

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER ALDERMAN OAKS RETIREMENT CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 727 HUDSON AVENUE SARASOTA, FL 34236		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 000	Initial Comments An unannounced relicensure, emergency power plan, health facility reporting system, generator, and visitation form survey was conducted on at Alderman Oaks Retirement Center, an assisted living facility in Sarasota, Florida. The following is a description of the deficiency. .	A 000			
A 052 SS=D	429.256(. . .); 59A-36.008(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, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (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	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 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 (4) Assistance with self-administration of medication 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) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , or preparations. (g) Assisting with 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 the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of	A 052		

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A 052	Continued From page 2 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. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (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 59A-36.011, 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, orally advising the resident of the name and dosage of the medication 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	A 052			

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A 052	Continued From page 3 resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility. 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record. 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with 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. (g) 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. (h) 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 record review, observation, and staff interview, the facility failed to ensure staff follow proper procedure when assisting with self-administration of medication for 2 (Residents	A 052			

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A	Continued From page 4 #10 and #11) of 2 residents reviewed for medication pass. The findings included: Alderman Oaks Self Administration of Medication Policies and Procedures: Our Med Assistants are advised to follow best practices with every resident. Med pass: 6. You must read all the directions for each of their medications to them. This includes the name of the medication and the directions. washing: you may use sanitizer after every resident in-between washes. we must wear gloves for assisting with . If both are receiving assistance with or creams, after assisting with one , we must use our other and to assist with the next . This is to ensure no cross contamination occurs between . If the resident has multiple , all steps must be redone with each different medication. It is important to remember, you may not simply state to the resident that they are receiving " ". You have to be specific as to the name of the and must be treated like any other medication they receive. 1. Observation during medication assistance on at 8:44 a.m., Staff D, Medication Technician (MT) was observed going to the medication cart and unlocking it. Staff D opened the med cart, pulled the medication cards for Resident #10 out and laid them on the top of the medication cart, logged into the electric Medication Observation Record (MOR) and verified medications. Without performing hygiene, Staff D gathered the medication cards, a spoon from the top of the medication cart and went to the Resident #10's room. Staff D read the names of the medications to the resident but	A 052			

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A 052	Continued From page 5 failed to notify the resident of the dosage of the medications. Staff D opened an applesauce cup and placed four pills into the apple sauce and scooped them up and handed the spoon for Resident #10 to take. Staff D repeated this until all the medication was taken. Staff D closed the foil top on the apple sauce and placed it Resident #10's refrigerator, tossed the spoon into the trash and gathered the medication cards. Staff D returned to the medication cart and replaced the med cards, no . . . hygiene was performed. Staff D proceeded to the next resident for assistance with self-administration of medications. 2. On . . . at 9:05 a.m., Staff D opened the MOR for Resident #11 without performing . . . hygiene. Staff D pulled the medication cards, liquid medications, . . . drops, and . . . for Resident #11 and went to the resident's room. Staff D knocked on the open door and the resident was lying in bed. Staff D approached the resident and told her it was time to take the medications. Staff D placed the medications on the table next to the resident's bed. Staff D told the resident she had . . . drops for the resident and it was a new prescription. The MT used her . . . to try to remove the protective safety seal around the top of the . . . drops. Staff D was unsuccessful at removing the safety seal and then asked the Resident #11 if she could use a pair of the resident's scissors laying on the table by the medication cards. Staff D took the scissors and opened them up and used the sharp end to pry off the safety plastic. Resident #11 was laying in the bed and her . . . was lying on the right . . . with the left . . . was exposed. Staff D counted 6 drops individually as she placed them into Resident #11's left . . . Staff D then informed Resident # 11 she will be giving her the	A 052		

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A 052	Continued From page 6 pills and asked Resident #11 to sit up on the bed. Staff D assisted Resident #11 to sit up in bed touching Resident #11 and the blanket on the bed. Staff D pushed her long hair over her _____ and pulled _____ the foil top on an applesauce cup and informed Resident #11 of what medications were to be given without informing her of dosage amounts. Staff D proceeded to take the spoon by the concaved section and place it into the applesauce. Staff D then popped pills into a clear medication cup and then four pills into the applesauce and scooped them up in the spoon. Staff D instructed the resident to hold onto her _____. Resident #11, who is _____ per note on the resident's door, felt around to find Staff D's _____ and was barely touching Staff D's _____ as Staff D spoon fed the medications into the Resident #11's _____. Staff D repeated this process until all medications had been taken. Staff D then informed Resident #11 that it was time to do the _____. Staff D used her _____ to push _____ her hair over her _____ and assisted Resident #11 to tilt _____ her _____. Staff D placed her _____ on Resident #11's forehead to guide her _____, and placed _____ in each _____. Staff D then instructed Resident #11 that there was an oral medication and proceeded to take a syringe from a zip lock bag, the medication and syringe were stored in, and inserted the syringe into the liquid medication, tipped up the liquid medication bottle and pull _____ the plunger on the syringe filling it with the liquid. Staff D instructed Resident #11 to open her _____ and Staff D placed the filled syringe in the residents open _____ and depressed the plunger dispensing the medication. Staff D closed the applesauce container and placed it in Resident #11's refrigerator. Staff D gathered the medication cards, _____ drops, and liquid medication and returned to the	A 052		

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A 052	Continued From page 7 med cart. Staff D asked another employee if she could return the zip lock bag with the liquid medication and the used syringe to the refrigerator as Staff D could not want to leave the medication cart. Staff D did not perform hygiene, put the medications in the cart and shut down the electronic MOR. On at 1:35 p.m., during an interview, the Compliance Officer stated the staff, when assisting with medications, needs to confirm the right resident, confirm the meds with the EMARs, let the resident know what they are taking, or ask them if they want to know what they are taking, popping the meds into a soufflé cup in front of the resident and observing the resident take the medications. Then coming ... to the cart, returning the meds to the cart and checking that the medications have been given. For ... hygiene, they are to perform hygiene after the med pass, and after every 3rd person they have to wash their ... Syringe medications are to be in prefilled syringes and the residents and the staff should be pouring meds into a little cup and not drawing up medications into a syringe as they meds should be prefilled. The staff are to tell the resident the medication and the dosage when giving medications. She confirmed the med techs should not be drawing up medications into a syringe as it should come into a prefilled syringe or should be poured into a cup. She confirmed the med techs should be sanitizing between each resident when assisting with medications with an ...-based rub and should wash their ... with soap and water after every 3rd resident. She confirmed the med tech did not follow the protocol for assisting with medications and should not be drawing up medications in a syringe and plunging into the resident	A 052		

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