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
	AL11965054	A. BUILDING: _____ B. WING _____	R 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLONNADE AT NORTHDALE	3401 WEST BEARSS AVENUE TAMPA, FL 33618

(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 biennial survey and a complaint investigation (complaint numbers: 2025015668 and 2025016899) and a generator monitoring visit were conducted at The Colonnade at Northdale on . Deficiencies were identified at the time of survey.	{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 or her . (d) Applying , medications.	{A 052}		

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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 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 observation, record review, and interview, the facility failed to compare medication labels to the medication observation record for two (#3 and #4) of two sampled residents. Additionally, the facility failed to orally advise residents of the dosages for two resident (#3 and	{A 052}		

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{A 052}	Continued From page 4 #4) of two sampled residents. Furthermore, the facility failed to provide a without removing a constant and a place for air drying the mouthpiece after washing for one (#4) of one sampled resident. Findings included: During a medication pass observation with Staff A (unlicensed Medication Technician) for Residents #3 and #4, conducted on at 9:25 AM Staff A assisted Resident #3 with the medications , 81 milligrams (mg), Citrus 200-250mg, 100mg, , 25mg, 25mg, and . 100mg. Staff A did not compare the medication labels to the medication observation records. Staff A did not orally advise Resident #3 of the medication dosages. Staff A assisted Resident #4 with 50mg, -S 8.6/50mg, , 20mg, 50mcg, , 5mg, Cobenfy 100mg/20mg, , , 5mg, and 0.5mg-2 milliliters (ml) treatment. Staff A did not compare the medication labels to the medication observation records. Staff A stated drug names by memory and did not state the drug dosages. Staff A fed the medications to the resident one by one. Staff A hooked up the with the mouthpiece after removing the from Resident #4. Staff A replaced Resident #4's after the resident was through with the . There was no bag or place to set the piece after it had been washed. During an interview on at 10:43 AM Staff A stated the was removed because the resident can't have both at the same time. Staff A stated there had never been a bag for the	{A 052}		

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{A 052}	Continued From page 5 piece. During an interview on at 10:50 AM Staff B stated there were medication observation records that were documented much later than the one hour after the medications were due for Residents #2, #3, #4, #5, and #6. During an interview on at 1:45 PM the Administrator stated there was no reason to remove Resident #4's while receiving the treatment. The Administrator agreed Residents #2, #3, #4, #5, and #6 all received medications late. The Administrator agreed the unlicensed Medication Technicians were supposed to bring the medication to the resident after review of the medication labels with the medication observation records and state the name and dose of the medication, observe the resident take the medications, and document the resident taking the medications. Class III	{A 052}		

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A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure staff was trained for the sit to stand assistive device. Additionally, the facility failed to ensure the sit to stand assistive device was kept clean. Furthermore, the facility failed to ensure the sit to stand assistive device was documented for one of one sampled Resident (#7). Findings included: An observation of a sit to stand assistive device, conducted on at 9:15 AM, revealed a sit to stand assistive device was located in the hallway at the end of the hall. The ˬ rests and rest were covered in white flakes and smears	A 034		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 034	Continued From page 1 of an unknown substance and covered in dust (Photographic evidence obtained). During an interview on at 9:24 AM Staff A stated the sit to stand assistive device was for Resident #7. A record review for Resident #7, conducted on , revealed Resident #7 did not have a sit to stand assistive device documented on the health assessment form. There were no orders in Resident #7's record regarding the sit to stand assistive device. The sit to stand assistive device was not on the Personal Service Plan. Resident #7 was admitted to the facility on . A review of the facility's assistive device policy and procedures, conducted on , revealed the assistive device policy and procedures noted the assistive devices would be noted in the residents' records and noted on the Personal Service Plan. During a review of the sit to stand cleaning schedule, conducted on , revealed there was no cleaning schedule. During an interview on at 12:30 AM Staff B stated the sit to stand assistive device was not listed on Resident #7's health assessment form or anywhere in the resident's record. Staff B stated the facility used the sit to stand for Resident #7 and other resident's that may need it. During an interview on at 1:50 PM the Administrator stated the facility did not have a cleaning schedule and there was nothing documented in any of the residents' records including Resident #7 regarding the sit to stand	A 034		

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A 034	Continued From page 2 assistive device. The Administrator agreed there was no staff training regarding the sit to stand assistive devices and there individual trainings were not done. The Administrator agreed the sit to stand assistive device was dirty. Class III	A 034		
A 053 SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not	A 053		

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A 053	Continued From page 3 required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff administering medications were licensed to administer medication to one of one Resident (#4). Findings included: During a medication pass observation with Staff A (unlicensed Medication Technician), conducted on from 9:42 AM through 10:40 AM, revealed Staff A administered or fed the medications to Resident #4 which included 50 milligrams (mg), -S 8.6-50mg, 20mg, 5mg, Cobenfy 100mg-20 milliliters (ml), and 5mg. During an interview on at 1:45 PM the Administrator stated Staff A was not supposed to feed or administer the residents their medications but rather supposed to assist with medications using the over technique. Class III	A 053		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer	A 054		

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A 054	Continued From page 4 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 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 ensure the directions for use included the site to apply ˏ , cream for one resident (#3) of one resident sampled. Findings included: During a medication pass observation with Staff A	A 054		

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A 054	Continued From page 5 (an unlicensed Medication Technician) for Resident #3, conducted on , revealed Staff A applied Resident #3's ´ 100000/gram to both arms from to . A review of the medication label for Resident #3, conducted on , revealed the medication label noted the ´ should be applied to the affected area in the morning and at bedtime. There was no notation regarding where the affected area was located. A medication observation record review for Resident #3, conducted on , revealed the medication observation record review for Resident #3 noted the ´ was to be applied to the affected area in the morning and at bedtime. There was no notation regarding where the affected area was located. During an interview on at 10:40 AM Staff A stated Staff A knew where the cream was to be placed. During an interview on at 1:45 PM the Administrator agreed medication labels and medication observation records should have the directions for use of the medications written and spelled out. Class III	A 054		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they	A 056		

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A 056	Continued From page 6 are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the	A 056		

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A 056	Continued From page 7 medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order.	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965054	A. BUILDING: _____ B. WING _____	R 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLONNADE AT NORTHDALE	3401 WEST BEARSS AVENUE TAMPA, FL 33618

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A 056	Continued From page 8 This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure medications were given on time for five (#2, #3, #4, #5, and #6) of five residents Furthermore, the facility failed to ensure all medications had a medication label that described the drug, strength, and directions for use for one (#4) of five residents. Findings included: During a medication pass observation with Staff A (unlicensed Medication Technician), conducted on from 9:42 AM through 10:40 AM, revealed there was no medication label that noted the drug, strength, and directions for use on Resident #4's Cobenfy milligrams (mg). Resident #3 received the scheduled 8:00 AM medication at approximately 9:30 AM. Resident #4 received the scheduled 8:00 AM medication at approximately 10:00 AM. A review of the medication observation records, conducted on , revealed Resident #2 received the scheduled 8:00 AM medications at 11:41 AM. Resident #3 received the scheduled 8:00 AM medications at 9:40 AM. Resident #4 received the scheduled 8:00 AM medications at 11:49 AM. Resident #5 received the scheduled 8:00 AM medications at 10:55 AM. Resident #6 received the scheduled 8:00 AM medications at 11:46 AM. During an interview on at 01:45 PM the Administrator agreed there was no medication label for Resident #4's Cobenfy medication. The Administrator agreed the residents were supposed to receive medications within one hour	A 056		

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A 056	Continued From page 9 before and up to one hour after the medication was scheduled and Resident #2, #3, #4, #5, and #6 all received medications late. Class III	A 056		
A 058 SS=D	429.42( ) FS; 59A-36.023(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 59A-36.023(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III	A 058		

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A 058	Continued From page 10 deficiency directly relating to facility medication practices as established in Rule 59A-36.008, F.A.C., is documented by agency personnel 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 a class I or class II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure documented Class III deficiencies regarding medicinal drugs were corrected as required (Cross Reference:	A 058		

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
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A 058	Continued From page 11 A0052). Findings included: Due to the uncorrected Class III deficiencies concerning the facility's medication practices, conducted on . . . . , the facility shall be required to employ the consultation services of a licensed Pharmacist Consultant or a Registered Nurse Consultant. 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. During an interview on at 2:00 PM the Administrator verbalized understanding the facility was required to employ or contract with a licensed Pharmacist Consultant or Registered Nurse Consultant due to the facility's uncorrected medication Class III deficiency. Class III	A 058		