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
	AL11965569	A. BUILDING: ______ B. WING ______	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

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A 000	Initial Comments An unannounced Relicensure with Limited Nursing Services (LNS), Complaint (#2024005917 & #2024008256) and Generator Monitoring survey was conducted on at Boca Raton. Deficiencies were identified related to the Relicensure and LNS.	A 000		
A 052	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 or her . (d) Applying , medications.	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 (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 administration, the amount, the strength of dosage, the method of administration, or the	A 052		

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A 052	Continued From page 2 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 resident's record. (e) When a resident who receives assistance with	A 052		

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A 052	Continued From page 3	A 052		

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 interview, the facility failed to adhere to their control procedures while assisting a resident with the self-administration of medications. This was evidenced by 1 out of 1 sampled staff's (Staff E) failure to prevent the

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A 052	Continued From page 4 contamination of the medications during the medication pass for 1 out of 2 sampled residents (Resident #16). The findings included: A review of the facility's medication policy titled, "Assistance with Self-Administration of Medication Policy" [effective] revealed the following information: Assistance with Self-Administration of Medication Procedure: Definition: Assistance with self-administration is described in detail in the regulations and includes taking previously dispensed, properly labeled containers from where they are stored and bringing them to the resident; reading the label, opening the container, removing a prescribed amount of medication, and closing the container; placing an oral dosage in the resident's or in another container. During an observation of a medication pass on at 1:08 PM, Staff E (LPN) was starting her medication pass for Resident #16. At 1:15 PM, Staff E was observed dropping Resident # 16's medication [50 MG] directly on to the medication cart. Staff E then picked the medication up directly with her and placed it in to a clear plastic cup. At 1:17 PM, Staff E was observed placing Resident #16's medication [50 MG] directly into her and placed it into same clear plastic cup that the previous medication was in. Staff E proceeded with the	A 052		

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A 052	Continued From page 5	A 052		

medication pass and gave Resident #16 the clear plastic cup to take the medications.

During an interview conducted with Staff E (LPN) on at 1:21PM, she stated she did not know the facility's protocol for contaminating medication and discarding contaminated medications. Staff E further stated, she never heard that she would have to replace the medication if it had on the medication cart and she touched it.

A review of Staff E (LPN)'s file revealed, Staff E had a hire date of . Further review of the file revealed a job description for her current role, Wellness Manager (RN/LPN) . A review of the job description revealed the following information:

Job description for : Wellness Manager (RN/LPN)
Last updated: ,

Responsibilities:

The Wellness Manager (LPN/RN) is responsible for the administration of nursing services as directed by the Wellness Director. The Wellness Manager (LPN/RN) assists with directing, planning, and coordinating services of professional nursing and auxiliary nursing personnel in rendering resident care.

As assigned by the Wellness Director, assists in facilitating the overall coordination and management of care and services for residents and supervision of the Resident Services department through some or all of the following:

Control:

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A 052	Continued From page 6 a) Maintains compliance with community policies on immunizations, control and management Further review of Staff E's file revealed training completed for the following subjects: a) Control : Basic Concepts b) Managing Biomedical Waste c) About Control and Prevention d) Basics of Personal Protective Equipment During an interview conducted with Staff B (Wellness Director) and the Administrator on at 5:25 PM, Staff B stated that was not the policy and procedure of the facility to have staff (licensed or unlicensed) make direct contact with the medications. Additionally, she stated that Staff E received training on the facility's control protocols. At this time, they were informed that Staff E directly contaminated the medication pass by using her throughout the process. The Administrator stated she and Staff B would provide an in-service for the nursing staff to ensure they comply with the facility's control and medication assistance policies. Class III	A 052		
AN276	59A-36.022(1) FAC LNS - Nursing Services (1) NURSING SERVICES. In addition to any nursing service permitted under a standard license pursuant to Section 429.255, F.S., a facility with a limited nursing services license may provide nursing care to residents who do not require 24-hour nursing supervision and to residents who do require 24-hour nursing care and are enrolled in hospice.	AN276		

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AN276	Continued From page 7	AN276		

This Statute or Rule is not met as evidenced by: Based on review of policy and procedure, observation, interview and record review, the facility failed to follow professional standards for 1 of 2 sampled residents receiving Limited Nursing Services (LNS); observed with a , in place, Resident #18.

The findings included:

Review of the facility policy titled . , . Care Policy provided by the Director of Health and Wellness (DHW) revised documented in the Policy Statement: The Wellness Associates may be authorized by the Wellness Director to assist with , care when it had been determined that the Resident is unable to complete this care independently. , . care includes cleansing the , area and changing, cleaning, and storing the collection bag. Periodic changing of the , is considered skilled care ....

Resident #18 moved into the facility on with diagnoses which included History of , ( )s, near , ., . , , . , History of 's, with , , and , , of the ; his LNS services began on . Resident #18's Mental Status is noted as----alert; he is currently under Trustbridge Hospice effective .

During an observational tour conducted on at 12:25 PM, Resident #18 was observed sitting up in his room in his recliner chair awaiting his lunch. Resident #18's , . . bag was observed to be sitting directly inside and "folded inward," and "overlapping upon

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AN276	Continued From page 8 itself," on the inside bottom of a "clean" garbage can or pail, located right next to the resident's recliner chair. The tubing was not observed as being attached, nor secured to a source, by its own clamp, which would allow the bag to hang down, allowing the in the tubing to flow freely and unobstructed into the bag. A brief interview was conducted with the resident on at 12:32 PM regarding the location of his bag. The resident revealed that his bag had been placed directly down inside of the bottom of the "clean" garbage can, out of concern for "potential" leakage. On at 4:16 PM an interview was conducted with Staff H, Certified Nursing Assistant, (CNA), in which she stated that sometimes the resident's will have a "leak," and they will place it in the garbage can. However, Staff H also stated that the is not normally supposed to be kept directly in the garbage can; she added that the tubing and bag are supposed to be hanging at a place where it does not touch or come into contact with the floor. During an interview conducted on at 4:20 PM with Staff J, Licensed Practical Nurse (LPN), he also stated that the tubing and bag should be kept off the floor, with its drainage spout tucked neatly into its protective sheath. Staff J acknowledged that the should not have been kept and stored that way nor in that manner, and he said that it should have been clipped appropriately in order to make sure that it is off the floor and draining	AN276		

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appropriately via gravity for accurate drainage, measurements and visualization.

On at 5:05 PM, a telephone interview was conducted with the facility's Registered Nurse (RN), LNS Supervisor in which she also acknowledged that the , tubing and bag should not have been kept and stored in that way on the bottom of a garbage can and should have been properly positioned to allow the to drain properly.

On the LNS log documented that Resident #18's physician's order for LNS services began on , for daily and on-going , care.

Record review of the Resident #18's Care plan-Change of Condition Form initiated and revised indicated Focus: Limited Nursing Services ....Resident requires assistance with care ....Staff to physically assist Resident with caring for . Staff and Family/Visitors should notify the nurse of any noted changes in toileting behaviors including signs of (odor, frequency, , itching, etc.) Nursing will evaluate changes and report to Primary Care Physician (PCP)/Responsible Party as needed.

Record review of the daily nurses' progress notes dated thru essentially revealed that facility staff documented that, " , patent and draining amber . Staff nurse performs care."

However, further record review of one (1) of the facility's nurses' progress notes by Staff E, LPN, dated at 2:07 PM documented that ... ... "A new one (,) was placed today as

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AN276	Continued From page 10 the other was painful; he is no longer in , ." There was no apparent evidence of any leaking from the resident's , that was observed by this surveyor, at any time, during the survey In a side-by-side record review (and interview), the DHW further recognized and acknowledged on at 4:40 PM that the resident's , . . should not have been kept and stored in that manner and should have been properly positioned and placed to allow the to drain down properly. Class III	AN276		