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
	AL11910716	A. BUILDING: _____ B. WING _____	03/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH LAKE RETIREMENT HOME	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint investigation (CCR 2017000093) was conducted at North Lake Retirement Home, Inc. (license 7395) in Hollywood, Florida on . . . . . Deficient practice was found at the time of the visit.	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 , ... 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. (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	A 052		

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A 052	Continued From page 1 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. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide assistance with self-administration of medication as directed under 429.256 FS, for 11	A 052		

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A 052	Continued From page 2 of 11 residents observed for the provision of assistance with the self-administration of medications. The Medication Assistant failed to identify the medications provided to Residents # 1 to #11 and failed to secure the medication cart when not in use. The findings include: Observations were made of the resident medication pass on ..... beginning at 7:31 AM : 1. During an observation at 7:31 AM of medication provision for Resident # 1, the surveyor observed the following: the Medication Assistant (MA) #A checked the resident's medication observation record. The MA then sanitized her hands, removed Resident #1 ' s pharmacy labeled medication prefilled square packet from the medication cart, pushed the medications into the residents hand and asked the resident to swallow the medications. During this observation, at no time did the MA identify the medications or use for the medication being provided to the resident. 2. During an observation at 7:35 AM of medication provision for Resident # 2, the surveyor observed the following: the Medication Assistant (MA) #A checked the resident's medication observation record. The MA then sanitized her hands, removed Resident #2 ' s pharmacy labeled medication prefilled square packet from the medication cart, pushed the medications into the residents hand and asked the resident to swallow the medications. During this observation, at no time did the MA identify the medications or use for the medication being provided to the resident.	A 052		

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A 052	Continued From page 3 3. During an observation at 7:36 AM of medication provision for Resident # 3, the surveyor observed the following: the Medication Assistant (MA) #A checked the resident's medication observation record. The MA then sanitized her hands, removed Resident #3 ' s pharmacy labeled medication prefilled square packet from the medication cart, pushed the medications into the residents hand and asked the resident to swallow the medications. During this observation, at no time did the MA identify the medications or use for the medication being provided to the resident. 4. During an observation at 7:40 AM of medication provision for Resident # 4, the surveyor observed the following: the Medication Assistant (MA) #A checked the resident's medication observation record. The MA then sanitized her hands, removed Resident #4 ' s pharmacy labeled medication prefilled square packet from the medication cart, pushed the medications into the residents hand and asked the resident to swallow the medications. During this observation, at no time did the MA identify the medications or use for the medication being provided to the resident. 5.During an observation at 7:42 AM of medication provision for Resident # 5, the surveyor observed the following: the Medication Assistant (MA) #A checked the resident's medication observation record. The MA then sanitized her hands, removed Resident #5 ' s pharmacy labeled medication prefilled square packet from the medication cart, pushed the medications into the residents hand and asked the resident to swallow the medications. During this observation, at no time	A 052		

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A 052	Continued From page 4 did the MA identify the medications or use for the medication being provided to the resident. 6. During an observation at 7:44 AM of medication provision for Resident #6, the surveyor observed the following: the Medication Assistant (MA) #A checked the resident's medication observation record. The MA then sanitized her hands, removed Resident #6 ' s pharmacy labeled medication prefilled square packet from the medication cart, pushed the medications into the residents hand and asked the resident to swallow the medications. During this observation, at no time did the MA identify the medications or use for the medication being provided to the resident. 7. During an observation at 7:45 AM of medication provision for Resident # 7, the surveyor observed the following: the Medication Assistant (MA) #A checked the resident's medication observation record. The MA then sanitized her hands, removed Resident #7 ' s pharmacy labeled medication prefilled square packet from the medication cart, pushed the medications into the residents hand and asked the resident to swallow the medications. During this observation, at no time did the MA identify the medications or use for the medication being provided to the resident. 8. During an observation at 7:47 AM of medication provision for Resident # 8, the surveyor observed the following: the Medication Assistant (MA) #A checked the resident's medication observation record. The MA then sanitized her hands, removed Resident #8 ' s pharmacy labeled medication prefilled square packet from the medication cart, pushed the medications into the residents hand	A 052		

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A 052	Continued From page 5 and asked the resident to swallow the medications. During this observation, at no time did the MA identify the medications or use for the medication being provided to the resident. During the observation of the medication pass at 7:52 AM , a resident requested MA #A to come to the dining table to ask MA #A a question. MA #A was observed to walk across the . . . . , leaving the cart unlocked with the keys hanging in the lock. Residents were observed ambulating past the cart during her absence. 9. During an observation at 7:55 AM of medication provision for Resident #9, the surveyor observed the following: the Medication Assistant (MA) #A checked the resident's medication observation record. The MA then sanitized her hands, removed Resident #9 ' s pharmacy labeled medication prefilled square packet from the medication cart, pushed the medications into the residents hand and asked the resident to swallow the medications. During this observation, at no time did the MA identify the medications or use for the medication being provided to the resident. 10. During an observation at 7:59 AM of medication provision for Resident #10, the surveyor observed the following:the Medication Assistant (MA) #A checked the resident's medication observation record. The MA then sanitized her hands, removed Resident #10 ' s pharmacy labeled medication prefilled square packet from the medication cart, pushed the medications into the residents hand and asked the resident to swallow the medications. During this observation, at no time did the MA identify the medications or use for the medication being provided to the resident.	A 052		

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A 052	Continued From page 6 11. During an observation at 8:06 AM of medication provision for Resident #11, the surveyor observed the following: the Medication Assistant (MA) #A checked the resident's medication observation record. The MA then sanitized her hands, removed Resident #11 ' s pharmacy labeled medication prefilled square packet from the medication cart, pushed the medications into the residents hand and asked the resident to swallow the medications. During this observation, at no time did the MA identify the medications or use for the medication being provided to the resident. During an interview immediately after Medication Assistant #A had completed providing the Residents with their medications, she stated that she routinely doesn't identify the medications to the residents. During an interview with the Administrator on . . . . . at 12:30 PM, he stated that all medication assistants had been retrained on the proper assistance with self administration of medication procedures, which included to inform the resident what medications they were being provided. Class III	A 052		
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	A 056		

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A 056	Continued From page 7 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 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	A 056		

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A 056	Continued From page 8 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; 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	A 056		

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A 056	Continued From page 9 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 ensure that prescription medications were properly dispensed according to regulatory guidelines. This was evidenced by the failure to dispense medications from properly labeled containers for 3 of 14 sampled residents,(Resident #12, #13 and #14) and failure to follow physician prescription order for 1 of 1 residents, (Resident #10) who required a medication prior to meal service. The findings include: During an observation of the medication cart located in the nursing station on ..... at 6:50 AM, Medication Assistant (MA) #A was observed to open the cart, then opened the top drawer revealing 2 trays with multiple small prefilled unit dose boxes with resident names and medication names printed on the top. In addition, to the small prefilled boxes, there were 3 paper souffle cups with a resident name handwritten on the outside of each, Resident #12, Resident #13 and Resident #14. Unidentified pills were observed inside each of the 3 cups. See photographic evidence. During an interview with MA #A on at 7:15 AM she was questioned what medications were inside the paper cups for the 3 residents. She stated " I know Resident #12's pill is ... but I can't locate packaging from pharmacy, it must have been the last pill". She stated that MA #B who worked on the evening shift, will routinely	A 056		

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A 056	Continued From page 10 organize and prepare all the medications for the AM, including prepouring Resident #12, #13 and #14's medications. She stated that she had recently completed annual medication assistance training in . , 2016 and had been trained to not transfer medications into other containers. During an interview with the Medication Assistant Manager on . . . . . at 9:30 AM, she stated that most of the medications are prefilled by the pharmacy into the small unit dose boxes which are provided to the residents by facility staff. She stated that any medications that are sent from the pharmacy in bottles are to be given to a resident at the prescribed time and removed from container only at that time. She was informed of the observation of prepoured medications in paper souffle cups and she stated that that was not proper practice. She expressed her concerns about the actions by staff, MA #B and MA #A and stated that she would counsel them and arrange for all MA's to be re- trained on proper assistance with self administration of medications. She stated that MA #B worked evenings and his duties included to provide evening medications. During an interview with MA #B on . . . . . at 10:45 AM, he stated that he worked most days until 7:30 or 8 PM. He stated that he passed evening medications and he would prepare any "as needed medications" along with the following AM medications, placing them inside the medication cart. He stated that he transferred the prescribed medications that come in a bottle/container into a souffle cup and then would write the resident name on the cup. He stated that he was "just trying to help out the morning MA". He stated that he understood the safety concerns when medications are removed from their original pharmacy containers.	A 056		

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A 056	Continued From page 11 During an interview with the Administrator on [redacted] at 11:30 AM he was informed of the surveyor observation and staff interviews. He stated that he was unaware that MA#A and MA#B were transferring medications from original containers and therefore not following proper assistance with self administration guidelines. He stated that all staff who handle medications will be re-inserviced. Review of Resident #10's 2017 Medication Observation Record (MOR) indicated the resident was prescribed Levothyrox 75mcg by mouth every morning at 7AM on an empty stomach. During an observation at 7:59 AM of medication provision for Resident #10, the surveyor observed the following: Resident #10 had eaten half of his breakfast consisiting of scrambled eggs and sausage when Medication Assistant (MA) #A approached the resident to provide his medications. She removed Resident #10 ' s pharmacy labeled medications in the prefilled square packet from the medication cart, punched the medications into the residents hand and asked the resident to swallow the medications. During this observation, at no time did the MA identify the medications or use for the medication being provided to the resident. When questioned why she had not followed the physician order to give medication on an empty stomach, she did not respond. In an interview with the facility pharmacist on [redacted] at 4:40PM, he reviewed Resident #10's medication orders and stated that the "Levothyrox 75mcg should be given at least 1/2 hour prior to a meal." He stated that the medication does not absorb as effectively on a full stomach.	A 056		

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A 056	Continued From page 12 Class III	A 056		
A 084 SS=D	58A-5.0191(5) FAC Training - Assis Self-Admin Meds & Med Mgmt (5) ASSISTANCE WITH SELF-ADMINISTERED MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with self-administered medications as described in Rule 58A-5.0185, F.A.C., must meet the training requirements pursuant to Section 429.52(5), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates an ability to: 1. Read and understand a prescription label;	A 084		

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A 084	Continued From page 13 2. Provide assistance with self-administration in accordance with Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , and nasal dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an " as needed " prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident ' s health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; and g. Recognize the general signs of adverse reactions to medications and report such reactions. (c) Unlicensed persons, as defined in Section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 4 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training shall only be provided by a licensed registered nurse, or a licensed pharmacist. This Statute or Rule is not met as evidenced by: Based on observation,interview and record review,the facility placed residents at risk by failing to ensure care staff have completed the necessary trainings for assistance with self administration of medications and safe	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	03/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 084	Continued From page 14	A 084		

medication practices. This was evidenced by the failure of staff to complete required annual continuing education training for 6 of 6 sampled employees, (Employee # C, #D ,#E, #F, #G and #H) who work from 7 PM until 8 AM.

The findings include:

Review of the employee schedule posted from Friday to Wednesday indicated that Employees #C - #H were listed as direct care staff, scheduled on the night shift 7 PM until 8 AM. Review of the schedule on Employees #C, #D and # E worked the night shift and on Employees # F, #G and #H worked the night shift. Review of the schedule revealed no other employees were documented as scheduled to work on those days/ hours .

Review of the facility's personnel records on indicated that the job description for "Resident Care" staff to include item # 5 - "to remind residents and assist with self administered medications".

Review of Employees #D, # F, #G and #H personnel record indicated they did not have any documentation of attending a continuing education training on providing assistance with self-administration of medications and safe medication practices. Further record review indicated that Employee # C last completed medication training on and Employee #E last completed training on , both employees had not meet the annual training requirement.

During an interview with the Administrator on at 1 PM he stated that he was aware

Agency for Health Care Administration

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A 084	Continued From page 15 that a few employees needed to have the annual medication training. He stated that he would be coordinating the required training for the employees and would modify the schedule to include care staff who had completed the training. He did not provide any additional documentation for review. Class III	A 084		