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
	AL11911234	A. BUILDING: _____ B. WING _____	R 08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA ON TURKEY CREEK	2800 FORDHAM ROAD, NE PALM BAY, FL 32905

(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 093} SS=D	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and	{A 093}		

AHCA Form 3020-0001

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

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{A 093}	Continued From page 1	{A 093}		

date reviewed. Portion sizes must be indicated on the menus or on a separate sheet.
1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.
2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.
(d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.
(e) Therapeutic diets must be prepared and served as ordered by the health care provider.
1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.
2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.
(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly

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{A 093}	Continued From page 2	{A 093}		

distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of . . . . . the time between meals.
(g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . . .
(h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority

This Statute or Rule is not met as evidenced by:
DEFICIENCY REMAINED UNCORRECTED

Based on record review and interview, the facility failed to ensure dietician approved menus were followed, with substitutions noted before or when the meal is served and kept on file in the facility for 6 months.

Findings:

On arrival to the facility on Sunday, at 5PM, the residents were seated in the dining

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{A 093}	Continued From page 3	{A 093}		

room for dinner. The dinner observed being served on Sunday, was cream of potato soup, a half of a turkey sandwich (1 slice of lunch meat turkey) on white bread, fruit cup. The menu posted in the kitchen for dinner on Sunday, was 6oz beef barley soup; 2 oz stuffed sliced turkey sandwich on 2 slices bread; ½c carrot raisin salad; 1/2c fresh fruit.

On at 6:00PM, the cook stated he did not have the beef barley soup, so he made the cream of potato instead. He stated he did not have any carrot-raisin salad and confirmed he did not provide a substitute for the vegetable. The cook said he did not write any of the menu changes on the substitution log. He looked around the kitchen, and then said, "it's locked in the manager's office."

Observation of the lunch meal served on at 12:30PM was fried fish, tartar sauce or ketchup; 1/2c macaroni & cheese; 1/2c stewed tomatoes; 1 slice white bread, 1/2c chocolate pudding. Several residents had chosen an alternate of chicken bread with brown gravy, mashed potatoes & mixed vegetables. Review of the posted menu for Monday, was 3oz grilled fish w/ 2oz tartar sauce, 1/2c macaroni & cheese casserole, 1/2c stewed tomatoes, 1 whole wheat roll, 1/2c chocolate pudding. Alternate posted menu was lemon chicken, whipped potatoes and mixed vegetables.

On at 1:45PM, the dietary manager confirmed they did not have grilled fish but served fried fish instead. She also said they did not have whole wheat rolls, so she gave the residents a slice of white bread. She provided the substitution log for review. She said the weekend cooks do have access to the log and could not explain why

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{A 093}	Continued From page 4 he did not write the changes down. She also stated the carrot-raisin salad was available but confirmed he did not serve it. The log showed the substitution for the soup served on which she said was reported to the next shift cook. No other changes to the menu for or were on the log prior to the meals being served. On . . . . . at 2PM, the manager confirmed the menu had not been followed and substitutions were not written down. Class III	{A 093}		
{AN278} SS=D	58A-5.031(3) FAC; 429.07 (3)(c)2, FS LNS - Records 58A-5.031(3) RECORDS. (a) A record of all residents receiving limited nursing services and the type of services provided must be maintained at the facility. (b) Nursing progress notes must be maintained for each resident who receives limited nursing services. (c) A nursing assessment conducted at least monthly must be maintained on each resident who receives a limited nursing service. 429.07 (3)(c)2, FS A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED	{AN278}		

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{AN278}	Continued From page 5 Based on record review and interview the facility failed to ensure nursing progress notes were maintained for 2 of 14 sampled residents (#1 and #4) residents who received Limited Nursing Services (LNS). Findings: On at 9:30 AM residents #1 and #4 were identified as receiving LNS. Record review for resident #1 revealed a healthcare provider's order dated that indicated left brace/arm on in AM and off in PM. Review of the LNS binder on at 11 AM revealed the nurse's progress notes were dated but did not indicate the time when the service was provided. There were no notes for , . . There was one note only for , and . Resident record review for resident #4 revealed an order dated indicated , hose to both , on in AM off in PM. Review of the LNS binder on at 11 AM revealed the nurse's progress notes were dated but did not indicate the time when the service was provided. There were no notes for , , , , , . There was one note for , and no notes for . In an interview on at 1:30 AM with the nursing director who confirmed the findings and offered no additional comment. Class III	{AN278}		

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{CZ814}	Continued From page 6	{CZ814}		
{CZ814} SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print [illegible] notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: DEFICEINCY REMAINED UNCORRECTED Based on record review and interview the facility failed to maintain the employment status of all employees within the background screening	{CZ814}		

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{CZ814}	Continued From page 7 (BGS) clearinghouse. Findings: Review of the facility's BGS roster on 10:30 AM revealed that staff E, date of hire uncertain but before , was not listed on log. Resident record review for resident # 6 revealed that staff E conducted monthly nursing assessments on . In an interview with the Director of Nursing on at 10 AM who said she was unsure of the hire date for staff E, but it had been a while. In an interview with the Business Office Manager on at 10:30 AM who said the agreement made with staff E was done with the prior administrator. She had search for the personnel record was unable to locate it. She though it may have been in a zip drive but was not available to locate that either. She had no documentation (paperwork) for the nurse. Unclassified	{CZ814}		
{A 000}	Initial Comments A revisit to complaint investigations 2018018475 and 2019000507 was conducted at Bethesda On Turkey Creek on , and . Deficiencies remained uncorrected at the time of the survey.	{A 000}		
{A 008} SS=D	429.26( ) FS; 58A-5.0181(2) FAC Admissions - Health Assessment	{A 008}		

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{A 008}	Continued From page 8 429.26 (4) If possible, each resident shall have been examined by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner within 60 days before admission to the facility. The signed and completed medical examination report shall be submitted to the owner or administrator of the facility who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission and continued stay in the facility. The medical examination report shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, licensed physician assistant, or licensed nurse practitioner shall examine the resident and complete a medical examination form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission. The medical examination form shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request. (6) Any resident accepted in a facility and placed by the department or the Department of Children and Families shall have been examined by medical personnel within 30 days before	{A 008}		

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{A 008}	Continued From page 9	{A 008}		

placement in the facility. The examination shall include an assessment of the appropriateness of placement in a facility. The findings of this examination shall be recorded on the examination form provided by the agency. The completed form shall accompany the resident and shall be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or [illegible] nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident providing it was completed within 90 days prior to admission to the facility. The applicable department shall provide to the facility administrator any information about the resident that would help the administrator meet his or her responsibilities under subsection (1). Further, department personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The applicable department shall advise and assist the facility administrator where the special needs of residents who are recipients of [illegible] require such assistance.

58A-5.0181
(2) HEALTH ASSESSMENT. As part of the

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{A 008}	Continued From page 10 admission criteria, an individual must undergo a -to- medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of , or any other communicable , which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S. (b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form	{A 008}		

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{A 008}	Continued From page 11 1823, Resident Health Assessment for Assisted Living Facilities, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed. 1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider. 2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided. 3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823. (c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission. (d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted	{A 008}		

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{A 008}	Continued From page 12 for the medical examination requirements of section 429.26, F.S. and this rule. (f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida . . . . . Form, for residents who do not wish . . . . . to be administered in the case of or . (g) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on record reviews and interviews, the facility failed to ensure the 1823 health assessment form was complete and accurate for 2 of 10 sampled residents (#10 and #13). Findings: 1. Resident #10's record revealed a facility admission date of . Her current 1823, dated , indicates that she has a	{A 008}		

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{A 008}	Continued From page 13 communicable . . . . . , which could be transmitted to other residents or staff and a comment that indicates " . . . . . (colonized.") In addition, the form indicates that she requires both no assistance with medications and assistance with self-administration of medications. On . . . . . at 2:25 p.m. the director of nursing confirmed the findings and said she confirmed with the hospital prior to the resident's return that the . . is colonized and not . . . and said the resident requires assistance with self-administration of her medications. Therefore, the information on the 1823 was inaccurate. Photographic evidence obtained. 2. Resident #13 had a health assessment report 1823 dated . . . . . that listed diagnoses of , and high , . According to the health assessment he was independent with eating; needed assistance with all activities of daily living. Page 4, letter B, of the assessment did not address the resident's needs regarding medications, that portion of the assessment was blank. In an interview on at 11 AM with the nursing director who confirmed the findings and offered no additional comment. Class III	{A 008}		
{A 025} SS=G	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision	{A 025}		

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	AL11911234	A. BUILDING: _____ B. WING _____	R 08/27/2019

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{A 025}	Continued From page 14 429.26 (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 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.	{A 025}		

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{A 025}	Continued From page 15 (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: DEFICIENCY REMAINED UNCORRECTED Based on observations, record reviews, and interviews, the facility failed to document in the record of 2 of 10 sampled residents (#15 and #17) who experienced a significant change, failed to notify the family when 1 of 10 sampled residents (#15) was sent to the hospital, failed to prevent the development and worsening of a , for 1 of 10 sampled residents (#17,) and failed to provide adequate interventions when 1 of 10 sampled residents (#11) experienced multiple . . . Findings: 1. Resident #15's record revealed a facility admission date of . A facility note, dated , indicated that "reported to writer through paper work she was sent to emergency room last evening on . -7 shift. Unclear of exact time. She complained of , and requested to go to the hospital. Family came in to visit and was unaware she was sent to the ER at her request. Executive Director and wellness director notified. Physician notified via fax." The record did not contain a facility note to indicate when she was initially sent to the hospital, which is a significant change.	{A 025}		

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{A 025}	Continued From page 16 On at 1:15 p.m. the director of nursing confirmed the findings and said an agency nurse sent the resident to the hospital on , did not document the occurrence in the record, and did not notify anyone, including her family, the director of nursing, and the administrator. The record contained documentation of family designation as her health care surrogate and durable power of attorney. 2. Observations made with a home health nurse on at 1:10 p.m. revealed resident #17 had a on her left inner ankle that measured approximately 2 centimeters (cm) x 3 cm. The bed was covered with a yellow and brown scab and the peri skin was red. 2. Resident #17's record review revealed admission date . An 1823 Health Assessment dated from another Assisted Living Facility. "Photographic evidence obtained" Resident #17 was admitted into the facility with a on left onset with measurement of 1.5 centimeters (cm) x 1.5cm x 0.3cm revealed by the Home Health notes. Three (3) more developed on or after as follows: 1. on left onset with measurement of 2.5cm x 1.5cm x 0.2 cm. 2. left dorsum (inner ankle) onset with measurement of 2cm x 2cm x0.1cm.	{A 025}		

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{A 025}	Continued From page 17 3. , on left , onset with measurement 1cm x 1cm x 0cm. Observations made with a home health nurse on at 1:10 p.m. revealed resident #17 had a on her left inner ankle that measured approximately 2 centimeters (cm) x 3 cm. The bed was covered with a yellow and brown scab and the peri skin was red There was no documentation to confirm that the healthcare provider and legal representative were notified of the development of the , (a significant change). There was no documentation to confirm that the facility had developed and implemented a plan for the preventions of the development of , and to prevent them from worsening. "Photographic evidence obtained" On at 3 PM, an interview with the Resident Care Coordinator, Resident Care Director and the Administrator confirmed the findings. 3. On at 6:00PM, the resident was observed in her bed, resting. She had a hospital bed with half rails, provided by hospice. She was able to get in and out of the bed without assistance. There was a wheelchair in her room, which staff stated they use to bring her to the dining room. Review of the record for resident #11, admitted , revealed she had a history of frequent in the facility. Her most recent health assessment, dated , revealed diagnoses which included , and , . She was alert and	{A 025}		

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{A 025}	Continued From page 18 oriented to self. She was receiving hospice services. She was independent with ambulation, eating and toileting, and required supervision with her other activities of daily living. Further review revealed extension observation notes which documented a history of frequent . There were notes for 10 unwitnessed in the past 11 months, with 4 of the 10 occurring this . The documented occurred on the following dates: - unwitnessed , in room, sent to ER for , , not admitted - unwitnessed , in room, , , no - unwitnessed , in room- no issues, or - unwitnessed , in room- no issues, or - unwitnessed , in room- no issues, or - unwitnessed , in room- no issues, or - unwitnessed , location not noted- no issues, or - unwitnessed , in room; refused ER - unwitnessed in dining room; c/o , called ER; able to stand and walk, refused treatment - unwitnessed outside on ground in of property on shift previous night. Records document she received her 6AM medications. Staff found her outside on property at 6:30AM, reported to nurse at 11AM. Sent to hospital. At 2PM note documented "Hospital called, resident being admitted. Diagnosis , high levels of , was inquiring about AM meds." Resident documented to have received 8AM dose of prior to going to hospital. Returned to facility on at 5:30PM. No new 1823.	{A 025}		

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{A 025}	Continued From page 19 - unwitnessed in , hit , sent to emergency room, returned 530PM from - and for treatment. The notes documented assessment of the resident for injuries and notification of family, hospice and healthcare provider on each occasion. But there was no documentation of a plan or steps taken to prevent future . On at 11:00AM, the nursing director stated resident #11 was able to get up and use the bathroom on her own and that was often when she lost her balance. She said the staff did "frequent checks" of the resident, but she confirmed that plan was not written anywhere. She stated it was communicated in their morning staff meetings. There was no documentation to confirm when or how often the checks were being done. Class II	{A 025}		
{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	{A 055}		

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{A 055}	Continued From page 20 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 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.	{A 055}		

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{A 055}	Continued From page 21 (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 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: DEFICIENCY REMAINED UNCORRECTED Based on observations and interview the facility failed to ensure medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, room, or area at all times, out	{A 055}		

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{A 055}	Continued From page 22 of sight of other residents. Findings: Observations on at 5 PM noted 3 medication carts in the dining room. Two (2) staff attended to their carts. A third medication cart had keys hanging from the lock, but the cart was unlocked. A male staff was observed assisting a resident with medications. He noted the Agency representative, he approached the cart, locked it and removed the keys. In an interview on at 111:30 AM with the nursing director who offered no additional comment. Class III	{A 055}		