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
	AL11969376	A. BUILDING: _____ B. WING _____	08/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT WINTER HAVEN	1801 LAKE MARIAM DR WINTER HAVEN, FL 33884

(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 numbers: 2026008189 and 2026013003) and a generator monitoring visit were conducted at Best Care Senior Living at Winter Haven on . Deficiencies were identified at the time of survey. A Class I deficiency was found at Tag: A0052. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. The facility failed to ensure the process of assistance with self-administration of medications for unlicensed staff was provided by evidence of the facility did not notify the residents' health care providers when residents were not taking their prescribed medications and when readings were repeatedly high or low. The facility failed to ensure unlicensed Medication Technicians did not medication dosages. The Class I noncompliance began on . The facility's Resident Care Coordinator (person in charge) was notified of the Class I noncompliance on at 3:45 PM, in the Administrator's absence. The census at the start of the survey was 46. The following is a description of the deficiencies found at the time of the visit:	A 000		

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	A 052		
A 052 SS=J	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. (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	A 052		

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A 052	Continued From page 2 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. (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.	A 052		

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A 052	Continued From page 3 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 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,	A 052		

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A 052	Continued From page 4 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 interviews the facility failed to ensure assistance with self administration of medication as evidenece by the facility did not notify the residents' health care providers when residents were not taking their prescribed medications and when ˬ readings were repeatedly high or low, affecting five or five residents reviewed (Residents #1, #3, #4, #5, and #6). Additionally, the facility failed to ensure unlicensed Medication Technicians did not medication dosages, as required by statute, affecting one of one resident reviewed for	A 052		

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A 052	Continued From page 5 dosage (Resident #1). Findings included: During an interview with Resident #1, conducted on at 9:29 AM, Resident #1 stated "the nurses sent me out to the hospital for high . I don't refuse my medications, and it was a rare occasion that my sugar was high. They [referring to unlicensed Medication Technicians] can't administer any medications if my sugar goes above 350." A review of Resident #1's record revealed that the resident was admitted on . The most recent health assessment form, dated , documented that Resident #1 was legally , had diagnoses including , and , and required assistance with self-administration of medications. On , Resident #1 was hospitalized due to an elevated level of 504 mg/dL. After the resident returned to the facility, documentation showed that on , the resident's scheduled 8:00 AM dose of was not provided. Resident #1 had elevated and three with a 0 mg/dl: - at 12:00 PM = 389 milligrams (mg)/ deciliters (dl). - at 12:00 PM = 337mg/dl - /2206 at 4:00 PM = 321mg/dl - at 8:00 AM = 410mg/dl - at 12:00 PM = 363mg/dl - at 8:00 AM = 356mg/dl - at 12:00 PM = 341mg/dl - at 4:00 PM = 324mg/dl - at 4:00 PM = 0mg/dl - at 8:00 PM = 0mg/dl - at 8:00 AM = 347mg/dl	A 052		

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A 052	Continued From page 6 - at 12:00 PM = refused - at 12:00 PM = 369mg/dl - at 4:00 PM = 357mg/dl - at 8:00 PM = 381mg/dl - at 8:00 AM = 375mg/dl - at 4:00 PM = 454mg/dl - at 8:00 AM = 380mg/dl - at 12:00 PM = 490mg/dl - at 8:00 PM = 446mg/dl - at 8:00 AM = 507mg/dl - at 12:00 PM = 0mg/dl - at 4:00 PM = 588mg/dl - at 8:00 PM = 464mg/dl - at 12:00 PM = 366mg/dl - at 4:00 PM = 455mg/dl - at 8:00 PM = 387mg/dl - at 8:00 AM = 393mg/dl - at 12:00 PM = 388mg/dl" There was no documentation in the resident's record the health care provider was notified regarding the high or the '0' from through . A record review of Resident #1's medication observation records, conducted on , showed Resident #1 had high and refusals throughout his stay at the facility. Resident #1's medication observation records showed " Monitoring: Instructions: Check levels 4 times daily." A second entry on Resident #1's medication observation records showed "Prodigy No Coding In Vetro Strips: Instructions: Test level 3 times daily as directed." There was no documentation that Resident #1 had been refusing his and . There was no documentation the	A 052		

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A 052	Continued From page 7 health provider was notified on , medication observation records regarding the , the needles, monitoring, or the Prodigy No Coding In Vetro Strips. A third entry on Resident #1's medication observation records showed "Trulicity Pen 1.5mg/0.5 [milliliter]ml injectable: Instructions inject half ML every week by route as directed." The Trulicity Pen was not given to Resident #1 and exception reasons were documented as follows: - as "not needed" - as "waiting on pharmacy for delivery" - as "refused" - as "resident stated that it gives him A fourth entry on Resident #1's medication observation record for showed, " Aspart Solution Pen-Injector 100 Unit/ML: Instructions: Inject , per 200-250 2 unit, 250-300 4 unit, 300-350 6 unit, 350-400 8 unit up to 50 unit daily by route as directed for 100 days." The was noted as not given and exception reasons were documented as follows: - - "Resident stated he did his own , also took his own and said they are kept in his room and stated that it was 147" - , 8:00 AM - "Following up with doctor" - , 8:00 AM - "Refused" - - "Waiting on doctor orders" - , 8:00 AM - "Waiting on doctor's orders"	A 052		

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A 052	Continued From page 8 - , 8:00 AM - "Waiting on doctor's orders" - - "Waiting for pharmacy" - , 8:00 AM - "Waiting on doctor orders" - , 8:00 AM - "Waiting on pharmacy for delivery" - , 8:00 AM - "Refused" There was no documentation in Resident #1's record that the health care provider was notified that he did not receive the . A fifth entry on Resident #1's medication observation record showed, " 30 units Suspension Pe-injector (70-30) 100 UNIT/ML: Instructions: Inject 30 units twice a day." The was noted as not given and exception reasons were documented as follows: - " - "Resident stated he did his own , also took his own and said they are kept in his room." - , 8:00 AM - "Following up with the doctor. - , 8:00 AM - "Refused" and " was too low. - , 8:00 PM - " was 166 and no units given." There were no documentation in the resident's record that the health care provider was notified of the missed medication or clarification for the orders. A medication observation record review for Resident #1, conducted on , revealed Resident #1 had an order for monitoring at 8:00 AM, 12:00 PM, 4:00PM, and	A 052		

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A 052	Continued From page 9 8:00 PM. However, the "Prodigy No Coding In Vitro Strip" and the " ˘ injection" orders noted the ˘ were to be taken at 8:00 AM, 2:00 PM, and 8:00 PM. There were no parameters to call the doctor on the ˘ monitoring or the Prodigy No Coding in Vitro Strip. A record review for Resident #3's most recent health assessment form (date not obtained), conducted on , revealed Resident #3 had and needed assistance with self-administration of medications. Resident #3 had refused his ˘ seventeen times between and and five times between and . On the medication observation records, the orders for Resident #3's ˘ noted this was to be done four times every day. There was no documentation by the facility staff that the doctor was notified and made aware of Resident #3's refusals. During an interview with Resident #3, conducted on at 10:10 AM, Resident #3 stated he only takes his ˘ twice every day. A record review for Resident #4's most recent health assessment form (date not obtained), conducted on , revealed that Resident #4 had and needed assistance with self-administration of medications. Resident #4 was on 30 units every day for the month of and ˘ . There were no orders for ˘ monitoring for Resident #4. There was no documentation from the facility that showed doctor notifications regarding ˘ monitoring. A record review for Resident #5's most recent	A 052		

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A 052	Continued From page 10 health assessment form (date not obtained), conducted on , revealed Resident #5 had and needed assistance with self-administration of medications. A medication observation record review on at 12:00 PM, Resident #5 had a of 405mg/dl. There was no documentation in Resident #5's record that the doctor was notified Resident #5 had a of 405mg/dl at 03:25 PM. There was no notation of when to notify the health care provider on the medication observation records. A record review for Resident #6's most recent health assessment form (date not obtained) revealed Resident #6 had and needed assistance with self-administration of medications. There was a discrepancy in the parameters for Resident #6's . It was noted that if Resident #6's was 25 to 300 he would get 6 units of and from 30 to 350 he would get 8 units of . There was no documentation from the facility to the doctor to clarify the order found in Resident #6's record. A review of the facility's medication policy and procedures (undated), revealed there was a medication policy and procedures entitled [facility's name] that noted, "medication administration record was maintained for each resident documenting the administration of all prescribed medications and communication between staff members, residents, and healthcare providers is essential to ensure accurate medication administration and timely identification of any issues or changes in the resident's condition." A review of a second facility medication policy	A 052		

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A 052	Continued From page 11 and procedures (undated) noted, "Upon admission, each resident's ability to self-administer medication was assessed by a license health care professional. Residents who are deemed capable of self-administering medications are provided with information regarding their rights and responsibilities, including the option to request assistance with medication administration." During an observation of the medication pass with Staff D for Resident #1, conducted on at 4:08 PM, Staff D checked Resident #1's . Staff D dialed up the to 30 units and handed it to Resident #1. Staff D noted the was provided on the medication observation records. The times noted for the according to the order dated was 8:00 AM, 2:00 PM, and 8:00 PM. During an interview with Staff A, conducted on at 10:20 AM, Staff A stated she had known Resident #1's was high because he did not want to take his . During an interview with the Resident Care Coordinator, conducted on at 12:55 PM, the Resident Care Coordinator stated Resident #1 had his taken away in when she first started as the Resident Care Coordinator. The Resident Care Coordinator stated that staff did a room search and found in his refrigerator. The Resident Care Coordinator got permission to go into the refrigerator and remove the . Resident #1 was and there was a concern that him giving his own . "He is totally from my understanding." The Resident Care Coordinator stated Resident #1 first stated he did not know	A 052		

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A 052	Continued From page 12 how to administer his but then stated that he counted the clicks. The Resident Care Coordinator stated while in Resident #1's room staff found only one , the 7030 in the refrigerator. The Resident Care Coordinator stated Resident #1 was administering his (long-acting) like the (short acting). The Resident Care Coordinator stated Resident #1 had no in his refrigerator. The Resident Care Coordinator stated Resident #1 has a Dexcom G7 mobile sensor in his skin to check the three times every day. During an interview on at 3:35 PM, the Resident Care Coordinator stated there was no documentation of communication with the doctor in Resident #1's medical record showing he was not taking his as prescribed. The Resident Care Coordinator stated Resident #3's doctor was not told he had been refusing his 12:00 PM and 8:00 PM . The Resident Care Coordinator stated there were no being taken on Resident #4. The Resident Care Coordinator stated Resident #5's doctor was not notified today that her check was 405mg/dl at 12:00 PM. Class I	A 052		
A 056 SS=G	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	A 056		

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A 056	Continued From page 13 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 medication container that directs staff to examine the revised directions for use in the medication	A 056		

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
	AL11969376	A. BUILDING: _____ B. WING _____	08/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 056	Continued From page 14 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. This Statute or Rule is not met as evidenced by:	A 056		

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A 056	Continued From page 15 Based on record review and interview, the facility failed to ensure that all medications were properly labeled for three (#1, #5, and #6) of five residents sampled. The facility's noncompliance directly threatened the health and safety of all residents residing in the facility. Findings included: An observation of medications in the medication cart, conducted on at 9:45 AM, revealed Resident #1's and , Resident #5's , and Resident #6's did not have medication labels. Observed resident #1, #5 and #6 names written in marker on the . During a medication pass observation with Staff D for Resident #1, conducted on at 4:08 PM, Staff D reviewed the medication observation records and dialed Resident #1's to 30 units. There was no label on Resident #1's . During an interview with Staff D, conducted on 4:08 PM, Staff D stated she was not sure the reason why Resident #1 did not have a medication label on his and . A review of the facility's medication policy and procedures (undated), conducted on , there was a policy and procedures regarding the storage and access to medications (undated) which noted that the "medications are stored securely in accordance with State regulations and facility policies to prevent unauthorized access and ensure medication safety". During an interview with the Resident Care	A 056		

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A 056	Continued From page 16 Coordinator, conducted on at 12:55 PM, the Resident Care Coordinator stated she did not know the reason why there were no medication labels on Resident #1, #5, and #6's , . Class II	A 056		