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
	AL11910970	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TGL RESIDENCE & ALF	3210 SW 104 COURT MIAMI, FL 33165

(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 077 SS=G	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must:	A 077		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 077	Continued From page 1 1. Be at least ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of	A 077		

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A 077	Continued From page 2 facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that it was under the supervision of an Administrator who ensured the appropriate	A 077		

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A 077	Continued From page 3	A 077		

care of all residents. Resident #1 was in , for two days before being transported to the hospital. Resident #3 refused his medications for more than nine days without any arrangements for health care including notification to the primary care physician. The Administrator allowed residents to keep medications in their room. The Administrator allowed an employee to give Resident #7 medications for four days to an unknown location, without receipt of medications. Resident #7 needed assistance with self-administration of medication. The Administrator failed to ensure that employees were effectively trained regarding the implementation of the emergency plan.

Findings:

1)
A review of Resident #1's hospital records dated showed the resident was in , for two days before being sent to the hospital at the request of the resident.

Interviewed on at 11:03 AM the Administrator stated that Resident #1 went to the hospital for his .

2)
Observation on at 8:20 AM unlocked medications found in residents' rooms (#1, 2, and 6).

Interviewed on at 1:52 PM during a preliminary exit conference, the Administrator stated, "Residents can have medications in their rooms. We are talking about , . We removed the medications from the rooms, and they brought medications again." However, the central storage medication policy revealed

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A 077	Continued From page 4 medication will be stored in a locked cabinet or closet, and only authorized staff will always have access to the keys for the medication storage. 3) Interviewed on at 1:02 PM Staff B stated that Resident #3 refused to take medications Mapap 325 MG and , 0.5 MG. However, a review of the medication observation records showed more than eight days each of medication refusal, and Resident #3's progress notes showed no notification to the resident's primary care physician. 4) Interviewed on at 12:39 PM Staff B stated that Resident #7 left the facility on in the morning to be with her aunt until Sunday, , . . Staff B stated further that she was given her medications until Sunday. However, Resident #7 needed assistance with self-administration of medication, there was no receipt that medications were transferred to resident, and the Administrator was unaware of her whereabouts. 5) Observation on at 9:05 AM Staff B and D (Caregivers) did not know the places residents would be evacuated to in the event of a mandatory evacuation. Interviewed on at 1:52 PM during the exit conference, the Administrator acknowledged that the employee was to explained the places residents would be evacuated to in the event of a mandatory evacuation. However, the Hurricane season began on and will end on . According to the Florida Disaster database, Hurricane Season is the time of the	A 077		

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A 077	Continued From page 5 year when tropical cyclones, tropical , , tropical storms, and hurricanes develop. A review of the Administrator's personnel records showed a hire date of /20219. Class II	A 077		
A 093 SS=F	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used	A 093		

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A 093	Continued From page 6 by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.	A 093		

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A 093	Continued From page 7 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of _ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to have a menu dated at least one week in advance.	A 093		

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A 093	Continued From page 8 Findings included: Observation on at 11:30 AM showed that the menu posted in the dining area was not dated. On at 11:40 AM, the Administrator confirmed that the menu posted was not dated. Class III	A 093		
A 152 SS=F	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and,	A 152		

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A 152	Continued From page 9 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe living environment, free of hazards and to ensure that all existing architectural, mechanical, electrical, and structural systems and appurtenances were maintained in good working order. Findings included: On at 8:15 AM, showed that the closet door was missing in # . On at 8:40 AM showed that a wet patch roof leak repair and all-purpose , , were on the terrace on top of the refrigerator. The patio had uneven pavers creating a significant trip hazard. There were discarded household appliances on the patio. The residents have access to the area. On at 1:00 PM, the Administrator confirmed the findings. Class III	A 152		

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A 162	Continued From page 10	A 162		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded	A 162		

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A 162	Continued From page 11	A 162		

semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that not be taken.
(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.
(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C.
(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C.
(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S.
(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S.
(l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has

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A 162	Continued From page 12 made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to have a complete health assessment for one out of eight (Resident #2) sampled residents.	A 162		

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A 162	Continued From page 13 Findings included: A review of Resident # 2's health assessment dated showed the resident was diagnosed with , type 2 , and major . The physician indicated the resident was independent with ambulation, eating, toileting, and transferring; needed supervision with and self-care; and needed assistance with bathing. The health assessment did not indicate if the resident had physical and sensory limitations. On at 1:00 PM, the Administrator confirmed that Resident #2's health assessment was incomplete. Class III	A 162		
A 164 SS=D	59A-36.015(4) FAC; 429.35(1) & (3) FS Records - Inspection Availability 59A-36.015 (4) RECORD INSPECTION. (a) The resident's records must be available to the resident; the resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; or the resident's estate, and such additional parties as authorized in writing or by law. (b) Pursuant to Section 429.35, F.S., agency reports that pertain to any agency survey, inspection, or monitoring visit must be available to the residents and the public. In facilities that are co-located with a licensed nursing home, the inspection of record for all common areas is the nursing home inspection report.	A 164		

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	AL11910970	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TGL RESIDENCE & ALF	3210 SW 104 COURT MIAMI, FL 33165

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A 164	Continued From page 14 429.35 Maintenance of records; reports.- (1) Every facility shall maintain, as public information available for public inspection under such conditions as the agency shall prescribe, records containing copies of all inspection reports pertaining to the facility that have been issued by the agency to the facility. Copies of inspection reports shall be retained in the records for 5 years from the date the reports are filed or issued. (3) Every facility shall post a copy of the last inspection report of the agency for that facility in a prominent location within the facility so as to be accessible to all residents and to the public. Upon request, the facility shall also provide a copy of the report to any resident of the facility or to an applicant for admission to the facility. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide proof of resident records for one out of ten (Resident #9) sampled residents. The record was not available at the facility for review at the time of the survey. Findings included: A review of the facility's admission and discharge log showed Resident #9 was admitted on and discharged on . A review of resident records showed that Resident #9's record was not available at the facility for review. On at 1:45 PM, the Administrator stated that he did not have Resident 9's file at the	A 164		

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A 164	Continued From page 15 facility for review. He added that he stores the closed records in his clinic. Class III	A 164		
A 182 SS=D	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff were trained in their duties and able to implement the emergency management plan for two out of three (Staff B and C) sampled staff. The staff did not know where residents should be evacuated to in the event of an emergency evacuation. Findings included: On ;2026 at 9:04 AM, Staff C stated that she was trained in the facility emergency plans. Staff C did not know the places residents would be evacuated to in the event of a mandatory evacuation. On at 9:12 AM, Staff B, when asked which places residents would be evacuated to in the event of a mandatory evacuation, stated that	A 182		

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A 182	Continued From page 16 she did not know. A review of the mutual aid agreement showed one location where residents could be evacuated to in the event of a mandatory evacuation. Class III	A 182		
A 000	Initial Comments A re-licensure and generator monitoring was conducted at TGL Residence ALF on through . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (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.	A 025		

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A 025	Continued From page 17 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 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 interview and record review, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general health, safety, and physical and emotional well-being of one out of	A 025		

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A 025	Continued From page 18	A 025		

eight (Resident #7) sampled residents. Resident #7 left the facility on , and her whereabouts were unknown for one day. During this time, the facility could not ensure that Resident #7 received her required prescribed medications. The facility failed to maintain a written record, updated as needed, of any significant changes or any illness for two out of eight (Resident #1 and 2) sampled residents.

Findings included:

1)
On at 8:20 AM, Staff B stated that Resident #7 was with her brother.

On at 12:33 PM, Staff B stated that Resident #7 left the facility around 7 AM that day. She said Resident #7 told her she would be visiting her aunt and would return the following Sunday. She gave her four days of medications but did not document the medication observation record (MOR). She did not know who picked her up from the facility and did not have the resident's aunt's contact information. She added that she did not notify the resident's brother at any time.

On at 12:40 PM, the Administrator was unaware of Resident #7's whereabouts

A review of Resident #7's medication observation record (MOR) showed:

- 20 mg indicated to take one capsule at 7 AM; was signed as given on .
- 1 mg indicated to take one tablet at 7 AM; was signed as given on .
- 290 mcg indicated to take one capsule at 7 AM; was signed as given on .
- , , ER 50 mg indicated to take one tablet

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A 025	Continued From page 19 at 7 AM; was signed as given on . - , 50 mg indicated to take one tablet at 2 PM and 7 PM. - , 1 mg indicated to take one tablet at 7 AM, 2 PM, and 7 PM; was signed as given on . - , 500 mg indicated to take one tablet at 7 AM, 2 PM, and 7 PM; was signed as given on . - , 5 mg indicated to take one tablet at 7 AM; was signed as given on . - , 100 mg indicated to take one tablet at 7 AM and 7 PM; was signed as given on . A review of Resident #7's medications showed that the medications for , , , and were missing. There was no documentation that the resident received her medications for , , , and before leaving the facility. A review of Resident # 7's health assessment dated showed the resident was diagnosed with , , , , and . The physician indicated the resident was independent with all the activities of daily living and needed assistance with self-administration of medications. 2) A review of Resident # 1's health assessment dated showed the resident was diagnosed with , , status post (two-sided), , , , ex-smoker,	A 025		

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A 025	Continued From page 20 , , , type 2 , idiopathic , , ambulatory with wheelchair. The physician indicated that the resident was independent with eating and toileting, needed supervision with and self-care, and needed assistance with ambulation, bathing, and transferring. On at 11:14 AM, Staff B stated that the resident had in his and was transferred to the hospital on . A review of Resident # 2's health assessment dated showed the resident was diagnosed with , , , type 2 , , , , and major , . The physician indicated the resident was independent with ambulation, eating, toileting, and transferring; needed supervision with and self-care; and needed assistance with bathing. On at 11:30 AM, Staff B stated that Resident #2 had and was transferred to the hospital on . Reviews of Resident #1 and 2 records showed no documentation that her primary physicians and family members were notified when they were transferred to the hospital. Class II	A 025		
A 027 SS=D	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care	A 027		

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A 027	Continued From page 21 as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the prescribed medications orders schedule was followed for one out of eight (Resident #3) sampled residents. Findings included: A review of Resident #3's medication observation record (MOR) showed the medications , 0.5 mg, indicated to take one tablet at 12 PM, and , 325 mg, indicated to take one tablet as needed at 12 PM was not marked as given from to . A review of Resident #3's medications showed that the resident did not receive the medications , 0.5 mg, indicated to take one tablet at 12 PM, and , 325 mg, indicated to take one tablet as needed at 12 PM from to . A review of Resident #3's health assessment dated showed the resident was diagnosed with , , , , , , flexed deformity of the ,	A 027		

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A 027	Continued From page 22 and . The physician indicated the resident needed assistance with self-administration of medication. A review of Resident #3's record showed no documentation of any attempts the facility made to contact Resident #3's physician regarding the refusal of medications. A review of webmd.com showed that , is used to treat , and, in some cases, a type of . It works by calming the and , which helps lower , and stop . It is important to take it exactly as prescribed and never stop it suddenly without talking to your doctor. On at 1:02 PM, Staff B stated that Resident #3 refused to take the medications , 0.5 mg and , 325 mg prescribed at 12:00 PM. Class III	A 027		
A 030 SS=G	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the	A 030		

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A 030	Continued From page 23 facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and . ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and	A 030		

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A 030	Continued From page 24 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of	A 030		

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A 030	Continued From page 25 other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health	A 030		

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A 030	Continued From page 26 care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a	A 030		

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A 030	Continued From page 27 prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall	A 030		

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	AL11910970	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TGL RESIDENCE & ALF	3210 SW 104 COURT MIAMI, FL 33165

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A 030	Continued From page 28 such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure assistance with obtaining access to adequate and appropriate health care for two (Residents #1, and 3) out of eight sampled residents. Resident #1 was in for two days in the facility before being transported to hospital. Resident #3 refused to take prescribed medications for more than nine days without any medical arrangement with the primary care physician. The facility failed to ensure a safe and decent living environment free of and neglect and treated with consideration and respect. Findings: 1) A review of Resident #1's hospital records dated revealed: " male patient with past medical history of with multiple procedures in the past including an fem-fem that got and an axillary- , both on the right lower extremely and a left above , presented to the emergency department with chief complaint of right lower extremity since two days." Interviewed on at 11:14 AM Staff B (Caregiver) stated that Resident #1 asked her to	A 030		

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A 030	Continued From page 29 call rescue because of , in his and that rescue arrived and transported him to the hospital. Interviewed on at 11:03 AM when asked what happened to Resident #1 and why he was hospitalized, the Administrator stated that it was his . A review of Resident #1's health assessment dated showed diagnoses of essential , , , , , , ambulatory with wheelchair. The physical limitations showed right side above , , wheelchair bound. The status showed preserved function. The nursing status showed as required. The resident had universal precautions. The activities of daily living showed assistance with ambulation, bathing, transferring, and supervision with , self-care and independent with eating, and toileting. The resident needed assistance with self-administration of medication. 2) A review of Resident #3's medication observation record showed the medication , 0.5 MG prescribed for 7:00 AM was unsigned for , , , , , , , , , and Mapap 325 MG prescribed for 1:00 PM , , , , , , , , , , /, , . A review of Resident #3's medication pack (Mapap 325 MG Afternoon) showed medications remained in the pack for the following dates: , , , , , , , remained in the pack. However, the medication for was not present.	A 030		

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A 030	Continued From page 30 A review of Resident #3's medication pack (, 0.5 MG Afternoon) showed the medications from through remained in the pack. Interviewed on at 1:02 PM Staff B stated that Resident #3 refused to take his medications. However, no medical arrangements were made to Resident #3's primary care physician for refusing medications for more than nine days. Interviewed on at 1:52 PM during the exit conference, the Administrator acknowledged the deficiency. A review of Resident 3's health assessment dated showed diagnoses with essential , , reaction, flexed deformity ( ). The physical status showed flexed deformity, . The status showed preserved function. The nursing status showed as required. The resident had precautions. The activities of daily living showed independent with ambulation, bathing, , eating, self-care, toileting and transferring. The resident needed assistance with self-administration of medication. The Food and Drug Administration states Mapap 325 MG (, 325 MG) was a , reliever/ reducer. Medlineplus.gov showed , is used to relieve , and treat . , is in a class medication called benzodiazepines. It works by slowing activity in the to allow for relaxation.	A 030		

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A 030	Continued From page 31 Class II	A 030		
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. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section.	A 052		

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A 052	Continued From page 32 (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. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered	A 052		

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A 052	Continued From page 33 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 enable the resident to take medication as prescribed: 1. The health care provider may prescribe a	A 052		

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A 052	Continued From page 34 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 ensure Staff B (Caregiver) orally advised one (Resident #5) out of eight sampled residents who needed assistance with self-administration of medication of the name and dosage of each medication offered. Staff B failed to observe Resident #5 take the medication before signing the medication observation record. Findings:	A 052		

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A 052	Continued From page 35 Observation on at 12:10 PM Staff B only named the medications and not the dosage of each medication , , / tablet 300-30 MG and 10 MG. Staff B initialed the MOR before observing Resident #5 take , , / 300-30 MG. A review of Resident 5's records found no medication waiver listing each medication taken to opt out of being orally advised of the name and dosage of each medication. A review of Staff B's personnel records showed a hire date of and six hours of assistance with self-administration of medication training on . Interviewed on at 1:52 PM during the exit conference, the Administrator acknowledged the deficiency. A review of the facility's self-administration of medications to residents' policy states: "Observe the resident self-administering the medications. Record the observed dosage taken on the medication administration record at the time taken." Class III	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer 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	A 054		

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A 054	Continued From page 36 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 ᵕ 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 an up-to-date medication observation record for one out of eight (Resident #7) sampled residents. Findings included: On at 8:20 AM, Staff B stated that Resident #7 was with her aunt. On at 12:33 PM, Staff B stated that Resident #7 left the facility around 7 AM that day.	A 054		

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A 054	Continued From page 37 She said Resident #7 told her she would be visiting her aunt and would return the following Sunday. She gave her four days of medications but did not document the medication observation record. She did not know who picked her up from the facility and did not have the resident's aunt's contact information. She added that she did not notify the resident's brother at any time. A review of Resident #7's medication observation record (MOR) showed: - 20 mg indicated to take one capsule at 7 AM; was signed as given on . - 1 mg indicated to take one tablet at 7 AM; was signed as given on . - 290 mcg indicated to take one capsule at 7 AM; was signed as given on . - , ER 50 mg indicated to take one tablet at 7 AM; was signed as given on . - , 50 mg indicated to take one tablet at 2 PM and 7 PM. - , 1 mg indicated to take one tablet at 7 AM, 2 PM, and 7 PM; was signed as given on . - , 500 mg indicated to take one tablet at 7 AM, 2 PM, and 7 PM; was signed as given on . - , 5 mg indicated to take one tablet at 7 AM; was signed as given on . - , 100 mg indicated to take one tablet at 7 AM and 7 PM; was signed as given on . There was no documentation that the medications for , , , and were given to the resident. A review of Resident #7's medications showed that the medications for , ,	A 054		

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A 054	Continued From page 38 , and were missing. A review of Resident # 7's health assessment dated showed the resident was diagnosed with , , ( ), , , and . The physician indicated the resident was independent with all the activities of daily living and needed assistance with self-administration of medications. Class III	A 054		
A 055 SS=F	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 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;	A 055		

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A 055	Continued From page 39 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 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	A 055		

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A 055	Continued From page 40 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: Based on observation, interview, and record review, the facility failed to maintain all prescribed or over-the-counter medications stored in a secure place and kept always locked for five out of eight (Resident #2, 5, 6, 7, and 8) sampled residents. Findings included: An observation on at 8:20 AM revealed unlocked medications in # , , and 6 and in the kitchen. The residents have access to the areas. A bottle of Subsalicylate 525 mg/ 15 ml	A 055		

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A 055	Continued From page 41 was inside the fridge in # , where Resident #6 lived. A bottle of C 1000 MG and capsules were on the floor next to the nightstand in # , where Resident #5 lived. A bottle of 12% lotion that belonged to Resident #7 and a bottle of 0.1 cream that belonged to Resident #8 were in # A bottle of 20% that belonged to Resident #10 was in the closet in # , where Residents #2 and 3 lived. On at 8:32 AM, unlocked medications inside the refrigerator in the kitchen. The unlocked medications were Mounjaro 2.5 mg that belonged to Resident #7 and Repatha 140 mg/ml that belonged to Resident #5. On at 11:30 AM, showed that the medication basket labeled with Resident #7's name had three loose unknown medication tablets. A review of the admission and discharge log showed that Resident #10 was discharged on . A review of Resident #5's health assessment dated , Resident #6's health assessment dated , Resident #7's health assessment dated and Resident #8's health assessment dated showed that they needed assistance with self-administered medications. On at 9:20 AM, the Administrator	A 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910970	A. BUILDING: _____ B. WING _____	09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 055	Continued From page 42 stated, "Those are over-the-counter medications." He stated that Resident #10's medication was left in the closet, but no one was using it. On at 11:30 AM, Staff B stated that she did not know why there were three loose, unknown medication tablets in Resident 7's medication basket. She added that she did not know why Resident #10's medication was in the closet in # . Class III	A 055		
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	A 056		

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A 056	Continued From page 43 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 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	A 056		

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A 056	Continued From page 44 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: Based on observation, interview and record review, the facility failed to ensure the prescribed medications orders schedule was followed for one out of eight (Resident #3) sampled residents. Findings included: A review of Resident #3's medication observation record (MOR) showed the medications , 0.5 mg indicated to take one tablet at 12 PM, and , 325 mg indicated to take one tablet as needed at 12 PM was not marked as given from to . A review of Resident #3's medications showed that the resident did not receive the medications . 0.5 mg indicated to take one tablet at	A 056		

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A 056	Continued From page 45 12 PM, and , 325 mg indicated to take one tablet as needed at 12 PM, from to . A review of Resident #3's health assessment dated showed the resident was diagnosed with , , , , , , flexed deformity of the , and . The physician indicated the resident needed assistance with self-administration of medication. On at 11:40 AM, Staff B stated that Resident #3 refused to take the medications , 0.5 mg and , 325 mg prescribed at 12:00 PM. Class III	A 056		