. The . . . was signed out on . . . . . at 8:17 AM and 7:22 PM and on . . . . at 8:16 AM. On . there were 58 tablets of . . remaining. There was no documentation to review that indicated what happened to the remaining 119 tablets of . . . .

5) On . . . . . at 2:30 PM the administrator stated there were . . . . . sheets that were missing for that resident. The nurse witnessed that the medications had dropped on the floor and did not document that the pills were discarded. She also stated the . . . sheets for bottles #1 and #2 were missing. She also stated she had not authorized staff to use her password for charting medications.

d. Resident #1.

1) A review of records revealed that this resident had an order for . (for . 0.25 (mg 1 daily as needed on . . . . . However, a . Sign Out sheet was not available for review for the . . . order. There was no documentation to indicate the resident received the medications on .

NOTE: These dates are unclear. Sometime in . 2014 the facility ordered Alprazolam from the pharmacy, medication was delivered to the facility (see below). There was no Narcotic sheet available to confirm the resident received the medication that was refilled in April 2014, the facility did not know what happened to the 4/2014 order that was delivered.

2) The administrator provided a Pharmacy printout for the medication which noted that on . . . . . a quantity of 30 . 0.25 mg pills was delivered to the facility.

3) On . . . . . at about 3:00 PM the administrator stated she could not locate the . . . sign out sheet for the 30 . 25 mg pills. That medication was not at the

facility and there was no way to determine what happened to the 30 pills that were sent to the facility.

49. Florida law regarding medication practices concerning records is stated in ¶ 44 .

50. In sum, Respondent again failed to ensure it maintained accurate daily medication records for all residents, to wit, Residents 1 & 15.

51. Respondent was cited again for this class III violation, defined in ¶ 10.

52. The same constitutes an uncorrected class III violation with the fine determined as follows:

> **429.19 Violations; imposition of administrative fines; grounds.—**
> (1) In addition to the requirements of part II of chapter 408, the agency shall impose an administrative fine in the manner provided in chapter 120 for the violation of any provision of this part, part II of chapter 408, and applicable rules by an assisted living facility …
> (2) Each violation of this part and adopted rules shall be classified according to the nature of the violation and the gravity of its probable effect on facility residents. The agency shall indicate the classification on the written notice of the violation as follows:
> (c) Class "III" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class III violation in an amount not less than $500 and not exceeding $1,000 for each violation.
> …
> Section 429.19, Fla. Stat. (2014)
>
> **WHEREFORE**, the Agency intends to impose a $500 fine.

COUNT VI – $5,000 UNCORRECTED CLASS II FINE
(**Case #2015003501** - Tag A0025: Resident Care - Supervision)

53. The Agency re-alleges and incorporates paragraphs 1-5 and Count II as if fully set forth herein.

1st Survey – (see Count II - paragraphs 13-16)

2nd Survey (see Count II - paragraphs 17 –22)

3d Survey – (paragraphs 54 – 59)

54. On 11 , 2015, the Agency conducted a second revisit for complaint investigation for CCR #2014004285, in conjunction with the revisit for the complaint investigations for CCR #2014007505 & CCR #2014010408.

55. a. During this survey the Agency learned based on a review of records and interviews that the facility failed to 1) maintain a written record and that the family and health care provider were contacted of significant changes, i. e., illness which resulted in a hospital admission for sampled Resident #3, and 2) offer personal supervision appropriate for residents which included general awareness of their whereabouts by allowing female Resident #1 to elope from the facility after she was identified as an elopement risk.

b. Resident #3.

1) On at about 12 PM the Resident Care Coordinator (RCC) stated Resident #3 was admitted into the hospital on and she did not know why.

2) The resident had no documentation as to what had transpired that caused her to be admitted into the hospital. In addition, there was no documentation to confirm that the family and health care provider were contacted to inform them of the hospital admission.

3) On at about 3 PM the RCC stated there was no documentation in the resident's record regarding both the nature of the hospital admission and that his family and health care provider were contacted.

c. Resident #1.

1) Her records showed that she was admitted to the facility on

2) She had an Elopement Risk Evaluation Form. It was undated but signed by a nurse. The resident was assessed to be an elopement risk. Her health assessment, AHCA Form 1823 dated listed under the or behavioral status section has . The Form showed under special precautions: at night. The physician also checked for her to be observed daily.

3) Review of the observation log about her revealed the following:

Resident moved in at 4 PM

From until 9/22/19 it is documented that the facility did "2 hour checks" on the resident

"Resident is very and keeps stating she's going to leave the facility. As of 10 PM she is refusing to go to bed or into her Please check on her every hour because of elopement risk."

to two hour checks being performed

to the resident was on 2 hour checks according to the observation log

6:30 AM two hour checks performed resident continue to wander looking for exit

at 9 AM Resident observed in increased Denies pain at this time Resident placed on 1 hour checks staff to continue to monitor.

Resident eloped today family notified and PCP

NOTE: Please recheck all dates as these dates don't make sense.

4) Her records reflect documentation of interventions that were put place to keep her safe once the facility became aware she was at risk for elopement.

5) On at about 3:40 PM Staff 'A' (a med tech) stated she was assigned to watch the resident during her 3 - 11 PM shift on She was aware the resident was an elopement risk. 'A' took the resident outside by the smokers. Although the resident did not smoke she enjoyed being outside. At 5:00 PM Staff 'A' took her to her it was time for 'A' to conduct a medication pass. 'A' conducted a medication pass for 5:00 - 6:00 PM. When she went downstairs law enforcement was there with the resident in the back seat. At this time the family was called. 'A' had no explanation for the period of time she finished the medication pass at 6:00 PM until the resident was brought by to the facility by law enforcement at 8:25 PM.

6) The Adverse Incident report dated documented the resident was brought back by police and the facility sent her to Central Florida Regional Hospital. The hospital case manager will find placement in a memory care unit since she is not appropriate to return to the facility.

7) The Sanford Police Department Dispatch Record reveals on the Department was contacted by an unknown person at 8:03 PM to report a white female walking towards Live Oak

Blvd. At 8:09 PM the subject was just past the far west entrance of Village Lakes. At 8:25 PM the resident was returned to the facility and turned over to staff.

8) The resident was left unsupervised for approximately two and half hours. The facility was unaware the resident had left the facility until the police returned her at 8:25 PM. According to the police report she was found on a busy four lane highway.

9) On [redacted] at about 2 PM the administrator stated he was not employed at the time of the incident but knows she went to the local hospital and was discharged to a Skilled Nursing Facility. At the time of the survey there was no documentation of disciplinary action or any training or retraining of staff taking care of residents assessed to be an elopement risk.

56. Florida law as regards the personal supervision required for residents is stated in ¶ 19.

57. In sum, the facility failed to 1) notify family and the health care provider of Resident #3, whose reason for hospitalization the facility did not take steps to learn, 2) provide personal supervision as appropriate for each resident, to wit, Resident #1, a known elopement risk, as evidenced by the resident's whereabouts being unknown for a substantial period of time given her vulnerability, such that she eloped and was exposed to risk of serious harm or [redacted] in the area of a busy 4 lane highway, and 3) following Resident 1's elopement the facility failed to take any disciplinary action and/or retraining of staff about protecting residents against the risk of elopement.

58. Respondent was cited for a third time for this class II violation, defined in ¶ 10.

59. The fine is for a class II violation is determined as stated in ¶ 22.

WHEREFORE, the Agency intends to impose a $5,000 fine.

COUNT VII – $5,000 UNCORRECTED CLASS II FINE
(**Case #2015003501** - Tag A0163: Records – Resident; Penalties for Alteration)

60. The Agency re-alleges and incorporates paragraphs 1-5 and Count III as if fully set forth herein.

1st Survey – (see Count III - paragraphs 24-27)

2nd Survey (see Count III - paragraphs 28 –33)

3d Survey – (paragraphs 61 – 65)

61. On 11 , 2015, the Agency conducted a second revisit for complaint investigation for CCR #2014004285, in conjunction the revisit for complaint investigations for CCR #2014007505 & CCR #2014010408.

62. a. During this survey the Agency learned based on a review of records and interviews the facility failed to ensure staff did not falsify MORs for sampled Resident #3.

b. On at about 12 PM the RCC stated this resident was admitted into the hospital on and she did not know why.

c. A review of the MORs for and , 2015, for this resident revealed that some of his medications were marked as given when the resident was not at the facility:

81 mg one daily in the morning - marked as given on & & 3/2 at 7 AM

5 mg take 2 tablets (10 mg) at bedtime - marked as given at 7 PM on

20 mg take one tablet once a day - marked as given at 8 AM on & 3/2

Glipizde 2.5 mg Tab ER one every other day - marked as given at 8 AM on 3/2

300 mg 1 daily - marked as given at 7 AM on and 3/2

25 mg give one half tablet 12.5 mg daily - marked as given at 8 AM on & 3/2

25 mg take one once a day - marked as given at 8 AM on & 3/2

0.4 mg give 2 capsules once daily at 7 PM - marked as given at 7 PM on

d. On at about 3:45 PM the RCC stated the staff falsified the MOR because the resident was in the hospital.

63. Florida law regarding falsifying ALF medical records is stated in ¶ 30.

64. Respondent was cited for a third time for this class II violation, defined in ¶ 10.

65. The fine is for a class II violation is determined as stated in ¶ 22.

WHEREFORE, the Agency intends to impose a $5,000 fine.

COUNT VIII – $1,000 CLASS II FINE
(Case #2015003501 - Tag A0056: Medication – Labeling & Orders)

66. The Agency re-alleges and incorporates paragraphs 1-5 and Count as if fully set forth herein.

67. On 11 2015, the Agency conducted a second revisit for complaint investigation for CCR #2014004285, in conjunction the revisit for complaint investigations for CCR #2014007505 & CCR #2014010408.

68. a. During this survey the Agency learned based on a MOR review and interviews the facility did not make every reasonable effort to ensure that prescriptions were filled or refilled in a timely manner for sampled Residents #2 & 15, who received assistance with the self-administration of their medications.

b. Resident #15.

1) On at about 12:15 PM this resident stated the facility was out of his HCTZ medication) for 2 days.

2) His MOR for noted he did not get 0.3% eye drops as follows:

8:46 AM - Pharmacy notified, awaiting delivery from Pharmacy
5:57 PM - awaiting refill prescription from Physician
8:19 AM - Pharmacy notified, awaiting delivery from Pharmacy
6:13 PM - Pharmacy notified, awaiting delivery from Pharmacy
8:07 AM - resident refused
6:06 PM - Pharmacy notified, awaiting delivery from Pharmacy
1:56 PM - awaiting refill prescription from Physician
5:10 PM - awaiting for order clarification from MD

3) The MOR for 2015 noted at 8:19 AM and at 8:09 AM 25 mg tab - Pharmacy notified, awaiting delivery from Pharmacy.

4) There was no documentation that the facility staff had made a reasonable effort to ensure that his medication was refilled in a timely manner. He did not receive his high medication for 2 days.

5) On at 3 PM the RCC stated they were aware there were still issues with the medications being timely refilled and were working on them.

b. Resident #2.

1) This resident's record revealed that he was prescribed the following:

25 mg tablets 1 tablet by mouth twice daily

500 mg capsule 1 capsule by month three time daily times 7 days

2) The facility ran out of 25 mg tablets 1 tablet by mouth twice daily. His MOR shows that on he did not receive his medication as the facility was awaiting on the physician for the refill.

3) On he did not receive his 500 mg capsule 1 capsule by month three time daily times. The MOR shows the pharmacy was notified and the facility was awaiting delivery.

4) His chart revealed no documentation to indicate the facility made any effort to ensure his medication was timely filled.

5) On at about 2 PM the administrator stated he will discipline the staff and provide more training.

69. Florida law regarding a facility's requirement to refill resident prescriptions is stated in ¶ 30.

70. Respondent was cited for a class II violation, defined in ¶ 10. (This violation was originally cited on as a class III violation with no resulting fine, and then again as a class II violation that resulted in Count

71. The fine is for a class II violation is determined as stated in ¶ 22.

WHEREFORE, the Agency intends to impose a $1,000 fine.

COUNT XIV – $1,000 UNCORRECTED CLASS III FINE
(**Case #2015003501** - Tag A0054: Medication – Records)

72. The Agency re-alleges and incorporates paragraphs 1-5 and Count V as if fully set forth herein.

1st Survey – (see Count V - paragraphs 42 - 46)

2nd survey (see Count V - paragraphs 47 - 52)

3d survey – (paragraphs 72 - 77)

73. On 11 2015, the Agency conducted a second revisit for complaint investigation for CCR #2014004285, in conjunction with the revisit for the complaint investigations for CCR #2014007505 & CCR #2014010408.

74. a. The Agency learned based on a review of records and interviews that the facility failed to maintain accurate MOR and sign out sheets for sampled Residents #9 & 15.

b. Resident #15.

1) The sign out sheets revealed that for 5 mg 1 twice daily for revealed there was a blank space on the sheet that required the signature of the staff that gave him his medication and date that the medication was provided. On the sheet next to the blank spaces was the time 8:15 (AM/PM not noted). The next space was dated and noted 6:41 (AM/PM not noted).

2) There was another sign out sheet that noted 5 mg take 1 tablet twice daily, Take 1 tablet by mouth twice daily as needed for On the time of the medication noted 7:42 (AM/PM was not noted), on the time noted 8:05 and 7:42 (AM/PM not noted). On the time noted 6:20 (AM/PM was not noted). There was another pill given on and the space for the time the medication was given was left blank.

c. Resident #9.

1) On the sign out sheet revealed that resident is prescribed the following

5-325 1 tablet by mouth four times daily

5 mg tablet, take 3 half tablets 7.5 mg by mouth three times daily

2) The sheet also revealed that:

a) Staff signed the log between and {there is no date nor is there a time of day that the medication was given to the resident}.

b) The sheet revealed no signature for staff on and no time.

c) Additionally after staff provided this medication to the resident but the sheet reveals that there is no date or time as to when the resident received the medication.

3) The MOR revealed that all medication prescribed was given and no medicine was missed.

d. On at about 4 PM the RCC confirmed that the sign out sheet was not up to date.

75. Florida law regarding medication practices concerning records is stated in ¶ 44.

76. In sum, Respondent again failed to ensure it maintained accurate daily medication records for all residents, to wit, Residents 9 & 15.

77. Respondent was cited for a class III violation, defined in ¶ 10.

78. The same constitutes an uncorrected class III violation with the fine determined as stated in ¶ 52.

WHEREFORE, the Agency intends to impose a $1,000 fine.

COUNT X – $500 UNCORRECTED CLASS III FINE
(Case #2015003503 - Tag A0055: Storage & Disposal)

79. The Agency re-alleges and incorporates paragraphs 1-5 as if fully set forth herein.

1st Survey (paragraphs 80 - 84)

80. On the Agency started a complaint inspection for CCR #2014007505 in conjunction with the revisit to the complaint investigation for CCR #2014004285.

81. a. The Agency learned based on observation and interviews that the facility failed to ensure medications were kept in a locked storage area at all times for sampled Resident #1.

b. On at about 3:40 PM on the second floor there was a medication cart in the hallway next to the nurse's station. On top of the cart was a container with 2 bubble packs with medications inside, 600 milligram (mg) and 20 mg, that belonged to Resident #1. Residents were observed walking past the cart and no staff was there. At about 3:42 PM the RCD was observed sitting in her office and informed that the medications were on top of the cart unsecured. The RCD left her office to also observe the unsecured medications. During this time Staff 'H' arrived and stated he left the medications on top of the cart because he had an emergency.

82. Florida law regarding medication practices concerning storage states:

58A-5.0185 Medication Practices.
Pursuant to Sections 429.255 and 429.256, F.S., and this rule, licensed facilities may assist with the self-administration or administration of medications to residents in a facility. …
…
(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 that is out of sight of other residents. However, 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 58A-5.0181, F.A.C.

...

Rule 58A-5.0185, F.A.C.

83. Respondent was cited for a Class III violation, defined in ¶ 10.

84. The Agency notified Respondent by letter dated 12 , 2014, that it had 30 days to correct all deficiencies, to wit, by on or about 12 , 2014.

2nd survey – (paragraphs 85 – 90)

85. On 11 , 2015, the Agency conducted a revisit to the prior complaints, CCR #2014007505, 2014004285 & 2014010408.

86. a. The Agency learned based on observations and interviews that the facility failed to ensure that medications kept in residents' or apartments were kept locked when residents were absent, and/or that it kept medications in a secure place within the or apartments or in some other secure place out of sight of other residents, to wit, Resident #2.

b. On at about 11:35 AM Resident #2 was observed sitting in the living There was a tube of medication on the table next to the couch (Flurouracil 5% cream apply to affected areas twice daily) and a container HFA inhaler was on the table next to the television.

c. Resident #2 on at about 11:40 AM stated that medications belonged to his who was not in the

d. On at about 12:15 PM Resident #15 was observed walking down the hall back to his At about 12:20 PM he stated he always left his medications out and that his would not bother his medications. At about 12:20 PM it was observed that when the resident opened his it was unlocked, there was no one in the the medications remained on the tables.

87. Florida law regarding medication practices concerning storage is stated in ¶ 82.

88. In sum, Respondent again failed to ensure it properly secure/store medications as regards Resident #2.

89. Respondent was cited for a class III violation, defined in ¶ 10.

90. The same constitutes an uncorrected class III violation with the fine determined as stated in ¶ 52.

WHEREFORE, the Agency intends to impose a $1,000 administrative fine.

Submitted this ____ day of 2015.

Edwin D. Selby
Fla. Bar. No. 262587
Assistant General Counsel
Office of the General Counsel
Agency for Health Care Administration
525 Mirror Lake Drive, 330H
St. Petersburg, FL 33701
(727) 552 - 1942
Counsel for Petitioner

NOTICE OF RIGHTS

Respondent is notified that it has a right to request an administrative hearing pursuant to Section 120.569, Florida Statutes. Respondent has the right to retain, and be represented by an attorney in this matter. Specific options for administrative action are set out in the attached Election of Rights.

All requests for hearing shall be made to the Agency for Health Care Administration, and delivered to Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Bldg #3, Tallahassee, FL 32308;Telephone (850) 922-5873.

RESPONDENT IS FURTHER NOTIFIED THAT THE FAILURE TO REQUEST A HEARING WITHIN 21 DAYS OF RECEIPT OF THIS COMPLAINT WILL RESULT IN AN ADMISSION OF THE FACTS ALLEGED IN THE COMPLAINT AND THE ENTRY OF A FINAL ORDER BY THE AGENCY.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served by USPS certified mail, Return Receipt No. XXXXXXXXX on ____ 2015, to Administrator Amanda Tenpenny, Renaissance Retirement Center, 300 West Airport Blvd, Sanford, FL 32771, and by regular USPS mail to Registered Agent CT Corporation System, 1200 South Pine Island Rd, Plantation, FL 33324.

Edwin D. Selby, Esq.

cc: Theresa DeCanio, AHCA Area 7 Field Office Manager

Citation Text for Tag 0025, Regulation BSII

Bulger, Vanessia C.

Borhman, Margaret J.
Findings:

Record review for Resident #1 revealed that she was admitted to the facility on . Resident #1 was assessed to be an elopement risk on the Elopement Risk Evaluation Form, date unknown but signed by a nurse. The Resident Health Assessment (1823), dated had a diagnosis of . sun and observe resident #1 daily.

Review of Resident #1 ' s chart revealed a Resident Observation Log. The log documented:

Resident moved in at 4pm

From until documented that the facility did 2 hour checks on the resident.

On it is noted that the resident is very and keeps stating she is going to leave.

From until the facility did 2 hour checks.

On at 9am the note reads that the resident was observed in high and high . Resident was placed on 1 hour checks.

On there is a note stating the resident eloped and that family and PCP (Primary Care Physician) was notified.

Review of Resident Observation log revealed that there was no documentation in the record of interventions that were in place to keep the resident safe. Form 12/16/13-9/22/14.

At approximately 3:40pm on an interview with Staff A, med tech was completed. She stated she knew resident #1. She stated that the facility asked her to watch the resident during her shift. Staff A stated that resident #1 did elope. She stated she was at the facility and that she was aware that resident #1 was an elopement risk. Staff A stated the facility assigned her to watch resident #1 and she took resident #1 outside by the smokers. Staff A stated Resident #1did not smoke but enjoyed being outside. Staff A stated she then took Resident #1 to her she needed to assist the residents with self-administration of medication. Staff A stated that after passing medications she went down stairs, and was not aware that the resident had eloped. She stated once downstairs she observed a police vehicle in the front driveway and the resident sitting in the back seat. Staff A stated that the facility then called the family and the facility began discharge process.