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
	AL11969410	A. BUILDING: _____ B. WING _____	R 08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT TERRA BELLA	2200 LIVINGSTON ROAD LAND O LAKES, FL 34639

(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 A Revisit to 05/21/19 Complaint Investigation (Complaint Number: 2019004161) and a Complaint Investigation (Complaint Number: 2019009436) were conducted at Keystone Place at Terra Bella Assisted Living Facility on . Deficiencies were identified at the time of survey.	{A 000}		
{A 052} SS=D	429.256( ); 58A-5.0185 (3) Medication - Assistance with Self-Admin 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 -	{A 052}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 052}	Continued From page 1	{A 052}		

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.
(m) Assisting with bags.

(4) Assistance with self-administration does not include:
(a) Mixing, converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
(b) The preparation of syringes for injection or the administration of medications by any injectable route.
(c) Administration of medications by way of a tube inserted in a of the body.
(d) Administration of preparations.
(e) Irrigations or debriding agents used in the treatment of a skin condition.
(f) , , or 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

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

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 , 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, 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

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{A 052}	Continued From page 3 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)(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 observation, record review, and interview, the Facility failed to ensure proper assistance with self-administration of medications according to the required steps in 429.256 Florida Statutes and failed to follow control standards while assisting with medications for two Residents (#7 and #8) of two sampled residents	{A 052}		

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{A 052}	Continued From page 4 that required assistance with self-administration of medication. Findings Included: During a medication pass observation for Residents #7 and #8 with Staff C, conducted on between 09:14am and 09:37am, revealed that Staff C, an unlicensed Medication Technician did not assist Residents #7 and #8 properly with medications according to the required steps in 429.256 Florida Statutes and did not follow control standards with centrally stored medications. Staff C popped out all of Resident #7 and #8's medications in two separate plastic medication cups at the medication cart and neither resident was present. Resident #7's medication included C 500milligram (mg), 100mg, 500mg, 75mcg, Cerovite Senior 23mg, 5mg, 80mg, 750mg, 10mg, 5mg, Saw Palmetto 450mg, E 400units, Vita-Bee/C, 500mg, 20mg, and Cream 1%. Resident #8's medications included /HCTZ-20/12.5mg (two tablets), 75mg, 100mg, Oyster Shell 500mg, D3 1000international units, and 10mg. Upon entry into Resident #7 and #8's room, Staff C laid the medication packs on top of the microwave without a barrier and handed Resident #8 one plastic cup of medications and stated, "you have seven pills". Staff C did not read medication labels to Resident #8. Staff C left the medication packs on top of the microwave and went into the bedroom, which was out of sight of the medications. Staff C assisted Resident #7 out of bed and instructed the	{A 052}		

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{A 052}	Continued From page 5 resident to go to the dining room for medications. Staff C returned to the kitchenette area and retrieved the medication packs and returned to the dining room and laid the medication packs on the dining table without a barrier. Staff C handed Resident #7 the plastic cup of medications and put on gloves and placed the cream on both of the resident's . Staff C left the medications on the dining table and went to the kitchenette sink and washed own . Resident #8 stated that this was the first time that Staff C had brought the medication packs into the resident's room. Staff C returned the medication pack to the central storage medication cart. A record review for Staff C, conducted on , revealed that Staff C's record did not include the six-hour required training for Assistance with Self-Administration of Medications. Staff C did have a certificate for four-hours of training dated . Staff C was hired on . During an interview with Staff A, conducted on at 11:10am, Staff A agreed that unlicensed Medication Technicians were required to read the medication labels to residents and in front of the resident pop the pill out of the pill packs. Staff A agreed that Staff C only had evidence of a four-hour Medication Technician Training in the employee's record. Class III	{A 052}		
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	A 054		

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A 054	Continued From page 6 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 , 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 record review and interview, the Facility failed to update Medication Observation Records (MORs) immediately each time medications (meds) were offered to five Residents (#1, #6, #9, #10, and #12) of five sampled residents that required assistance with self-administration of meds or med administration. Findings Included:	A 054		

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A 054	Continued From page 7 A review of Resident #1's MORs, conducted on , revealed that Resident #1's MORs had meds not documented as given to the resident. On , Resident #1 had the prescribed meds not documented as given at 06:00am, which included 1000milligram (mg), 81mg, and Wixela 500/50 Inhaler. On , Resident #1 had the prescribed meds not documented as given at 02:00pm, which included 1000mg. On , Resident #1 had the prescribed meds not documented as given at 09:00pm, which included 1000mg. A review of Resident #6's MORs, conducted on , revealed that Resident #6's MORs had meds not documented as given to the resident. On , Resident #6 had the prescribed meds not documented as given at 09:00am, which included 81mg, 75mg, 10mg, 50mg, 20mg, 850mg, 0.1mg, and 5mg. A review of Resident #9's MORs, conducted on , revealed that Resident #9's MORs had meds not documented as given to the resident. On , Resident #9 had the prescribed meds not documented as given at 09:00am, which included 2.5mg, 20mg, 2.5mg, Multgen 50mg, 20milliequivalent, and 40mg. A review of Resident #10's MORs, conducted on , revealed that Resident #10's MORs had meds not documented as given to the resident. On , Resident #10 had	A 054		

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A 054	Continued From page 8 the prescribed meds not documented as given at 09:00am, which included Acidophilus, , 81mg, . . ., 2.5mg, . . ., Succinct 25mg, , 20mg, Softener 8.6-50mg, ... 600mg, , . . ., /. . . . . Solution, . 10mg, and . . . . . Diskus Inhaler. A review of Resident #12's . . . MORs, conducted on , revealed that Resident #12s MORs had meds not documented as given to the resident. On , Resident #12 had the prescribed meds not documented as given at 10:00am, which included 50mcg spray and . . . . 300mg. On . . . . . , Resident #12 had the prescribed meds not documented as given at 09:00am, which included . . . . 300mg and 40mg. During an interview with Staff A, conducted on . . . . . at 11:10am, Staff A agreed that Residents #1, #6, #9, #10, and # MORs had prescribed meds not documented as given or offered to the residents. 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	{A 056}		

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{A 056}	Continued From page 9	{A 056}		

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.
(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

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{A 056}	Continued From page 10 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 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 review and interview, the Facility failed to follow Health Care Provider's order for stated medication times, failed to obtain an order for change in medication times, and failed to	{A 056}		

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{A 056}	Continued From page 11 store prescription medication with proper labeling for eight Residents (#1, #6, #8, #9, #10, #11, #12, and #13) of eight sampled residents who required medication administration or assistance with self-administration of medications (meds). Findings Included: During an interview with Resident #8, conducted on at 09:30am, Resident #8 stated that the resident sometimes does not get meds as ordered because they run out of supply. During an interview with Staff D, conducted on at 09:05am, Staff D stated that "sometimes the resident don't have their meds" but "it's a lot better now that we have [medication] cycle [fill]". During an interview with Resident #1, conducted on at 01:30pm, Resident #1 stated that meds were "sometimes late" and "one night last week, I never got" my meds. During an interview with Resident #13, conducted on at 02:10pm, Resident #13 stated that "on two occasions they (referring to meds) were three to four hours late" and "one day they skipped my meds completely". During an interview with Staff B, conducted on at 03:05pm, Staff B stated that the Facility "only provided meds to residents when they leave the Facility if they ask for them". A review of Resident #1's Medication Observation Records (MORs), conducted on , revealed that Resident #1 had prescribed meds documented as given late on . Resident #1's prescribed	{A 056}		

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{A 056}	Continued From page 12 50milligram (mg) was due at 05:00pm and documented as given at 07:22pm. Resident #1's prescribed 100mg was due at 06:00pm and documented as given at 07:22pm. Resident #1's prescribed 100mg and 50mg were due at 09:00pm and documented as given at 10:26pm. According to Resident #1's most recent Health Assessment Form, the resident required assistance with self-administration of meds. A review of Resident #6's MORs, conducted on , revealed that the Facility did not make provisions for Resident #6 to receive prescribed meds when the resident was "out of the building" on and for the resident's 09:00am meds, which included 81mg, 75mg, 10mg, 50mg, 20mg, 850mg, 0.1mg, and 5mg. According to Resident #6's most recent Health Assessment Form, the resident required medication administration. A review of Resident #9's MORs, conducted on , revealed that Resident #9 had prescribed meds documented as given late. On , Resident #9 received 05:00pm meds at 10:17pm, which included 2.5mg, 50mg. On , Resident #9 received 09:00am meds at 10:23am, which included 2.5mg, 20mg, 2.5mg, Multigen 50mg, 20milliequivalent, and 40mg. According to Resident #9's most recent Health Assessment Form, the resident required assistance with self-administration of meds. A review of Resident #10's MORs,	{A 056}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT TERRA BELLA	2200 LIVINGSTON ROAD LAND O LAKES, FL 34639

(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 056}	Continued From page 13 conducted on [redacted], revealed that Resident #10 had prescribed meds documented as given late. On [redacted], Resident #10 received a dose of [redacted] 250mg two tablets at 09:00am and [redacted] 250mg one at 09:00am. It appeared that Resident #10 received a double dose of the [redacted] medication as there was a duplication of orders on the residents MORs. On [redacted] neither [redacted] doses were signed as given to Resident #10 and the reason given was due to the medication "not on ". The [redacted] order read 250mg tablets take two tablets for one dose and 250mg tablets take one tablet every day for four more days. The [redacted] restarted on [redacted] for 250mg two tablets for one dose and 250mg one tablet for four more days. There was no documentation that Resident #10 received any [redacted] on [redacted] or on [redacted]. The Facility did not make provisions for Resident #10 to receive prescribed meds when the resident was "out of the building" on for the 09:00am meds, which included Acidophilus, [redacted] 81mg, [redacted] 2.5mg, [redacted] Succinct 25mg, [redacted] 20mg, [redacted] Softener 8.6-50mg, [redacted] 600mg, [redacted] Solution, [redacted] 10mg, and Diskus. According to Resident #10's most recent Health Assessment Form, the resident required medication administration. A review of Resident #11's [redacted] MORs, conducted on , revealed that Resident #11 had prescribed meds documented as given late. On , Resident #11 received 09:00am meds at 03:32pm, which included [redacted] 2.5% Cream, Preservision Areds, [redacted] 100mg, [redacted] 5mg, and [redacted] 1000mcg. The Facility did not make	{A 056}		

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{A 056}	Continued From page 14 provisions on . . . . . for Resident #11 to received the resident prescribed meds at 09:00am when the resident was "out of building". There was documentation that Resident #11 received the meds upon return . . . . to the Facility but did not state what time that the resident received the meds. There was no orders found that the Facility obtained an order from Resident #11's Health Care Provider to change the time of med administration. A review of Resident #12's . . . . . MORs, conducted on . . . . . ., revealed that Resident #12 had prescribed meds documented as given late. On . . . . . , Resident #12 received 08:00pm meds at 09:42pm, which included . . . . . 50mcg . . . . spray, ... 10mg, and . . . . . 300mg. On . . . . . , Resident #12 received 08:00pm meds at 09:45pm, which included . . . . . 50mcg spray, ... 10mg, and . . . . . 300mg. On . . . . . , Resident #12 received 10am meds at 08:44am, which included . . . . . 50mcg . . . . spray, ... 300mg, and . . . . . 300mg. The Facility did not make provisions for Resident #12 to receive the resident's prescribed meds when the resident was "out of the building" on . . . . . , and . . . . . for 09:00am and 10am; and, on . . . . . for 09:00am and 10am meds when the resident was at the Facility's "swimming pool". According to Resident #1's most recent Health Assessment Form did not specify the type of assistance that the resident required for med administration. A review of Resident #13's . . . . . MORs, conducted on . . . . . , revealed that Resident #13 had prescribed meds documented as given late. On . . . . . ., Resident #13 received all	{A 056}		

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{A 056}	Continued From page 15 08:00pm meds at 09:45pm, which included 80mg and , . On , Resident #13 received all 08:00pm meds at 10:36pm, which included 80mg and , 5mg. On , Resident #13 received all 07:00am meds at 08:45am, which included 1000mcg, , 5mg, 80mg, and , 5mg. On, , Resident #13 received all 07:00am meds at 10:14am, which included 1000mcg, , 5mg, 80mg, and , 5mg. A review of two medication carts, conducted on , revealed that both med carts stored prescribed meds that did not have proper labels. Med Cart 1 and 2 had the meds Wixela Diskus, 500/50 Diskus, and , 50mcg Spray that had no labels on them (See Photographic Evidence2). Med Cart 3 and 4 had the meds Bayer , 81mg, Thera-Tears , Solution, and 100mg that had no labels on them (See Photographic Evidence1). During an interview with Staff E, conducted on at 02:47, Staff E stated that Resident #2 and #26 had complained recently that they had not been getting their meds on time or not at all. During an interview with Staff A, conducted on at 11:10am, Staff A agreed that Resident's #1, #6, #9, #10, #11, #12, and #13 had meds documented as given late and documented as not given when the residents were away from the Facility or at the Facility's swimming pool. Staff A acknowledged that Resident #10 had a duplication of orders on the MORs and that the med was not given as ordered to Resident #10. Staff A stated that the Facility's Pharmacy disputed med orders that caused	{A 056}		

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{A 056}	Continued From page 16 major delays for meds not arriving to the Facility in a timely manner. At 03:30pm, Staff A agreed that all stored prescribed meds required med labels. Class III	{A 056}		
A 058 SS=D	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies.	A 058		

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A 058	Continued From page 17 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), 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, record review, and interview, the Facility failed to ensure	A 058		

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A 058	Continued From page 18 documented class III deficiencies regarding medicinal drugs were corrected as required. Findings Included: During a Revisit to 05/21/19 Complaint Investigation (Complaint Number: 2019004161), conducted at the Facility on 08/22/19, revealed that the Facility had uncorrected and recited Class III medication deficiencies. During the Exit Conference with the Administrator, conducted on . . . . . at 03:30pm, the Administrator verbalized understanding of the requirement that the Facility must employ or contract with the consultant services of a licensed Pharmacist or a licensed Registered Nurse Consultant. The consultant services at a minimum provide for onsite quarterly consultation until the Inspection Team from the Agency determines that such consultation services are no longer required. Class III	A 058		
{A 162} SS=D	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2. ; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance ; 8. Name, address, and telephone number of next	{A 162}		

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{A 162}	Continued From page 19 of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in Rule 58A-5.0181, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider ' s order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 58A-5.020, F.A.C., if applicable. (e) The resident care record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 58A-5.025, F.A.C.	{A 162}		

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{A 162}	Continued From page 20 (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 58A-5.0181, F.A.C. (o) The resident ' s , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at	{A 162}		

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{A 162}	Continued From page 21 the discretion of the facility: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required in this paragraph; 3. The health assessment described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to maintain resident records with a copy of an informed consent for unlicensed staff assisting residents with self-administration of medication and health assessment forms complete with all required data as described in Rule 58A-5.0181, Florida Administrative Code for five Residents (#7, #8, #10, #11, and 12) of five sampled residents. Findings Included:	{A 162}		

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{A 162}	Continued From page 22 During an interview with Resident #8, conducted on at 09:30am, Resident #8 stated that self and Resident #7 (spouse) were not informed that unlicensed Medication Technicians were assisting with medications. Resident #8 stated "that is why we left the [former Facility], because this place has nurses 24/7" and we were never told that they had unlicensed staff here". A record review for Residents #7 and #8, conducted on , revealed that there was not a signed informed consent for unlicensed staff assisting residents with self-administration of medication in either Residents #7 and #8's record. A record review for Resident #10, conducted on , revealed that Resident #10's Health Assessment Form dated did not include the residents required nursing service of Hospice on page one. A record review for Resident #11, conducted on , revealed that Resident #11's Health Assessment Form dated did not include if the resident required 24-hour nursing or care or not on page two. A record review for Resident #12, conducted on , revealed that Resident #12's Health Assessment Form dated did not specify the type of medication assistance that the resident required and there was no elopement risk assessment as required. Resident #12's name and date of birth were not on the top of page four. There was no identified name of Examiner or the Examiner's license number, title, address, or phone number as required. During an interview with Staff A, conducted on	{A 162}		

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{A 162}	Continued From page 23 . . . . . at 11:10am, Staff A stated that the Facility "started hiring Medication Technicians to assist with medications" about two weeks ago. Staff A agreed that Residents #10, #11, and #12's Health Assessment Forms did not include all required data. Staff A stated that "the hospitals send the 1823 (Health Assessment Form) and the hard part is getting the hospitals to comply". Two requests for a signed informed consent that unlicensed Medication Technicians were assisting resident with medications were conducted on . . . . . at 11:10am and 02:40pm. The documents were never provided by Exit Conference at 03:30pm. Class III	{A 162}		