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
	AL11966273	A. BUILDING: _____ B. WING _____	05/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK	4279 JUDITH AVE MERRITT ISLAND, FL 32953

(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
CZ821 SS=C	59A-35.110 FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under chapter 408, part II, F.S., or authorizing statutes for the provider type as specified in section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections; and, (f) Approval of revisions to emergency management plans. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On	CZ821		

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CZ821	Continued From page 1 Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: a. Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 days after the occurrence of the incident as required in section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. b. Liability claim reports required pursuant to section 429.23(5), F.S., and rule 58A-5.0242, F.A.C. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted	CZ821		

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CZ821	Continued From page 2 electronically to the Agency within 15 calendar days after the occurrence of the incident as required in section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to electronically submit to the Agency for Health Care Administration (AHCA) a preliminary report within 1 business day and a full report within 15 days of an event over which the facility personnel could exercise control rather than as a result of the resident's condition when 2 of 6 sampled residents were transferred to the hospital for receiving the wrong medications (#4 & 9). Findings:	CZ821		

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CZ821	Continued From page 3 1. On at 10:45 a.m., resident #4 said about a month ago the director of nursing (DON) brought him two pills and told him to take them. She returned about a half hour later and asked where the pills were. He told her he did as she instructed him to and took the pills. She told him not to panic but she gave him the wrong pills and she would monitor him. An ambulance showed up and when he asked them why he was being taken to the hospital, they told him because he got the wrong medication. Resident #4's record revealed a facility admission date of . His current 1823 health assessment form, dated , indicated that his diagnoses included , and he required medication administration. A facility nurse's note, dated at 6 p.m. indicated that he was accidentally given his neighbor's medications, 500 milligrams (mg.) and 600 mg. He was sent to the hospital. A hospital emergency room note, dated , indicated that he was seen for an accidental overdose with and . He had with uncontrolled rate, mild Insufficiency, and mild . The hospital instructions were to be "more diligent and careful nursing care at the facility and don't give the patient someone else's medications." On at 10:28 a.m., the DON said she mistakenly gave resident #4 the wrong pills on	CZ821		

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CZ821	Continued From page 4 . . . . . , and said the pills were prescribed for another resident. She said he was sent to the hospital and returned. A request was made to review the required preliminary and full adverse reports submitted to AHCA. At 11:07 a.m. on . . . . . , the administrator said preliminary and full adverse reports were not submitted because he did know the medication error occurred. 2. Record review for resident #9 revealed a nurse's note on . . . . . at 9:30 AM that indicated that the resident was sent to the hospital via 911 due to a medication error. The resident's sister was notified as well as the DON and administrator. On . . . . . at 11:10 AM, the administrator said there was no adverse report completed for the medication error for resident #9. The administrator was asked on . . . . . at 12 PM if an adverse incident report was completed because the medication error resulted in the the transfer of the resident to the hospital providing acute care due to the incident rather than the resident's condition before the incident, he said there was no adverse incident report completed for the med error. On at 2:15 PM, the DON said licensed practical nurse (LPN) G gave the resident the wrong medication in error that belonged to the resident who resided in another room. She said the medications given were D, Venlafazine 75 mg., ... 300 mg. and , 5 mg. She was told by LPN G that she	CZ821		

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CZ821	Continued From page 5 did not know why they wrong medications were given. Unclassified	CZ821		
A 000	Initial Comments Complaint Investigation #2019001727 was conducted from . Cedar Creek had deficiencies at the time of the visit.	A 000		
A 025 SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 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	A 025		

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A 025	Continued From page 6	A 025		

activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.
(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.
(d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change.
(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to notify a health care provider when 2 of 6 residents were given the wrong medication (#4 & 9), and 1 of 6 residents was sent to the hospital (#4).

Findings:

1. On [redacted] at 10:45 a.m., resident #4 said about a month ago the director of nursing (DON) brought him two pills and told him to take them. She returned about a half hour later and asked where the pills were. He told her he took the pills as instructed by her. She told him not to panic but she gave him the wrong pills and she would monitor him. An ambulance showed up, and when he asked them why he was being taken to the hospital, they told him because he got the

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A 025	Continued From page 7 wrong medications. Resident #4's record revealed a facility admission date of . His current 1823 health assessment form, dated , indicated he required assistance with medication administration. A facility nurse's note, dated at 6 p.m. indicated that he was accidentally given his neighbor's medications, ( ) 500 milligrams (mg.) and (& neuropathic) 600 mg. He was sent to the hospital. His power of attorney was notified. His record did not contain documentation to indicate his health care provider was notified when he received the wrong medication and when he was sent to the hospital. On at 10:28 a.m., the DON said she mistakenly gave resident #4 the wrong pills on , and that the pills were prescribed for another resident. She said he was sent to the hospital and returned. She said although it was not documented in his record, she notified his health care provider. 2. Resident #9's nurse's notes on at 9:30 AM revealed that the resident was sent to the hospital via 911 due to a medication error. The nurse's note revealed the resident returned to the facility on at 12:30 PM, informed the staff that the hospital did not give any instructions, and told him he was fine. There was no documentation to confirm what had occurred resulting in the medication error, and that the family and health care provider was contacted after the resident returned to the facility. On at 2:15 PM, the DON confirmed the	A 025		

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A 025	Continued From page 8 findings regarding resident #9. She said licensed practical nurse (LPN) G gave resident #9 the wrong medication in error that belonged to the resident who resided in another. She said the medications given were D, Venlafazine ( ) 75 mg., , 300 mg., and {used for high } 5 mg. Class III Photographic evidence obtained.	A 025		
A 028 SS=D	58A-5.0182(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs) for 1 of 6 sampled residents who was not given a shower (#6). Findings: On at 7 a.m., resident #6 said her showers were scheduled to be given every Tuesday, Thursday, and Saturday. However, she did not always get her shower depending on how many staff were working. She said the most recent time was on , and she was told by a staff member that she was unable to receive	A 028		

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A 028	Continued From page 9 her shower because there were not enough people working. At 3:30 p.m. on , caregiver D said the resident did not receive a shower because caregiver E was the only one working the 7 a.m. to 3 p.m. shift on . . . . until the director of nursing (DON) arrived to help at 10 a.m. He said there was no completed ADL flow sheet to indicate she received a shower, and a refusal sheet was not completed. He said her showers were scheduled to be given on the 11 p.m. to 7 a.m. shift but there was only a male caregiver working over night, and she does not allow male caregivers to assist her with care. At 3:40 p.m. on . . . . , the administrator said caregiver A called off for the 7 a.m. to 3 p.m. shift on . . . . so the DON came in to work. The DON said she arrived at approximately 8 a.m., and the resident did not receive a shower because no one from the night shift said she did not receive one. At 3:58 p.m. on . . . . , the administrator said he determined the reason she did not get her shower on the night shift was because caregiver J called off and would have been the female caregiver to give the shower. Her current 1823 health assessment form, dated , indicated she required assistance with bathing. Class III	A 028		
A 052 SS=D	429.256( ); 58A-5.0185 (3) Medication - Assistance with Self-Admin	A 052		

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A 052	Continued From page 10 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container. (c) Placing an oral dosage in the resident ' s or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (h) Using a to perform level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the prescribed settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs.	A 052		

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A 052	Continued From page 11 (m) Assisting with [illegible] bags. (4) Assistance with self-administration does not include: (a) Mixing, [illegible], converting, or [illegible] medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a [illegible] of the body. (d) Administration of [illegible] preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) [illegible], or [illegible] preparations. (g) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. 58A-5.0185 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] or older, trained to assist with self administered medication pursuant to the training requirements of rule 58A-5.0191, F.A.C., and	A 052		

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A 052	Continued From page 12 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, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (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	A 052		

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A 052	Continued From page 13 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)(g), 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)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's . . . . control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interview, the facility failed to ensure the unlicensed caregiver who assisted a resident with self-administered medications followed the correct procedure (D). Findings: Observations made during a medication pass for resident #1 on . . . . . at 9:35 a.m. revealed unlicensed caregiver D unlocked the medication cart, and while standing at the cart, removed a bottle of suspension, and poured 10 milliliters (ml.) into a cup. He returned the bottle to the cart. He removed one bubble package of medicine at a time and each time, he popped the medicine into a cup. He returned each package	A 052		

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A 052	Continued From page 14 to the cart, locked the cart, then he took the cup of meds to the resident in her room. He handed each cup to the resident, who took the meds without help. He observed her take the meds then he returned to the cart and signed the medication observation record. He did not take the packages and bottle to the resident, read the label aloud, and prepare the medications in her presence, as required. At 9:45 a.m. on , caregiver D confirmed the findings. Class III	A 052		
A 053 SS=G	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 to the medication or a significant change in the resident's health or behavior that may be caused by the medication 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 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 testing,	A 053		

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A 053	Continued From page 15 must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and chapter 483, Part I, 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 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 record reviews and interviews, the facility failed to provide the prescribed medication to 2 of 6 sampled residents who received assistance with medications (#4 & 9), gave medications for 1 of 6 residents not prescribed by the health care provider (#8), and gave 2 of 6 residents too much a medication (#7 & 8). Findings: 1. On at 10:45 a.m., resident #4 said about a month ago the director of nursing (DON) brought him two pills and told him to take them. She returned about a half hour later and asked where the pills were. He told her he took the pills as instructed by her. She told him not to panic but she gave him the wrong pills and she would monitor him. An ambulance showed up, and when he asked them why he was being taken to	A 053		

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A 053	Continued From page 16 the hospital, they told him because he got the wrong medications. Resident #4's record revealed a facility admission date of [redacted]. His current 1823 health assessment form, dated [redacted], indicated that his diagnoses included [redacted], and required medication administration. A facility nurse's note, dated [redacted] at 6 p.m. indicated that he was accidentally given his neighbor's medications, [redacted] ([redacted]) 500 milligrams (mg.) and [redacted] ([redacted] & neuropathic [redacted]) 600 mg. He was sent to the hospital. A hospital emergency room note, dated [redacted], indicated that he was seen for an accidental overdose with [redacted] and [redacted], and had [redacted] with uncontrolled rate, mild [redacted] Insufficiency, and mild [redacted]. The hospital instructions were to be "more diligent and careful nursing care at the facility and don't give the patient someone else's medications." On [redacted] at 10:28 a.m., the DON said she mistakenly gave resident #4 the wrong pills on [redacted], and that the pills were prescribed for another resident. She said he was sent to the hospital and returned. She said although it was not documented in his record, she notified his health care provider. 2. Resident #7's record revealed a facility admission date of [redacted]. Her current 1823, dated [redacted], indicated that she had a diagnoses of Degenerative Disc [redacted] and	A 053		

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A 053	Continued From page 17 . . . . . Disc at L4-L5, and required assistance with self-administration of medications. A FAX notification to a health care provider, dated . . . . . , indicated that she was inadvertently given an extra (-like , reliever) 50 mg. at 9 p.m. The provider's response was to inform the provider if she experienced any adverse effects. A nurse's note, dated . . . . at 9 p.m., indicated that she received an extra 50 mg. with no adverse effects. She declined to go to the hospital. On at 11:11 a.m., the administrator said he was unaware of the medication error. At 12:30 p.m., the DON said she was unaware of the error. 3. On . . . . . at 9:50 AM, resident #8 said she received her liquid (used to treat inflammatory conditions) dosage 6 days by the nurse. She said her doctor was upset when he found out and he started her . . . . . cycle all over again. She said the extra dosages caused her to gain . . . Record review for resident #8 revealed a resident health assessment form that was dated . The health care provider noted she required assistance with the self administration of her medications. A health care provider's order, dated . . . . , for syrup 15 mg./5 milliliters (ml.) twice 1 day and then 5 ml. once in the AM for 2 days. There was another health care providers order, dated , for . syrup 15 mg./5	A 053		

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A 053	Continued From page 18 ml. 1 teaspoon twice a day for 2 days and then 1 teaspoon once in the AM for 2 days. Review of the electronic medication observation record (MOR) revealed the the MOR noted the medication was only given at 6 PM on . There was no documentation on the MOR that noted she had received the medication twice. The MOR noted that on . . . . ., the medication was given at 10 AM and 6 PM, and should have only been given one time in the AM. The last dose should have been on . and the MOR noted that it was given on . . . . and . . . . . The health care provider's order, dated . . . ., for (for .) 100 mg. 1 . for 10 days, was not started until . at 9 PM. The medication was marked as given twice daily from . . . . ending on . . . . . The medication was marked as give for 12 ½ days when the order noted to give for 10 days. On . . . . . at 2:15 PM, the DON confirmed the findings regarding resident #8. 4. Resident #9's nurse's notes on at 9:30 AM revealed that the resident was sent to the hospital via 911 due to a medication error. The resident's sister, DON and administrator were notified. The nurse's note revealed the resident returned to the facility on . . . . . at 12:30 PM, informed the staff that the hospital did not give any instructions, and told him he was fine. On . . . . . at 2:15 PM, the DON confirmed the findings regarding resident #9. She said licensed practical nurse (LPN) G gave resident #9 the wrong medication in error that belonged to the resident who resided in another. She said the medications given were D, Venlafazine	A 053		

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A 053	Continued From page 19 ( ) 75 mg., 300 mg., and (used for high) 5 mg. She was told by LPN G that she did not know why they wrong medications were given. Class II Photographic evidence obtained.	A 053		
A 054 SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical	A 054		

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A 054	Continued From page 20 , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on the electronic medication observation record (MOR) review and interview, the facility failed to maintain a accurate MORs for 3 of 6 sampled residents (#4, 8 & 9). Findings: Review of the electronic MOR for residents #8 and #9, who both required assistance with the self administration of their medication, revealed blank spaces and no way to determine whether or not the residents received medications. 1. Resident #8's , and MORs: 20 milligrams (mg.) 1 three times daily ( ) was blank at 4 PM on and at 9 PM 400 mg. 1 at breakfast, lunch, dinner and bedtime was blank on at 4 PM and on at 10 PM 60 mg. 1 two times daily ( ) was blank on at 9 PM XL 10 mg. one at bedtime (HS) was blank at 9 PM on , and 0.5 mg. one four times daily ( ) was blank on at 6 PM and 10 PM, on at 2 PM, and on at 6 PM 160 mg. 1 was blank at 9 PM on HCl 50 mg. 2 was blank at 9 PM on , at 4 PM on , , at 9 PM and	A 054		

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A 054	Continued From page 21	A 054		

5 mg. one was blank at 9 PM on , , , , , at 9 AM on , , , , , and

, 50 micrograms (mcg.) at 9 AM was blank on , , and 40 mg. one half hour before breakfast was blank at 9 AM on , , and

2. Resident #9's and MORs:
10 mg. one daily (QD) was blank at 9 PM on , , , , / , , , , and

HCl 0.4 mg. one QD was blank at 9 PM on , , , , , , , , , and

, ER 10 mg. one QD at 9 AM was blank on , , and
Multi Adult Gummie Chew one QD at 9 AM was blank on , , and .

On at 3 PM, the director of nursing (DON) confirmed the findings and stated when agency nurses worked at the facility, they did not updated the electronic MORs.

3. Resident #4's record revealed a facility admission date of . His current 1823 health assessment form, dated , indicated that his diagnoses included , , , , , , , , and required medication administration.

His MOR listed , , 5

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A 054	Continued From page 22 mg., . . . 10 mg. QD, ... 10 mg. QD, and 0.4 mg. QD. These medications were not signed as given on . . . . and . . . . at 9 a.m. On . . . . at 12:27 p.m., the DON confirmed the findings and said perhaps an agency nurse worked on those dates, and they do not have access to chart on the electronic MOR. She said the facility did not utilize paper MORs for the agency nurses to chart on. Photographic evidence obtained. Class III	A 054		
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 they are 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. The 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.	A 056		

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A 056	Continued From page 23 (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 , , 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 that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (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.	A 056		

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A 056	Continued From page 24 (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 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 record reviews and interview, the facility failed to make every reasonable effort to ensure a prescription was filled in a timely manner for 1 of 6 sampled residents who received assistance with medications (#7). Findings: Resident #7's record revealed a facility admission date of . Her current 1823, dated , indicated that she had a diagnoses of , and required assistance with self-administration of medications.	A 056		

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A 056	Continued From page 25 Documentation on her , and Medication Observation Records revealed that on , , and her 1 milligram twice daily was not given, and the facility was awaiting delivery from the pharmacy. At at 2:30 p.m., the director of nursing confirmed the findings, said the facility ran out of her on , staff reordered it from the pharmacy, and it was delivered on . Photographic evidence obtained. Class III	A 056		
A 079 SS=D	58A-5.019(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16- 25 253 26-35 294 36-45 335 46-55 375 56- 65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 58A-5.024(3), F.A.C., who occupy beds included within the licensed capacity of an	A 079		

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A 079	Continued From page 26 assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 58A-5.0191(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager.	A 079		

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(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 079	Continued From page 27 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 58A-5.0182, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule	A 079		

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
	AL11966273	A. BUILDING: _____ B. WING _____	05/06/2019

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A 079	Continued From page 28 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 58A-5.029, 58A-5.030 or 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by:	A 079		

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 079	Continued From page 29 Based on staff schedule review, time sheet review and interviews, the facility did not maintain a staff schedule that accurately reflected its 24-hour staffing pattern for a given time period. Findings: Review of the staff schedule for revealed it noted caregiver B was not listed on the schedule as working on but the time sheet noted she worked on from 3:09 AM-10:10 AM. For caregiver H, the staff schedule noted he worked from 11 PM-7 AM on but the time sheet noted he worked from 11:05 PM-1:30 AM For caregiver I, the staff schedule noted she worked from PM but the time sheet noted she worked from 4: :04 PM, and on , the schedule noted she worked from PM but the time she noted, she did not work at all that day. For caregiver D, the schedule noted he was off on but the time sheet noted he worked from 7:29 AM-7:56 PM. On , the schedule noted that he worked from 7:30 AM-8 PM but the time sheet noted he did not work at all that day. On , the staff schedule noted that he did not work but the time sheet noted that he worked from 8:56 AM-9:07 PM. On , the staff schedule noted that he worked 7 AM-3 PM but the time sheet noted that he worked from 7:24 AM-12:01 PM. On , the staff schedule noted that he worked from PM but the time sheet noted that he worked from 248 PM-919 PM. For Licensed Practical Nurse (LPN) K, the	A 079		

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A 079	Continued From page 30 schedule noted she did not work on [redacted] but the time sheet noted she worked from 2:36 PM-11:20 PM. For caregiver L, the staff schedule noted she worked from 7 AM-3 PM but the time sheet noted she worked from 6:56 AM-11:57 AM on [redacted]. On [redacted], the staff scheduled noted she worked from 7 AM-3 PM but the time she noted she did not work at all that day. For caregiver M, the staff schedule noted she worked from 7 AM-3 PM on [redacted] but the time sheet noted she did not work at all that day, and on [redacted], the staff schedule noted she did not work that day but the time sheet noted she worked from 7:09 AM-3:30 PM that day. For caregiver B, the staff schedule noted she worked on [redacted] but the time sheet noted a personal day, and she did not work that day at all, and on [redacted], the staff schedule noted she did not work but the time sheet noted she worked from 7:31 AM-8:15 AM. On [redacted] at 4 PM, the administrator reviewed the staff schedules and time sheets and confirmed the findings. Class III	A 079		