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
	AL11967604	A. BUILDING: _____ B. WING _____	R 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HOPE OF PINELLAS	7575 65TH WAY PINELLAS PARK, FL 33781

(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 second revisit to the complaint survey, (CCR# 2016006729) was conducted at Good Hope of Pinellas on [redacted]. Good Hope of Pinellas, Assisted Living Facility, had uncorrected deficiencies and new deficiencies at the time of the visit. (License # 11615)	{A 000}		
{A 052} SS=D	58A-5.0185 (3) Medication - Assistance with Self-Admin (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self administration of medication must be [redacted] or older, trained to assist with self administered medication pursuant to the training requirements of Rule 58A-5.0191, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.	{A 052}		

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{A 052}	Continued From page 1 (d) Trained staff must observe the resident take the medication. Any concerns about the resident ' s reaction to the medication or suspected noncompliance must be reported to the resident ' s health care provider and documented in the resident ' s record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident ' s presence in the facility; 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident ' s medication record; 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident ' s medication record; or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging; (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. 1. As used in 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. 2. As used in Section 429.256(4)(i), F.S., the terms " judgment " and " discretion " mean interpreting vital signs and evaluating or assessing a resident ' s condition.	{A 052}		

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

This Statute or Rule is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that qualified staff (1) provided medication at the prescribed time, and used control techniques by handling medications with bare hand for one (#5) of seven sampled residents, (2) read the applicable medication labels, and removed the medications from primary packaging in the presence of the residents for six (#5,#6, #7, #8, #9 and #10) of seven sampled residents, and; (3) documented medications given to residents after the residents received their medication for five (#6, #7, #8, #9 and #10) of seven sampled residents.

Findings included:

During a medication assistance observation with Staff B, conducted on at 10:30 a.m., Staff B was observed removing medications by pushing the medication from the primary packaging (bubble pack), catching the individual tablets with her bare hands, and then placing the medications in a cup. Resident #5 was not present while the medications were removed from primary packaging.

On at 10:33 AM., Staff B called Resident #5 from an ongoing activity event, and gave the cup containing medications to Resident #5 for self-administration of oral dosage.

Review of Medication Observation Record (MOR)

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{A 052}	Continued From page 3 revealed that one of the morning medications for Resident #5 was to be given at 6:00 AM., and 10 medications were to be given at 8:00 AM. During an interview with Staff B, on at 10:47 AM., they confirmed that they handled the medication tablets with their bare hands, and stated that it was because they were nervous. When asked about the scheduled medication times listed in the MOR, Staff B stated that Resident #5 gets up late, so I gave it to them when they get up. Staff B stated that the facility should change the medication time for Resident #5 because the resident takes them late. Staff B confirmed that Resident #5 usually wakes up around 10 in the morning and that that they do not notify the physician when the medications are given after 10:00 in the morning. Staff B did not notice that one medication was to be given on an empty stomach. During an interview with Administrator, on at 11:12 AM., they confirmed that they were aware that Resident #5 usually wakes up late and receives their medication after ten in the morning. Administrator confirmed that they had not notified the health care provider when Resident #5 receives medication late, or requested a time change for Resident #5's morning medication. During medication assistance observation, on at 11:26 AM., Staff C was observed removing Resident #6's medication from the medication cart. Staff C removed the medication from the primary packaging and placed the	{A 052}		

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{A 052}	Continued From page 4 medication in a cup, staff initialed the MOR for the medication removed, placed medication packages in medication cart, and locked cart. Staff C carried the cup and found Resident #6 in the smoking area. Staff C placed the cup on the resident's mouth, while holding the cup, tipped the cup toward Resident #6's mouth to administer the oral dosage. Staff C then put a cup of water in Resident #6's mouth, tipped the cup so that the resident could swallow the medication. Resident #6's hands did not make any contact with the cup during medication administration observation. During interview with Staff C, on [redacted], at 11:31 AM., Staff C confirmed that they always administer the medication for Resident #6, and stated that Resident #6 is not able to self-administer their medications. During continued medication assistance observation with Staff C, on [redacted] at 11:37 AM., Staff C was observed removing Resident #7's medication from the medication cart. Staff C removed the medication from the primary packaging and placed the medication in a cup. Staff C initialed the MOR for the medication removed, placed medication package in medication cart, and locked cart. Staff C carried the cup and found Resident #7 in the smoking area. Staff C handed the resident the cup for self-administration of oral dosage. During continued medication assistance observation with Staff C, on [redacted] at 11:45 AM., Staff C was observed removing Resident	{A 052}		

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{A 052}	Continued From page 5 #8's medication from the medication cart. Staff C removed the medication from the primary packaging and placed the medication in a cup, Staff C initialed the MOR for the medication removed, placed medication package in medication cart, and locked the cart. Staff C carried the cup and found Resident #8 in the smoking area. Staff C handed the resident the cup for self-administration of oral dosage. During continued medication assistance observation with staff C, on [redacted] at 11:50 AM., Staff C was observed removing Resident #9's medication from the medication cart. Staff C removed the medication from the primary packaging and placed the medication in a cup. Staff C initialed the MOR for the medication removed, placed medication package in medication cart, and locked the cart. Staff C carried the cup and found Resident #9 in their [redacted]. Staff C handed the resident the cup for self-administration of oral dosage. During continued medication assistance observation with Staff C, on [redacted] at 11:58 AM., Staff C was observed removing Resident #10's medication from the medication cart. Staff C initialed the MOR for the medication and locked the cart. Staff C carried the container to the Resident #10 for self-administration of eye drops. During interview with the Administrator, on [redacted] at 1:22 PM., Administrator stated that staff should take the MOR and the medication to the resident prior to opening the medication and that staff should document in the MOR after medications are given to the resident.	{A 052}		

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{A 052}	Continued From page 6 Class III	{A 052}		
A 053 SS=D	58A-5.0185(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider ' s order or prescription label. (b) Unusual reactions or a significant change in the resident ' s health or behavior must be documented in the resident ' s record and reported immediately to the resident ' s health care provider. The contact with the health care provider must also be documented in the resident ' s record. (c) Medication administration includes conducting any examination or testing, such as . . . . . glucose testing, or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including . . . . glucose testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Part I of Chapter 483, F.S. A valid copy of the State Clinical Laboratory License, if required, and the federal CLIA Certificate must be maintained in the facility. A state license or federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a federal CLIA Certificate if facility staff assist residents in performing clinical	A 053		

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A 053	Continued From page 7 laboratory testing with the residents ' equipment. Information about the State Clinical Laboratory License and federal CLIA Certificate is available from the Laboratory Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850) 412-4500. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that staff, licensed to administer medication, administered oral dosage for one (Resident #6) of seven sampled residents, during two of two observed medication administration, by two (Staff C and E), of three observed staff. Findings included: During medication assistance observation, on [redacted] at 11:26 AM., Staff C was observed administering medication for Resident #6's oral dosage. Staff C placed the cup on the resident's mouth, while holding the cup, tipped the cup toward Resident #6's mouth to administer the oral dosage. Staff C then put a cup of water in the resident's mouth and tipped the cup so that the resident could swallow the medication. Resident #6's hands did not make any contact with the cup during medication administration observation. During an interview with Staff C, on [redacted], at 11:31AM., Staff C confirmed that they always administer the medication for Resident #6, and stated that Resident #6 is not able to self-administer their medications.	A 053		

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A 053	Continued From page 8 During additional observation of Resident #6, conducted on ..... at 03:27 PM., Staff E was observed making multiple attempts to hand the cup containing medications to Resident #6. Staff E had to help the resident hold the cup, bring the cup to the resident's mouth and administer the medication for the resident. Staff E also attempted to allow Resident #6 to hold the cup of water but the resident was not able to hold the cup due to shaky hands. The resident spilled the water on their shirt and pants, while almost dropping the medication out of their mouth. Staff E had to hold the cup of water, bring the cup to Resident #6's mouth so the resident could drink the water and prevent the medication from falling out of the resident's mouth. During an interview with Staff E, on at 03:30 PM, Staff E stated that Resident #6 usually cannot take the medication by themselves and needs assistance. Staff E stated that it depends on how shaky Resident #6's hands are for the day. Staff E confirmed that they had to help Resident #6 with the medication administration. Review of Resident #6's record revealed that resident requires assistance with self-medication. There was no documentation approving medication administration by staff or unlicensed staff. Review of Staffs C's and E's records confirmed that Staff C and Staff E were not licensed to administer medication.	A 053		

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A 053	Continued From page 9 Class III	A 053		
A 056 SS=D	58A-5.0185(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration 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 in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are " as needed " or " as directed, " the health care provider must 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 must 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, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a	A 056		

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A 056	Continued From page 10 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 or electronic copy of such order. The new directions must promptly be recorded in the resident ' s medication observation record. The facility may then place an " alert " label on the medication container that directs staff to examine the revised directions for use in the medication observation record, 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 or electronic copy of a signed order is acceptable. (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. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer ' s packaging, which must 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 must be kept in a container that bears a label containing the following: 1. Practitioner ' s name; 2. Resident ' s name;	A 056		

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A 056	Continued From page 11 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 must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to notify or obtain approval (verbal or written) from resident's health care provider for changes in direction to medications given to one (Resident #5) of seven sampled residents. Specifically, one medication given after breakfast, and four and a half hours late; and 10 medications given two and a half hours late. Findings included: During medication assistance observation with Staff B, conducted on [redacted] at 10:30 AM., Staff B was observed giving Resident#5 their morning medication and documenting in the Medication Observation Record (MOR) for medication given at 10:30 AM. Further review of the MOR revealed that one of the morning medications was to be given at 6:00 AM. and on an empty stomach. Review of the MOR also revealed that all other medications given to Resident #5 at 10:30 AM were scheduled for 8:00 AM.	A 056		

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A 056	Continued From page 12 During an interview with Staff B, on at 10:47 AM., Staff B stated, Resident #5 gets up late, so I gave it to them when they get up. Staff B stated that the facility should change the medication time for Resident #5 because the resident takes them late. Staff B confirmed that Resident #5 usually wakes up around ten in the morning, and that that Staff B does not notify the physician when the medications are given after ten in the morning. Staff B did not notice that the medication scheduled for six in the morning was to be given on an empty stomach. During an interview with Resident #5 at 1:16 PM., they confirmed that they ate breakfast before receiving their morning medications, and Resident #5 confirmed that they normally get their medication around the same time daily. During an interview with Administrator, on at 11:12 AM., Administrator confirmed that they were aware that Resident #5 usually wakes up late and receives their medication after ten in the morning. Administrator confirmed that they had not notified health care provider when Resident #5 received medication late, or requested a time change for Resident #5's morning medication. Class III	A 056		
{A 058} SS=D	429.42(1-2) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.-	{A 058}		

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{A 058}	Continued From page 13 (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. 59A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2),	{A 058}		

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	AL11967604	A. BUILDING: _____ B. WING _____	R 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HOPE OF PINELLAS	7575 65TH WAY PINELLAS PARK, FL 33781

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 058}	Continued From page 14 F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant ' s signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility had ongoing and uncorrected deficient practice related to the assistance with self-administration of medications. Findings included: During a survey conducted on . . . . . , the facility was cited with two Class II deficiencies for Medication - Assistance with Self-Administration of medications, and Medication - Records. During a revisit, conducted on . . . . . , the facility was cited for Medication - Assistance with	{A 058}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 058}	Continued From page 15 Self-Administration of medications at an uncorrected Class III. Record review, conducted on [redacted], revealed no documentation of plan of correction review by a licensed consultant pharmacist or registered nurse as established by the facility's plan of correction for citations from survey conducted on [redacted]. During medication assistance observation with Staff B, conducted on [redacted] at 10:30 AM to 10:47 AM., Staff B failed to remove the medications from primary packaging in the presence of the residents, failed to provide medication at the prescribed time, and failed to use control techniques by handling medications with bare hand. At 10:30 AM, Staff B was observed removing medications by pushing the medication from the primary packaging (bubble pack), catching the individual tablets with their bare hands, and then placing the medications in a cup. Resident #5 was not present while the medications were removed from primary packaging. At 10:33 AM., Staff B called Resident #5 from an ongoing activity event, and gave the cup containing medications to Resident #5 for self-administration of oral dosage. A review of Medication Observation Record (MOR) revealed that one of the morning medications for Resident #5 was to be given at 6:00 AM., and 10 of the morning medications were to be given at 8:00 AM.	{A 058}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 058}	Continued From page 16 During an interview with Staff B, on at 10:47 AM., Staff B confirmed that they handled the medication tablets with their bare hands, and confirmed that Resident received their 6:00 AM medication four and half hour late, and the 8:00 AM scheduled medications two and a half hours late. During medication assistance observation with Staff B, conducted on at 10:30 AM to 11:58 AM., Staff B failed to read the applicable medication labels, and remove the medications from primary packaging in the presence of the residents during the observation, and document medications given prior to actually giving the medication during the following observations: At 11:26 AM., Staff C was observed removing Resident #6's medication from the medication cart. Staff C removed the medication from the primary packaging and placed the medication in a cup, staff initialed the MOR for the medication removed, placed medication packages in medication cart, and locked cart. Staff C carried the cup and found Resident #6 in the smoking area. Staff placed the cup on the resident's mouth, while holding the cup, tipped the cup toward Resident #6's mouth to administer the oral dosage. Staff C then put a cup of water in the resident's mouth, tipped the cup so that the resident could swallow the medication. Resident #6's hands did not make any contact with the cup during medication administration observation. During an interview with Staff C, on , at 11:31 AM., Staff C confirmed that they always	{A 058}		

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{A 058}	Continued From page 17 administer the medication for Resident #6, and stated that Resident #6 is not able to self-administer their medications. At at 11:37 AM., Staff C was observed removing Resident #7's medication from the medication cart. Staff C removed the medication from the primary packaging and placed the medication in a cup, staff initialed the MOR for the medication removed, placed medication package in medication cart, and locked cart. Staff C carried the cup and found Resident #7 in the smoking area. Staff C handed the resident the cup for self-administration of oral dosage. At 11:45 AM., Staff C was observed removing Resident #8's medication from the medication cart. Staff C removed the medication from the primary packaging and placed the medication in a cup, staff initialed the MOR for the medication removed, placed medication package in medication cart, and locked cart. Staff C carried the cup and found Resident #8 in the smoking area. Staff C handed the resident the cup for self-administration of oral dosage. At 11:50 a.m., Staff C was observed removing Resident #9's medication from the medication cart. Staff C removed the medication from the primary packaging and placed the medication in a cup, staff initialed the MOR for the medication removed, placed medication package in medication cart, and locked cart. Staff C carried the cup and found Resident #9 in their . Staff C handed the resident the cup for self-administration of oral dosage.	{A 058}		

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
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{A 058}	Continued From page 18 At 11:58 AM., Staff C was observed removing Resident #10's medication from the medication cart. Staff C initialed the MOR for the medication and locked the cart. Staff C carried the container to the Resident #10 for self-administration of eye drops. During an interview with Administrator, on at 1:22 PM., they stated that staff should take the MOR and the medication to the resident prior to opening the medication and that staff should document in the MOR after medications are given to the resident. Based on the above stated uncorrected deficiency, the facility shall be required to employ the consultant services of a licensed pharmacist or a registered nurse. 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. This serves as a written notification of the requirement for the above described consultation services. Class III	{A 058}		

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0000 - Initial Comments

Assisted Living Facility

A second revisit to the complaint survey, (CCR# 2016006729) was conducted at Good Hope of Pinellas on . Good Hope of Pinellas, Assisted Living Facility, had uncorrected deficiencies and new deficiencies at the time of the visit.

(License # 11615)

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation and interview, the facility failed to ensure that qualified staff (1) provided medication at the prescribed time, and used control techniques by handling medications with bare hand for one (#5) of seven sampled residents, (2) read the applicable medication labels, and removed the medications from primary packaging in the presence of the residents for six (#5,#6, #7, #8, #9 and #10) of seven sampled residents, and; (3) documented medications given to residents after the residents received their medication for five (#6, #7, #8, #9 and #10) of seven sampled residents.

Findings included:

During a medication assistance observation with Staff B, conducted on at 10:30 a.m., Staff B was observed removing medications by pushing the medication from the primary packaging (bubble pack), catching the individual tablets with her bare hands, and then placing the medications in a cup. Resident #5 was not present while the medications were removed from primary packaging.

On at 10:33 AM., Staff B called Resident #5 from an ongoing activity event, and gave the cup containing medications to Resident #5 for self-administration of oral dosage.

Review of Medication Observation Record (MOR) revealed that one of the morning medications for Resident #5 was to be given at 6:00 AM., and 10 medications were to be given at 8:00 AM.

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During an interview with Staff B, on [redacted] at 10:47 AM., they confirmed that they handled the medication tablets with their bare hands, and stated that it was because they were nervous. When asked about the scheduled medication times listed in the MOR, Staff B stated that Resident #5 gets up late, so I gave it to them when they get up. Staff B stated that the facility should change the medication time for Resident #5 because the resident takes them late. Staff B confirmed that Resident #5 usually wakes up around 10 in the morning and that that they do not notify the physician when the medications are given after 10:00 in the morning. Staff B did not notice that one medication was to be given on an empty stomach.

During an interview with Administrator, on at 11:12 AM., they confirmed that they were aware that Resident #5 usually wakes up late and receives their medication after ten in the morning. Administrator confirmed that they had not notified the health care provider when Resident #5 receives medication late, or requested a time change for Resident #5's morning medication.

During medication assistance observation, on at 11:26 AM., Staff C was observed removing Resident #6's medication from the medication cart. Staff C removed the medication from the primary packaging and placed the medication in a cup, staff initialed the MOR for the medication removed, placed medication packages in medication cart, and locked cart. Staff C carried the cup and found Resident #6 in the smoking area. Staff C placed the cup on the resident's mouth, while holding the cup, tipped the cup toward Resident #6's mouth to administer the oral dosage. Staff C then put a cup of water in Resident #6's mouth, tipped the cup so that the resident could swallow the medication. Resident #6's hands did not make any contact with the cup during medication administration observation.

During interview with Staff C, on , at 11:31 AM., Staff C confirmed that they always administer the medication for Resident #6, and stated that Resident #6 is not able to self-administer their medications.

During continued medication assistance observation with Staff C, on [redacted] at 11:37 AM., Staff C was observed removing Resident #7's medication from the medication cart. Staff C removed the

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medication from the primary packaging and placed the medication in a cup. Staff C initialed the MOR for the medication removed, placed medication package in medication cart, and locked cart. Staff C carried the cup and found Resident #7 in the smoking area. Staff C handed the resident the cup for self-administration of oral dosage.

During continued medication assistance observation with Staff C, on at 11:45 AM., Staff C was observed removing Resident #8's medication from the medication cart. Staff C removed the medication from the primary packaging and placed the medication in a cup, Staff C initialed the MOR for the medication removed, placed medication package in medication cart, and locked the cart. Staff C carried the cup and found Resident #8 in the smoking area. Staff C handed the resident the cup for self-administration of oral dosage.

During continued medication assistance observation with staff C, on at 11:50 AM., Staff C was observed removing Resident #9's medication from the medication cart. Staff C removed the medication from the primary packaging and placed the medication in a cup, Staff C initialed the MOR for the medication removed, placed medication package in medication cart, and locked the cart. Staff C carried the cup and found Resident #9 in their . Staff C handed the resident the cup for self-administration of oral dosage.

During continued medication assistance observation with Staff C, on at 11:58 AM., Staff C was observed removing Resident #10's medication from the medication cart. Staff C initialed the MOR for the medication and locked the cart. Staff C carried the container to the Resident #10 for self-administration of eye drops.

During interview with the Administrator, on at 1:22 PM., Administrator stated that staff should take the MOR and the medication to the resident prior to opening the medication and that staff should document in the MOR after medications are given to the resident.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview and record review, the facility failed to ensure that staff, licensed to

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administer medication, administered oral dosage for one (Resident #6) of seven sampled residents, during two of two observed medication administration, by two (Staff C and E), of three observed staff.

Findings included:

During medication assistance observation, on . . . . . at 11:26 AM., Staff C was observed administering medication for Resident #6's oral dosage. Staff C placed the cup on the resident's mouth, while holding the cup, tipped the cup toward Resident #6's mouth to administer the oral dosage. Staff C then put a cup of water in the resident's mouth and tipped the cup so that the resident could swallow the medication. Resident #6's hands did not make any contact with the cup during medication administration observation.

During an interview with Staff C, on , at 11:31AM., Staff C confirmed that they always administer the medication for Resident #6, and stated that Resident #6 is not able to self-administer their medications.

During additional observation of Resident #6, conducted on . . . . . at 03:27 PM., Staff E was observed making multiple attempts to hand the cup containing medications to Resident #6. Staff E had to help the resident hold the cup, bring the cup to the resident's mouth and administer the medication for the resident. Staff E also attempted to allow Resident #6 to hold the cup of water but the resident was not able to hold the cup due to shaky hands. The resident spilled the water on their shirt and pants, while almost dropping the medication out of their mouth. Staff E had to hold the cup of water, bring the cup to Resident #6's mouth so the resident could drink the water and prevent the medication from falling out of the resident's mouth.

During an interview with Staff E, on . . . . . at 03:30 PM, Staff E stated that Resident #6 usually cannot take the medication by themselves and needs assistance. Staff E stated that it depends on how shaky Resident #6's hands are for the day. Staff E confirmed that they had to help Resident #6 with the medication administration.

Review of Resident #6's record revealed that resident requires assistance with self-medication. There was no documentation approving medication administration by staff or unlicensed staff.

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Review of Staffs C's and E's records confirmed that Staff C and Staff E were not licensed to administer medication.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, interview and record review, the facility failed to notify or obtain approval (verbal or written) from resident's health care provider for changes in direction to medications given to one (Resident #5) of seven sampled residents. Specifically, one medication given after breakfast, and four and a half hours late; and 10 medications given two and a half hours late.

Findings included:

During medication assistance observation with Staff B, conducted on at 10:30 AM., Staff B was observed giving Resident#5 their morning medication and documenting in the Medication Observation Record (MOR) for medication given at 10:30 AM. Further review of the MOR revealed that one of the morning medications was to be given at 6:00 AM. and on an empty stomach. Review of the MOR also revealed that all other medications given to Resident #5 at 10:30 AM were scheduled for 8:00 AM.

During an interview with Staff B, on at 10:47 AM., Staff B stated, Resident #5 gets up late, so I gave it to them when they get up. Staff B stated that the facility should change the medication time for Resident #5 because the resident takes them late. Staff B confirmed that Resident #5 usually wakes up around ten in the morning, and that that Staff B does not notify the physician when the medications are given after ten in the morning. Staff B did not notice that the medication scheduled for six in the morning was to be given on an empty stomach.

During an interview with Resident #5 at 1:16 PM., they confirmed that they ate breakfast before receiving their morning medications, and Resident #5 confirmed that they normally get their medication around the same time daily.

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During an interview with Administrator, on at 11:12 AM., Administrator confirmed that they were aware that Resident #5 usually wakes up late and receives their medication after ten in the morning. Administrator confirmed that they had not notified health care provider when Resident #5 received medication late, or requested a time change for Resident #5's morning medication.

Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on observation, interview, and record review, the facility had ongoing and uncorrected deficient practice related to the assistance with self-administration of medications.

Findings included:

During a survey conducted on , the facility was cited with two Class II deficiencies for Medication - Assistance with Self-Administration of medications, and Medication - Records. During a revisit, conducted on , the facility was cited for Medication - Assistance with Self-Administration of medications at an uncorrected Class III.
Record review, conducted on , revealed no documentation of plan of correction review by a licensed consultant pharmacist or registered nurse as established by the facility's plan of correction for citations from survey conducted on .

During medication assistance observation with Staff B, conducted on at 10:30 AM to 10:47 AM., Staff B failed to remove the medications from primary packaging in the presence of the residents, failed to provide medication at the prescribed time, and failed to use control techniques by handling medications with bare hand.

At 10:30 AM, Staff B was observed removing medications by pushing the medication from the primary packaging (bubble pack), catching the individual tablets with their bare hands, and then placing the medications in a cup. Resident #5 was not present while the medications were removed from primary packaging.

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At 10:33 AM., Staff B called Resident #5 from an ongoing activity event, and gave the cup containing medications to Resident #5 for self-administration of oral dosage.

A review of Medication Observation Record (MOR) revealed that one of the morning medications for Resident #5 was to be given at 6:00 AM., and 10 of the morning medications were to be given at 8:00 AM.

During an interview with Staff B, on at 10:47 AM., Staff B confirmed that they handled the medication tablets with their bare hands, and confirmed that Resident received their 6:00 AM medication four and half hour late, and the 8:00 AM scheduled medications two and a half hours late.

During medication assistance observation with Staff B, conducted on at 10:30 AM to 11:58 AM., Staff B failed to read the applicable medication labels, and remove the medications from primary packaging in the presence of the residents during the observation, and document medications given prior to actually giving the medication during the following observations:

At 11:26 AM., Staff C was observed removing Resident #6's medication from the medication cart. Staff C removed the medication from the primary packaging and placed the medication in a cup, staff initialed the MOR for the medication removed, placed medication packages in medication cart, and locked cart. Staff C carried the cup and found Resident #6 in the smoking area. Staff placed the cup on the resident's mouth, while holding the cup, tipped the cup toward Resident #6's mouth to administer the oral dosage. Staff C then put a cup of water in the resident's mouth, tipped the cup so that the resident could swallow the medication. Resident #6's hands did not make any contact with the cup during medication administration observation.

During an interview with Staff C, on , at 11:31 AM., Staff C confirmed that they always administer the medication for Resident #6, and stated that Resident #6 is not able to self-administer their medications.

At at 11:37 AM., Staff C was observed removing Resident #7's medication from the

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medication cart. Staff C removed the medication from the primary packaging and placed the medication in a cup, staff initialed the MOR for the medication removed, placed medication package in medication cart, and locked cart. Staff C carried the cup and found Resident #7 in the smoking area. Staff C handed the resident the cup for self-administration of oral dosage.

At 11:45 AM., Staff C was observed removing Resident #8's medication from the medication cart. Staff C removed the medication from the primary packaging and placed the medication in a cup, staff initialed the MOR for the medication removed, placed medication package in medication cart, and locked cart. Staff C carried the cup and found Resident #8 in the smoking area. Staff C handed the resident the cup for self-administration of oral dosage.

At 11:50 a.m., Staff C was observed removing Resident #9's medication from the medication cart. Staff C removed the medication from the primary packaging and placed the medication in a cup, staff initialed the MOR for the medication removed, placed medication package in medication cart, and locked cart. Staff C carried the cup and found Resident #9 in their . Staff C handed the resident the cup for self-administration of oral dosage.

At 11:58 AM., Staff C was observed removing Resident #10's medication from the medication cart. Staff C initialed the MOR for the medication and locked the cart. Staff C carried the container to the Resident #10 for self-administration of eye drops.

During an interview with Administrator, on at 1:22 PM., they stated that staff should take the MOR and the medication to the resident prior to opening the medication and that staff should document in the MOR after medications are given to the resident.

Based on the above stated uncorrected deficiency, the facility shall be required to employ the consultant services of a licensed pharmacist or a registered nurse.

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.

This serves as a written notification of the requirement for the above described consultation services.

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