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
	AL11963878	A. BUILDING: _____ B. WING _____	R 10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADENTON OAKS	1015 7TH AVENUE EAST BRADENTON, FL 34208

(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 08/02/19 Complaint Investigation (Complaint Numbers: 2019007002 and 2019009608), a Biennial Re-licensure Survey with Generator Monitoring, a Revisit to 08/02/19 Generator Monitoring, and a Complaint Investigation (Complaint Numbers: 2019010885, 2019010917, and 2019011032) were conducted at Bradenton Oaks Assisted Living Facility on and . 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	{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 dose of [illegible] solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the [illegible]. (h) Using a [illegible] to perform [illegible]-[illegible] level checks. (i) Assisting with putting on and taking off [illegible] stockings. (j) Assisting with applying and removing an [illegible] but not with titrating the prescribed [illegible] 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 [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], [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.	{A 052}		

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

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{A 052}	Continued From page 3 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)(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	{A 052}		

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{A 052}	Continued From page 4 according to the required steps in 429.256 Florida Statutes for four {Residents #2, #15, #22, and #24} of four sampled residents that required assistance with self-administration of medication. Findings Included: During a medication pass observation with Staff J, an unlicensed Medication Technician, for Resident #2, #15, and #24, conducted on . . . . . at 12:23pm, Staff J did not compare Resident #2, #15, and #24's medication labels to their Medication Observation Records(MORs) and did not read the residents their medication labels when assisting the residents as required. During an observation at 03:49pm on . . . . . , the Surveyor and the Wellness Director walked up to the medication cart and Staff J was popping pills out of medication packs into small plastic medication cup at the medication cart. There was a plastic medication cup with a liquid medication already in the cup. There were no residents present and there were no MORs opened. Staff J placed a medication pack . . . into the medication cart, closed the drawer, and locked the cart. Staff J picked up the small plastic medication cups and headed down the hall and entered the first room on the right just beyond the dining room. At 04:00pm on , Staff J confirmed that the medications belonged to Resident #22. During an interview with the Wellness Director, conducted on . . . . . at 03:50pm, the Wellness Director agreed that Staff J was not assisting Resident #22 properly with medications. At 04:30pm, the Wellness Director agreed that unlicensed Medication Technicians were required to pop out the pills from medication packs in front	{A 052}		

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{A 052}	Continued From page 5 of the resident and read the medication labels and that they were supposed to compare the medication labels to the Medication Observation Records for accuracy. 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 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	{A 054}		

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{A 054}	Continued From page 6 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 maintain Medication Observation Records (MORs) free of omissions, errors, and duplications and the facility failed to update the MORs immediately each time a medication (meds) were offered for six Residents (#1, #2, #5, #6, #14, and #18) of six sampled resident that required assistance with self-administration of medications. Findings Included: A review of Resident #1's MORs, conducted on , revealed that Resident #1 had prescribed meds not documented as given or offered to the resident, which included 50mg on at 02:00pm and 10:00pm; and, and at 10:00pm. A review of Resident #2's MORs, conducted on , revealed that Resident #2 had prescribed meds not documented as given or offered to the resident, which included 0.5mg on at 04:00pm. A review of Resident #5's MORs, conducted on , revealed that Resident #5 had prescribed meds not documented as given or offered to the resident, which included 600mg on at 12:00pm. A review of Resident #6's MORs, conducted on , revealed that Resident #6 had prescribed meds not documented as given or offered to the resident, which included:	{A 054}		

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{A 054}	Continued From page 7	{A 054}		

- [redacted] 50mg on [redacted] and [redacted] at 08:00am
- [redacted] 1000mg on [redacted] at 08:00am and 06:00pm and [redacted] at 06:00pm
- [redacted] 10-325mg on [redacted] at 08:00am, [redacted] at 04:00pm, and [redacted] at 08:00am
- [redacted] 40mg on [redacted] and [redacted] at 08:00am
- [redacted] 37.5mg on [redacted] and [redacted] at 08:00am

A review of Resident #14's [redacted] MORs, conducted on [redacted], revealed that Resident #14 had prescribed meds not documented as given or offered to the resident, which included [redacted] 30mg on [redacted] at 10:00pm and [redacted] at 02:00pm and 10:00pm and [redacted] 200mg on [redacted] and [redacted] at 10:00pm. Resident #14's prescribed [redacted], medication label did not match the resident's MORs. The dosing on the medication label on the medication pack matched the most recent orders prescribed by the resident's Health Care Provider.

A review of Resident #18's [redacted] MORs, conducted on [redacted], revealed that Resident #18 had prescribed meds not documented as given or offered to the resident, which included [redacted], 1mg on [redacted] at 12:00pm. Resident #18 had a prescribed medication [redacted] - [redacted], 7.5-325mg duplicated on the resident's MORs, which could potentially lead to an overdose of this medication if double dosed. The [redacted] was signed as given both doses on [redacted] at 08:00am.

During an interview with the Wellness Director, conducted on [redacted] at 04:30pm, the Wellness Director agreed that Resident #1, #2, #5, #6, #14,

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{A 054}	Continued From page 8 and #18's MORs had prescribed medications that were not signed as given to the residents. The Wellness Director agreed that Resident #14's Prescribed , medication label did not match the resident's MORs. The Wellness Director agreed that Resident #14 had the prescribed medication , - , duplicated twice the MORs and the unlicensed Medication Technician had signed as given twice on at 08:00am. Class III	{A 054}		
{A 055} SS=D	58A-5.0185(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for	{A 055}		

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{A 055}	Continued From page 9 whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 58A-5.0181, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it	{A 055}		

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{A 055}	Continued From page 10 is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the Facility failed to maintain all centrally stored medications in a locked cabinet, cart, or other locked storage receptacle at all times. Findings Included: During an observation, conducted on at 10:01am, the Surveyor entered a room with the door wide open. There was a mini-refrigerator that had a lock on it and the lock was not latched. There were medications inside the refrigerator (Photographic Evidence Obtained). The name plate on the outside of the entry door	{A 055}		

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{A 055}	Continued From page 11 stated, 'Wellness Director'. During an observation on [redacted] at12:23pm in the Memory Care Unit, Staff J walked away and out of sight from the medication cart to assist Resident #2 to the resident's room. Staff J left the medication cart unlocked with the keys in the key lock. During an interview with the Wellness Director, conducted on [redacted] at 10:05am, the Wellness Director stated that medications "should be locked and secured at all times". The Wellness Director agreed that the mini-refrigerator with [redacted] medications was left unlocked, unsecured, and unattended. At 10:20am, the Wellness Director stated that the mini-refrigerator was left unlocked for the Pharmacy delivery to refill medications. At approximately 12:25pm on [redacted] the Wellness Director observed the keys left in the medication by Staff J and stated that the staff "should have taken the keys and locked the medication cart". Class III	{A 055}		
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	A 058		

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A 058	Continued From page 12 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. 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	A 058		

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	AL11963878	A. BUILDING: _____ B. WING _____	R 10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADENTON OAKS	1015 7TH AVENUE EAST BRADENTON, FL 34208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 058	Continued From page 13 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 class III deficiencies regarding the facility's medications practices. Cross reference A0052, A0054 and A0055 Findings included: During a medication pass observation with Staff J, an unlicensed Medication Technician, for Resident #2, #15, and #24, conducted on at 12:23pm, Staff J did not compare Resident #2, #15, and #24's medication labels to their Medication Observation Records(MORs) and did not read the residents their medication labels when assisting the residents as required. During an observation at 03:49pm on , the Surveyor and the Wellness Director walked up to the medication cart and Staff J was popping	A 058		

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A 058	Continued From page 14 pills out of medication packs into small plastic medication cup at the medication cart. There was a plastic medication cup with a liquid medication already in the cup. There were no residents present and there were no MORs opened. Staff J placed a medication pack into the medication cart, closed the drawer, and locked the cart. Staff J picked up the small plastic medication cups and headed down the hall and entered the first room on the right just beyond the dining room. At 04:00pm on , Staff J confirmed that the medications belonged to Resident #22. During an interview with the Wellness Director, conducted on at 03:50pm, the Wellness Director agreed that Staff J was not assisting Resident #22 properly with medications. At 04:30pm, the Wellness Director agreed that unlicensed Medication Technicians were required to pop out the pills from medication packs in front of the resident and read the medication labels and that they were supposed to compare the medication labels to the Medication Observation Records for accuracy. A review of Resident #1's MORs, conducted on , revealed that Resident #1 had prescribed meds not documented as given or offered to the resident, which included 50mg on at 02:00pm and 10:00pm; and, and at 10:00pm. A review of Resident #2's MORs, conducted on , revealed that Resident #2 had prescribed meds not documented as given or offered to the resident, which included 0.5mg on at 04:00pm.	A 058		

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A 058	Continued From page 15 A review of Resident #5's MORs, conducted on , revealed that Resident #5 had prescribed meds not documented as given or offered to the resident, which included 600mg on at 12:00pm. A review of Resident #6's MORs, conducted on , revealed that Resident #6 had prescribed meds not documented as given or offered to the resident, which included: - 50mg on and at 08:00am - 1000mg on at 08:00am and 06:00pm and at 06:00pm - , 10-325mg on at 08:00am, at 04:00pm, and at 08:00am - , 40mg on and at 08:00am - 37.5mg on and at 08:00am A review of Resident #14's MORs, conducted on , revealed that Resident #14 had prescribed meds not documented as given or offered to the resident, which included 30mg on at 10:00pm and at 02:00pm and 10:00pm and 200mg on and at 10:00pm. Resident #14's prescribed , medication label did not match the resident's MORs. The dosing on the medication label on the medication pack matched the most recent orders prescribed by the resident's Health Care Provider. A review of Resident #18's MORs, conducted on , revealed that Resident #18 had prescribed meds not documented as given or offered to the resident, which included , 1mg on at 12:00pm.	A 058		

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A 058	Continued From page 16 Resident #18 had a prescribed medication , - , 7.5-325mg duplicated on the resident's MORs, which could potentially lead to an overdose of this medication if double dosed. The , was signed as given both doses on at 08:00am. During an interview with the Wellness Director, conducted on at 04:30pm, the Wellness Director agreed that Resident #1, #2, #5, #6, #14, and #18's MORs had prescribed medications that were not signed as given to the residents. The Wellness Director agreed that Resident #14's Prescribed , medication label did not match the resident's MORs. The Wellness Director agreed that Resident #14 had the prescribed medication , - , duplicated twice the MORs and the unlicensed Medication Technician had signed as given twice on at 08:00am. During an observation, conducted on at 10:01am, the Surveyor entered a room with the door wide open. There was a mini-refrigerator that had a lock on it and the lock was not latched. There were medications inside the refrigerator (Photographic Evidence Obtained). The name plate on the outside of the entry door stated, 'Wellness Director'. During an observation on at12:23pm in the Memory Care Unit, Staff J walked away and out of sight from the medication cart to assist Resident #2 to the resident's room. Staff J left the medication cart unlocked with the keys in the key lock. During an interview with the Wellness Director, conducted on at 10:05am, the Wellness	A 058		

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A 058	Continued From page 17 Director stated that medications "should be locked and secured at all times". The Wellness Director agreed that the mini-refrigerator with medications was left unlocked, unsecured, and unattended. At 10:20am, the Wellness Director stated that the mini-refrigerator was left unlocked for the Pharmacy delivery to refill medications. At approximately 12:25pm on the Wellness Director observed the keys left in the medication by Staff J and stated that the staff "should have taken the keys and locked the medication cart". Due to the uncorrected Class III deficiencies concerning the facility's medication practices, the facility shall be required to employ the consultation services of a licensed pharmacist or a registered nurse. The consultant shall at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. This written statement serves as notification of the above stated requirement. Class III	A 058		