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
	AL11967125	A. BUILDING: _____ B. WING _____	08/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELES SENIOR CARE	13751 SW 17 TERRACE MIAMI, FL 33175

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number 2019010713) was conducted Angeles Senior Care on . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must 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 shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 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 58A-5.020, 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.	A 025		

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A 025	Continued From page 1 (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 observation, interview and record review, the facility failed have evidence of contacting the resident's health care provider when there were problems with medications for three out of five sampled residents (#2, #3 and #4). Findings included: Review of Resident #2's Medication Observation Records (MORs) showed that there was a doctor's order for , 30 mg caps with instructions of taking one capsule by at bedtime. Reconciliation of medication showed that the bottle had a label of , 30 mg capsules including Resident #2's name and instructions of taking one capsule by at bedtime. The medication bottle was empty. On at 11:50 AM, the Administrator revealed that Resident #2's insurance did not cover her , . The resident took the last	A 025		

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A 025	Continued From page 2 capsule on . . . . . . The administrator already called the pharmacy who will contact the primary physician for finding a solution. On . . . . . at 11:53 AM, there was a bottle had a label of 150 mg tablet including Resident #2's name and instructions of taking one tablet by twice a day as needed for 90 days. The label showed that the medication was filled on . On at 11:55 AM, the Administrator revealed that Resident #2's family brought the for Resident #2 from home. Review of Resident #2's MORs showed that MORs did not include the 150 mg tablet with instructions of taking one tablet by . . . twice a day as needed for 90 days. Reconciliation of Resident #3's medication . . . cards showed that , 50 mg did not miss the 8 PM for . . . . . . None of her medications cards missed doses. On at 12:17 PM, there was a cup with four (4) medication tablets inside. The cup had a label with Resident #3's name. On at 12:17 PM, the Administrator revealed that Resident #3 was going to take her medications at lunch time. The tablets in the cup labeled with Resident #3's name matched in color and shaped to Resident's medications scheduled at 8 AM. Medications scheduled at 8 AM were: . . . . , . . 0.5 mg tablet with instructions to take one tablet by in the morning, ... , 10 mg tablet with instructions to take one tablet by daily,	A 025		

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A 025	Continued From page 3 20 mg tablet with instructions to take one tablet by in the morning and , 25 mg tablet with instructions to take one tablet by in the morning. Review of Resident #4's MORs showed that there was an order for 15 mg, one tablet at bedtime. On at 12 PM, the Administrator revealed that Resident #4 finished on when she took the last dose. The resident had a different pharmacy and the resident's daughter had to pick up in the pharmacy and delivery to the facility later on . Review of Residents #2, #3 and #4's records revealed that the facility completed progress notes in their records on . The last progress notes did not reflect any problems with the medications. There was no documentation in the residents' records indicating the facility contacted the residents' health care provider nor the pharmacy. Class III	A 025		
A 052 SS=D	429.256( ); 58A-5.0185 (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, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is	A 052		

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A 052	Continued From page 4 stored, and bringing it to the resident. (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container. (c) Placing an oral dosage in the resident ' s or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (h) Using a to perform level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the prescribed settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with bags. (4) Assistance with self-administration does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or	A 052		

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A 052	Continued From page 5 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) Irrigations or debriding agents used in the treatment of a skin condition. (f) , , or ˛ preparations. (g) 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 at the request of a competent resident. (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. 58A-5.0185 (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 58A-5.0191, 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, in the presence of the resident, reading the medication	A 052		

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A 052	Continued From page 6 label aloud 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, 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.	A 052		

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A 052	Continued From page 7 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. 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. (g) 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, interview and record review, the facility failed to follow the correct procedures with assistant of self-administration of medication as indicating in section 429.256(3), F. S with one out of five sampled resident (#3). Findings included: On at 12:17 PM, there was a cup with four (4) medication tablets inside. The cup had a label with Resident #3's name. On at 12:17 PM, the Administrator revealed that Resident #3 was going to take her medications at lunch time. Reconciliation of Resident #3's medications revealed that the tablets in the cup labeled with Resident #3's name matched in color and shaped to her medications scheduled at 8 AM. Review of Resident #3's Medication Observation Records revealed that the resident's medications scheduled at 8 AM were: ~ , 0.5 mg tablet with instructions to	A 052		

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A 052	Continued From page 8 take one tablet by . . . in the morning. ~ , 10 mg tablet with instructions to take one tablet by . . . daily. ~ , 20 mg tablet with instructions to take one tablet by . . . in the morning. ~ , 25 mg tablet with instructions to take one tablet by . . . in the morning. Staff B initialed Resident #3's medications for . . . . . at 8 AM. Class III	A 052		
A 054 SS=D	58A-5.0185(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 pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known . . . . . the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication . . .	A 054		

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A 054	Continued From page 9 is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to update the Medication Observation Records (MORs) immediately when a medication is offered or administer to a resident for two out of five sampled medications (#2 and #4). The facility failed to have a scheduled time in the for residents taking their medications for one out of five sampled residents (#1). The facility failed to ensure that MORs included the directions of how to take the medications for two out of five sampled residents (#4 and #5). Findings included: 1. Review of Resident #2's MORs showed that Staff B initialed , 30 mg caps scheduled at 8 PM. The , had instructions of taking one capsule by at bedtime. Reconsolidation of Resident #2's medications showed that there was a bottle had with a label of , 30 mg capsules including Resident #2's name and instructions of taking one capsule by at bedtime. On at 11:54 AM, the Administrator revealed that the initials completed to the , scheduled on belonged to Staff B. "It was a mistake."	A 054		

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A 054	Continued From page 10 Resident #4's MORs showed that Staff just initialed the , on and from thru while did not initial at all the , . On at 12:02 PM, the Administrator revealed that Resident #4 took all the medications but the staff forgot to initial the MORs. At 12:07 PM, she added that the resident was taking the , daily. Review of Resident #4 's MORs showed that Staff B initialed , 20 mg one tablet daily scheduled at 8 PM and , 15 mg one tablet at bedtime scheduled at 8 PM. The instructions in the MORs showed , 20 mg 1 tablet daily. , had instructions of taking one tablet at bedtime. The staff just initialed the , on and from thru while did not initial at all the , . There orders of , , , and , in their bottles did not match with the orders in their labels. Reconciliation of medications showed that there was a bottle with a label showing Resident #4's name for , 50 mg tablet and instructions to take one tablet by every twelve hours. The label showed that , 's bottle was filled on with 180 tablets. The bottle still had around 50% of the tablets. There was a bottle with a label showing Resident #4's name for , 20 mg tablet and instructions to take one tablet by every twice a day and discontinue the once daily doses. There was a bottle with a label showing Resident #4's name for , 5 mg tablet and instructions to take one tablet by twice daily with food and	A 054		

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A 054	Continued From page 11 stopped , 5 mg once daily. There was a bottle with a label showing Resident #4's name for 1 mg tablet and instructions to take one tablet by every day. 2. Review of Resident #1's MORs showed that medications scheduled hours showed "AM" and "PM". There was one order for , 5 mg tablet take one tablet by at bedtime and scheduled time showed "PM". There was one order for 8.6 mg tablet take one tablet by twice a day and scheduled time showed "AM" and "PM". On at 12:14 PM, the Administrator revealed that Resident #1's MORs came from the hospice company and they wrote that. 3. Review of Resident #4 's MORs showed that there were handwriting orders and they did not include the route of taking the medications. Orders were , 40 mg take one tablet in the morning, 10 mg one tablet daily, , 20 mg one tablet daily, , 50 mg one tablet daily, 1 mg one tablet daily, , 5 mg one tablet daily, and , 15 mg one tablet at bedtime. Review of Resident #5's MORs showed that there were some orders handwritten with unclear instructions. The orders were , 81 mg once daily, 3 mg at night, and 500 one time a day. The instructions in the MORs missed the number of tablets and the route of administration. Reconciliation of Resident #5's medications showed that there was no . On at 12:13 PM, the Administrator	A 054		

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A 054	Continued From page 12 revealed that Resident #5's sister brought the . Class III	A 054		
A 055 SS=D	58A-5.0185(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; 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	A 055		

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A 055	Continued From page 13 central storage of medication and that policy has been provided to the resident before admission as required in rule 58A-5.0181, 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 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	A 055		

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ANGELES SENIOR CARE	13751 SW 17 TERRACE MIAMI, FL 33175

(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 055	Continued From page 14 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 and interview, the facility failed to dispose of expired medications for one out of five sampled residents (#2). Findings included: On at 11:48 AM, there was a drawer labeled with Resident #2's name which stored her medications. There were 12 red and white capsule with a printed sign of 150 mg. The capsules matched with ER 150 mg that had instructions of taking one capsule by in the morning. There were also 11 single doses of , Liqui-Gels, , 25 mg capsules and had expiration date on ( ). On at 11:50 AM, the Administrator revealed that she did not know about the , while stated "Who knows since when they have been there". Resident #2 was not missing any capsules from current medication card.	A 055		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 055	Continued From page 15 Review of Resident #2's record showed that her admission date to the facility was on . . . . . . Class III	A 055		
A 056 SS=D	58A-5.0185(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff	A 056		

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A 056	Continued From page 16 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 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	A 056		

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A 056	Continued From page 17 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 and interview, the facility failed to follow doctor orders for one two of five sampled residents (#2 and #4). Findings included: On at 11:53 AM, there was a bottle had a label of . . . . 150 mg tablet including Resident #2's name and instructions of taking one tablet by . . . twice a day as needed for 90 days. The label showed that the medication was filled on . . . . . On . . . . . at 11:55 AM, the Administrator revealed that Resident #2's family brought the . . . . for Resident #2 from home. Review of Resident #2's record showed that her admission date to the facility was on . Review of Resident #2's Medication Observation Record (MOR) showed that MOR did not include the 150 mg tablet with instructions of taking one tablet by . . . twice a day as needed for 90 days.	A 056		

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A 056	Continued From page 18 Review of Resident #4's MOR showed that there were handwriting orders in Resident #4's MOR for , 20 mg one tablet daily, , 50 mg one tablet daily, 1 mg one tablet daily, , 5 mg one tablet daily, and , 15 mg one tablet at bedtime. Reconciliation of medications showed that there was a bottle with a label showing Resident #4's name for , 50 mg tablet and instructions to take one tablet by every twelve hours. The label showed that 's bottle was filled on with 180 tablets. The bottle still had around 50% of the tablets. There was a bottle with a label showing Resident #4's name for , 20 mg tablet and instructions to take one tablet by every twice a day and discontinue the once daily doses. There was a bottle with a label showing Resident #4's name for , 5 mg tablet and instructions to take one tablet by twice daily with food and stopped , 5 mg once daily. There was a bottle with a label showing Resident #4's name for 1 mg tablet and instructions to take one tablet by every day. There orders of , , and , in their bottles did not match with the orders in their labels. On at 12:07 PM, the Administrator revealed that Resident #4 took the , daily. Class III	A 056		