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
	AL11970108	A. BUILDING: _____ B. WING _____	07/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT PORT ORANGE	6241 S WILLIAMSON BLVD PORT ORANGE, FL 32128

(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 complaint investigation (complaint number 2025017390 and 2025013114) was conducted at The Gallery at Port Orange on , , . Deficiencies were identified at the time of survey.	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. (e) Returning the medication container to proper storage.	A 052		

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A 052	Continued From page 1 (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 reason for administration requires judgment or discretion on the part of the unlicensed person.	A 052		

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A 052	Continued From page 2 (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 medication is away from the facility and from facility staff, the following options are available to	A 052		

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A 052	Continued From page 3 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 interview, observation, and record review, the facility failed properly assist 3 of 3 residents with with self-administration of medication. The Medication Technician (Med Tech) failed to prepare medications in the presence of 1 of 3 residents, Resident #1. 2 or 3 residents, Residents #2 and #3, were not orally advised of the medication name and dosage,	A 052		

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A 052	Continued From page 4 when medications were given, and 1 of 3 residents, Resident #2, was not provided a medication when it was due. The findings include: 1. On at 8:30 AM, Employee A/Med Tech was observed assisting Resident #1 with self-administration of medication. Employee A removed a bottle of , - , milligrams (MG) and placed 1 tablet into a small medication cup. She then removed the remaining 7 medications from their packaging and placed the medication into a second small medication cup. She then brought the cups to Resident #1's room and informed the resident she was giving her , medication. Resident # 1 took the , medication on her own. Employee A proceeded to give Resident #1 the remaining medication. Resident #1 refused the medication and asked if she could take the medication after she had breakfast. Employee A didn't orally advise Resident #1 of the medications. On at 9:00 AM, Employee A/Med Tech was observed assisting Resident #2 with self-administration of medication. Employee A removed 13 prescribed medications from the medication cart. Employee A reviewed the medications against the online medication observation record and determined the , was not available. Employee A brought the 13 medications into the resident's room. She then removed the medication from their containers and put them in a medication cup. She informed Resident #2 of the names of only three of the medications she was giving her, and then stopped. Employee A did not notify Resident #2 that her , was not available.	A 052		

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A 052	Continued From page 5 On at 9:30 AM, Employee A/Med Tech was observed assisting Resident #3 with self-administration of medication. Employee A removed Resident #3's medication from the medication cart and brought 3 , , and 8 oral medications into Resident #3's room. She then removed the oral medications from their packaging and placed them in a small medication cup. She handed the cup to the resident. Resident #3 was able to take all the medication on his own. Employee A did not inform Resident #3 of the names or dosage of the medication she had given the resident. Employee A was asked if she had a release to not inform the residents of the names of the medication she was giving. She stated she did not. She was asked why she did not tell the residents what medications she was giving them. She stated she did not because if she told them the name of the medications, they would ask what it was for, and she would not be able to answer them. During an interview with the Health and Wellness Director on at 1:30 PM. She was asked about the missing for Resident #2. She stated she was on vacation and did not know until today the resident needed medication. She reviewed the online MOR and confirmed the medication was also not available on other days in , . Class III	A 052		
A 054	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 6 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 interview and record review, the facility failed to maintain a daily medication observation record (MOR) for 1 of 3 residents who receive assistance with self-administration of medication due to failure to document the reason the medication was not given. (Resident #2) The findings include:	A 054		

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A 054	Continued From page 7 During an observation of Employee A/Med Tech assisting Resident #2 with self-administration of medication on at 9:00 AM, the resident's , was observed missing from the medication cart. Employee A confirmed the medication was not available. Record review of the , medication observation record (MOR) for Resident #2 revealed the code 14 meant "medication not available" on the code legend. Resident #2's , was coded as "14" on and . On /2026, , , , , and the MOR was documented with code 9 for "Other/See Progress Note." Record review of Resident #2's progress notes with the Health and Wellness Director on at 1:30 PM revealed there were not any progress notes to show why the medication was not given. It was provided only 12 of the 21 days in the month. The Health and Wellness Director looked through the computer record and confirmed the findings. Photographic evidence obtained Class III	A 054		