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
	AL11911279	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEET WATER OF ORLANDO	8207 FOREST CITY ROAD ORLANDO, FL 32810

(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 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 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	A 056		

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A 056	Continued From page 1 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 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.,	A 056		

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A 056	Continued From page 2 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. This Statute or Rule is not met as evidenced by: Based on observation, record reviews, and interviews, Unlicensed Caregiver A failed to follow the physician's order for 3 of 3 sampled residents as required (#2, #3, #4). Findings: On observation revealed Unlicensed Caregiver A performing med passes for 3 residents. 1. On at 9:20 AM, observation revealed Unlicensed Caregiver A performing a med pass for Resident #2. Review of Resident #2's 1823 health assessment indicated needs assistance with self-administration of medications. Review of his MORs indicated SOD Cap 100 mg, Tab 1 gm to be administered at 8 AM and his , Tab 40 mg to be administered at 7 AM. Review of his , MORs indicated , Tab 40 mg to be administered at 4 PM. On recorded time of refused at 5:26 PM. On recorded time of refused at 7:24 PM. On recorded time of refused at 9:54 PM. On recorded time of refused at 9:28 PM.	A 056		

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A 056	Continued From page 3 On at 10:18 AM, Resident #2 stated his medications are late sometimes or he doesn't receive them at all. Further stating, he does not know the names but the times are between 4 - 5 PM and 8 PM. He said he's told if he's asleep and they cannot wake him he will not receive his medicine. On at 4:45 PM, the Administrator stated there was an issue with Resident #2's medication around those dates as he was being placed on hospice and getting his meds ordered with the correct dosage. 2. On at 9:30 AM, observation revealed Unlicensed Caregiver A performing a med pass for Resident #3. Review of Resident #3's 1823 health assessment indicated needs assistance with self-administration of medications. Review of his MORs indicated , Tab 40 mg, Polyeth Glyc Pow 3350, Therapeutic-M tab, Tab 40 mg, , Pam 25 mg Cap, , Tab 10 mg, , Tab 10 mg, , Tab 500 mg DR, , Tab 325 mg, and , Tab 81 mg all to be administered at 8 AM. On at 9:40 AM, Resident #3 stated he does not know if his meds are late. He said he takes them whenever they bring to him. 3. On at 9:40 AM, observation revealed Unlicensed Caregiver A performing a med pass for Resident #4.	A 056		

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A 056	Continued From page 4 Review of Resident #4's 1823 health assessment indicated needs assistance with self-administration of medications. Review of her MORs indicated , Tab 0.5 mg, , Tab 10 mg, , Tab 15 mg, Gel 1%, Cap 60 mg DR, , Cap 300 mg, Tab 800 mg, 200 mg Tab, Pot Tab 100 mg, , Tar Tab 25 mg, Mirabegron Tab 25 mg ER, , Tab 150 mg, and D 5000 U tab all to be administered at 8 AM. Her , Tab 40 mg to be administered at 7:30 AM. On at 2:20 PM, Unlicensed Caregiver A stated when asked why the meds were passed late. He said he has two different residents. Adding, sometimes they come to the cart or they will stay in their rooms. He said when he sees the resident he checks then passes the meds. Adding, if they are in the room and did not come to the cart he will then go to room but unable to state why he did not complete the med passes at the scheduled times. The facility's rev medication policy states you cannot make changes to a prescription label. Only a pharmacist can change the prescription label. Sleeping resident: we will not wake a sleeping resident to assist with medication, however if we see they are sleeping at same time a med pass is done every day we need to alert supervisor to get a time change on the Medications. On at 3:00 PM, Unlicensed Caregiver B stated after review of the medication policy for sleeping resident. She did not know about that	A 056		

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A 056	Continued From page 5 and she wakes up the resident to give them their medications. Adding, if they refuse she will try 3 times before updating the MORs. On at 3:42 PM, Unlicensed Caregiver D stated she follows the physician orders for the resident. Adding, if they refuse and are to make the decision she will document. Further stating if it's continual she will reach out to the doctor. If the resident is asleep during the med pass she will try to wake them or pass before they go to sleep. On at 4:45 PM, the Administrator stated she was unaware the residents were receiving their medications late or not receiving at all due to being asleep. She stated after reviewing the medication policy that the "sleeping residents" should only apply for meds and will update the policy. On at 6:20 PM, the Administrator and Owner confirmed the findings. (photographic evidence obtained) Class III	A 056		
A 000	Initial Comments A complaint investigation #2026009753 and generator monitoring was conducted at Sweet Water of Orlando Assisted Living on . The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26	A 025		

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A 025	Continued From page 6 (7) The facility shall 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 must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. 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 59A-36.012, 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	A 025		

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A 025	Continued From page 7 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. (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: Based on interviews and record reviews, the facility failed to follow a medication order as prescribed for 1 of 3 sampled residents (#4). Findings: On at 9:40 AM, Unlicensed Caregiver A, stated Resident #4 refused her , this morning providing no additional information. Review of Resident #4's 1823 health assessment indicated needs assistance with self-administration of medications. Review of her medication observation record revealed , tab 125 mcg, take 1 tablet by once daily at 6 AM, on , , , and recorded as refused by Unlicensed Caregiver E. Review of her , medication observation record revealed , tab 125 mcg, take 1 tablet by once daily at 6 AM, on , , , , and recorded as refused by	A 025		

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A 025	Continued From page 8 Unlicensed Caregiver E. Review of her , medication observation record revealed , tab 125 mcg, take 1 tablet by once daily at 6 AM, on , , , , , , , , and recorded as refused by Unlicensed Caregiver E. On at 5:15 PM, Unlicensed Caregiver E stated the resident told her that she does not want her to administer , at 6 AM. Adding, she said it's too early and would like to receive with her other medications on the next shift. The unlicensed caregiver stated she has not told anyone in management and told the staff during shift change when counting meds. Further stating, it's been on- going since she started and after no one did anything she stopped telling the staff and only documented in the MORs. On at 6:00 PM, Resident #4 stated she told the med tech that she did not want to receive that pill at 6 AM and asked to have it changed to be given with her other meds. She said she thought she had been getting it. Further stating she thought Unlicensed Caregiver A brought it this morning. Adding, since he doesn't tell her the names, she didn't realized she missed it today. The facility's revised medication policy states each staff person will be responsible for following the training and not deviate from it. Staff will be required to report any discrepancies to their immediate supervisor for them to follow up on. Please pass on any issues with medication pass to your supervisor, especially non-compliance, refusal, or possible checking of meds. On at 4:45 PM, the Administrator stated	A 025		

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A 025	Continued From page 9 she was unaware Resident #4 was not receiving her medication and had requested to have the time change. Further stating, that is an easy fix and will reach out to the doctor to have the time changed. On at 6:20 PM, the Administrator and Owner confirmed the findings. (photographic evidence obtained) Class III	A 025		
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	A 052		

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A 052	Continued From page 10 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. (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	A 052		

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A 052	Continued From page 11 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 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 [illegible] 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	A 052		

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A 052	Continued From page 12 the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from 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:	A 052		

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A 052	Continued From page 13 Based on observation, record reviews, and interviews Unlicensed care staff A failed to follow proper medication procedure for assistance with self-administration of medication for 3 of 3 sampled residents. (#2, #3, #4). Findings: On . at 9:15 AM, upon arrival to the facility observation revealed Unlicensed Caregiver A at the med cart. He was asked if he was preparing for a med pass and he replied yes. On at 9:20 AM, observation revealed a medicine cup with pre-popped pills later revealed for Resident #2 at the med cart who was not present. 1. Review of Resident #2's 1823 health assessment indicated needs assistance with self-administration of medications. Further review revealed no signed written waiver to opt out of being orally advised of the medication name and dose. On at 9:25 AM, Unlicensed Caregiver A stated he was going to put the pills for the resident in the . Upon entering the room, acknowledged resident, stating here are your morning meds. He handed the medicine cup and cup of water to resident #2 without stating the name and dose. The unlicensed caregiver turned his to the resident, exiting the room without watching the resident administer the medicine. Upon exiting the room and asking if the med pass was completed. The unlicensed caregiver stopped, stating he did not stay in the room with Resident #2 because he does not want him to watch. Further stating, when he stays the resident ask why he's watching him, so he goes out of the	A 052		

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SWEET WATER OF ORLANDO	8207 FOREST CITY ROAD ORLANDO, FL 32810

(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 052	Continued From page 14 room into the hallway. He proceeded to return to the med cart located in the common area near the front of the facility. He did not update the medication observation records (MORs) nor did he perform hygiene. On at 10:18 AM, Resident #2 stated they do not tell him what he's taking. Adding, he knows what his medications looks like and recognize the pills before taking them. He said Unlicensed Caregiver A always brings the medication in the cup without the package. He stated he had not signed a waiver. On at 2:20 PM, Unlicensed Caregiver A stated he did not tell the resident the names because he has two pills in the morning and he knows what he's taking. 2. Review of Resident #3's 1823 health assessment indicated needs assistance with self-administration of medications. Further review revealed no signed written waiver to opt out of being orally advised of the medication name and dose. On at 9:30 AM, Unlicensed Caregiver A did not perform hygiene before the med pass for Resident #3. He retrieved the medications from the med cart, updating the MORs as passed after reviewing the medications. He prepared the Polyethylene , Powder 3350 at the med cart for the resident who was not present. He measured the powder, placed it into a cup, poured water into the cup and began mixing until dissolved. He returned the Polyethylene , Pow into the cart. He gathered all other medications (pill form), entered residents' room and acknowledged them by name. He stated to Resident #3, "your meds are	A 052		

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A 052	Continued From page 15 ready", handing him the cup of pre-poured Polyethylene , Powder. While the resident administered the medication Unlicensed Caregiver A prepared the pills by placing them into another medicine cup. Afterwards, he stated, "here's your morning pills" and did not state the name and dose of the medications. Unlicensed Caregiver A returned to the med cart and did not perform hygiene. On at 12:10 PM, Resident #3 stated Unlicensed Caregiver A does not tell him the name and dose of his medications. He stated he always brings the Polyethylene , Powder in the cup already prepared. He said he has not signed a waiver. Adding, he does not want to know the names of the medication as long as the medicine makes him feel good. On at 2:20 PM, Unlicensed Caregiver A stated he did not prepare the powder in the room for the resident. Adding, when the resident sees the water and the solution he believes you. Caregiver A stated, he does not want the resident to see him prepare for it because he will not take it. He said if he puts the solution in the cup the facility has cameras and will see what he's doing and no need to prepare in the room. Unlicensed Caregiver A stated he does not state the name and dose of the medications because the resident is hard of hearing. Further stating, the resident knows all his pills by the color and will be able to tell him if one is missing. 3. Review of Resident #4's 1823 health assessment indicated needs assistance with self-administration of medications. Further review revealed no signed written waiver to opt out of being orally advised of the medication name and dose.	A 052		

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A 052	Continued From page 16 On at 9:40 AM, Unlicensed Caregiver A did not perform hygiene before the med pass for Resident #4. He retrieved the medications from the med cart, updating the MORs as passed after reviewing the medications. He prepared the Gel 1% at the med cart for the resident who was not present. He retrieved a medicine cup and squeezed an ample amount into the cup, returning the package in the cart. He gathered all other medications (pill form), entered residents' room and acknowledged them by name. He asked Resident #4 if she requested her "PRN" for . She stated yes and asked for it to be given now. He continued preparing the remaining medications stating the name and dose. After opening the third package he discontinued stating the names and doses of the remaining medications. Once Resident #4 administered the medications without any assistance he handed her the cup of Gel. Resident #4 said she does not know what the medication is for. Further stating, "what is it asking why does she need it." The unlicensed caregiver said, "it's for your , for you to put on." Further stating, if you don't know then he would just take it and say that she was refusing it." He returned to the cart changing the gel from passed to refused. Unlicensed Caregiver A did not perform hygiene after completing the med pass. On at 10:08 AM, Resident #4 stated Unlicensed Caregiver A does not tell her the name and dose of her medications. Further stating, she's never seen that cream before. She said he normally does not bring the medications, and she usually goes to the med cart. She stated she has not signed a waiver and would like to know what she's taking.	A 052		

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A 052	Continued From page 17 On at 2:20 PM, Unlicensed Caregiver A stated he did not take the gel box to the room because it's a cream. Further stating, he did not think it was a big thing that he put it in the cup. He said he didn't think she would refuse it because he did not bring the box. The unlicensed caregiver stated he did not state the name and dose because Resident #4 knows her pills. Further stating, she looks at what she's going to swallow as she can read and has the knowledge. Review of the facility's rev medication policy states residents are to be present when you are preparing their meds. MAR's must be signed at the time the medication is assisted with. On at 4:45 PM, the Administrator stated she was unaware of the 3 improper medication passes performed by Unlicensed Caregiver A. On at 6:20 PM, the Administrator and Owner confirmed the findings. (photographic evidence obtained) Class III	A 052		
A 055 SS=D	59A-36.008(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	A 055		

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A 055	Continued From page 18 rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for 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 59A-36.006, 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	A 055		

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A 055	Continued From page 19 pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it 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:	A 055		

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A 055	Continued From page 20 Based on observation, record reviews, and interviews, Unlicensed Caregiver A failed to properly dispose of unused medication for 1 of 3 sampled residents (#4). Findings: Review of Resident #4's 1823 health assessment indicated needs assistance with self-administration of medications. On at 9:40 AM, Unlicensed Caregiver A prepared the Gel 1% at the med cart for the resident who was not present. After entering residents' room, he handed her the cup of Gel. Resident #4 said she does not know what the medication is for. Further stating, "what is it asking why does she need it." The Unlicensed Caregiver said, "it's for your , for you to put on." Further stating, if you don't know then he would just take it and say that she was refusing it." He returned to the cart updating as refused and disposed of in the trash can nearby. On at 2:20 PM, Unlicensed Caregiver A stated he did not prepare in the resident's presence because it's easier to prepare at the cart. Further stating, he didn't think she would refuse it. The facility's revised medication policy states each staff person will be responsible for following the training and not deviate from it. You may place any unused medication into the bottle if it hasn't been contaminated. (If pills or solid medications are dropped onto a clean surface, they are probably not contaminated.) If out of package will be placed in destroyer container.	A 055		

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A 055	Continued From page 21 On at 4:45 PM, the Administrator stated she was unaware of Resident #4 refusing the gel or the improper medication pass performed by Unlicensed Caregiver A. On at 6:20 PM, the Administrator and Owner confirmed the findings. (photographic evidence obtained) Class III	A 055		