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
	AL11965578	A. BUILDING: _____ B. WING _____	04/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR, THE	2800 60TH AVENUE, WEST BRADENTON, FL 34207

(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 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a	A 165		

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A 165	Continued From page 1 preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report	A 165		

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A 165	Continued From page 2 this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to report an event in which they could have exercised control, that resulted in a resident eloping from the facility and being tranported to a local hospital, for 1 resident of 1 whose records were reviewed (Resident 1). Findings Included: A review of Resident 1's record on revealed an incident report dated . The report stated that the resident went out of the facility and refused to come . He ran out into oncoming traffic and was combative. He then threw himself down on to a sidewalk. The report said there were 5 prior occurrences of the resident's behavior. The local emergency management system was called and he was taken to a local hospital. The review of Resident 1's record on revealed that the resident had eloped from the facility on , according to an adverse incident report (#562071) filed with the agency. The record also showed notes in the record describing times when the resident had exit-seeking or aggressive behavior. On	A 165		

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A 165	Continued From page 3 the notes stated he had . . . . . , was forgetful and only oriented to himself and his significant other and that . . . . he wanted to leave the facility. The notes stated that on he attempted to leave facility, stating he could leave his home when he wanted to. The notes stated that on . . . . he attempted to enter a female resident's room and was agitated. He called a facility staff person an (expletive name) several times and became more violent and began punching. The resident became a threat to himself and others on , so the facility called the local law enforcement authority who came out and Resident 1 was . On . . . . . , the notes stated that the resident was seen standing on a busy street, off campus, by a staff person driving to work, and was later brought to facility by facility personnel. The resident's record also revealed the most recent 1823 assessment in Resident 1's record, dated . . . . , stated he was not an elopement risk. The record also contained only 1 elopement risk assessment tool which was dated . . . . . , which was never completed, as it had only 1 entry, a diagnosis of . . . . . and the rest of the assessment tool was blank and it was not signed by anyone. An interview with the Health and Wellness Director was conducted at 3:10pm on , in which she stated that the facility's only policy on elopements was the emergency policy for what to do in case of an actual elopement. She was about what the facility should have done to prevent an elopement from happening. She said she thought that in the facility, being an assisted living facility, residents were free to come and go as they wished. She stated that the facility conducted elopement assessments on all residents to determine if they were an elopement	A 165		

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A 165	Continued From page 4 risk. When asked about Resident 1's elopment assessment tool, which was never completed, she stated she had no knowledge of it. An interview with the the Administrator of the facility at 3:15pm on was conducted. When asked about the internal incident report for Resident 1, dated , she stated that the facility had not filed an adverse incident report with the agency for that incident. She stated that she thought the facility's elopement policy and procedure was just the protocol on what to do in case someone actually eloped, and was not sure of a policy and procedure of how to actually prevent elopement. Photographic evidence obtained. Class III	A 165		
A 000	Initial Comments A complaint investigation (complaint #2022000758 and #2022005195) was conducted at Windsor, The on . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=D	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	A 025		

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A 025	Continued From page 5 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 appointments for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider 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	A 025		

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A 025	Continued From page 6 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 record review and interview, the facility failed to provide supervision and prevent elopement attempts, for 1 of 1 resident, whose records were reviewed (Resident #1). Findings Included: A record review, conducted on , of a reported adverse revealed that Resident #1 eloped from the facility on . Another event, an in-house incident report, involving Resident #1 was dated and it showed that the resident, again, eloped from the facility. The note on the incident report stated that the resident had attempted to leave the facility 5 times prior and that his behavior was combative. A review of Resident #1's record on revealed progress notes that he arrived to live at the facility on . The notes stated that he had and that he was forgetful and oriented only to himself and his significant other. On , the notes stated he refused care service from staff and was agitated. On , the notes say that Resident #1 was heard, from the hallway, yelling at his significant other. On , he attempted to leave the facility, and he stated he could leave his home when he wanted to. On , a staff member tried to redirect the resident when he was attempting to enter a female resident's room. On this occasion, Resident #1 was agitated and called a facility staff	A 025		

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A 025	Continued From page 7 person an expletive name several times. He then became more violent and began punching. Resident #1 became a threat to himself and others, and the facility called the local law enforcement authority. When the law enforcement officers arrived at the facility on , they Resident #1, and took him to mental health facility for evaluation. The notes, dated , stated that Resident #1 returned from the mental health facility with no medication changes, but that they changed his plan of care to say that he should have more (to drink). The notes stated that on , the resident was walking around facility looking for his significant other. On , the notes stated that Resident #1 left the facility and was standing outside on a nearby busy street. On , Resident #1 became violent with a third-party staff member that was caring for him and threw a substance on her. The notes stated that later, on , the resident was agitated, again looking for his significant other and told staff members that he did not live at the facility. On , the notes stated that the resident was outside of the facility on the sidewalk, a staff member from the facility went outside to redirect him. The resident was yelling for help and attempted to hit a staff member. He eventually threw himself on the ground and the emergency management system was called and he was transported to a local hospital. He was returned by hospital transport later that evening, to the facility. The same evening, on the resident was seen pacing in the hallway and told a facility staff member to keep following him to his room so he could , her. On , the notes stated that the resident was pacing the hallway and seeking an exit door. The review of Resident #1's record on ,	A 025		

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A 025	Continued From page 8	A 025		

revealed the only elopement risk tool in his record was dated , just before he was admitted to the facility. The elopement risk tool was incomplete, as it had only one entry - a diagnosis of and it was not signed by anyone. The review revealed his most up to date health assessment (1823) on record, dated , which stated he had a diagnosis of and that he was not an elopement risk. The 1823 assessment, which was dated after he was for acting in a violent manner on , stated that his behavior and cognition were pleasant and .

An interview was conducted with the Administrator at 10:40am on . In the interview, she stated that Resident #1 showed signs of previous to the elopement that prompted an adverse incident report being filed with the agency on . She stated that Resident #1's significant other, whom he lived with at the facility, , in the summer of 2021, after being taken to the hospital, and the Resident #1 was never told about it. He, therefore, kept expecting her to come and would go around looking for her inside and outside of the facility.

In interview with the Health and Wellness Director at 3:10pm on , she stated that the facility's policy on preventing elopements was the emergency policy for what to do in case of a real elopement. She also said that their policy was to do an elopement risk assessment for every resident. That was it. She said she was because she thought that, in assisted living facilities, residents were free to come and go as they wished. When asked about the incomplete elopement risk assessment tool in Resident #1's record, she stated had no

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A 025	Continued From page 9 knowledge of it. Photographic evidence obtained. Class III	A 025		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their 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	A 055		

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A 055	Continued From page 10 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 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	A 055		

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A 055	Continued From page 11 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 records review and interview, the facility failed to ensure that medications were kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times, which lead to residents' [redacted] medications being misplaced and misappropriated for 1 of 1 resident (Resident #2). Findings Included: A review of a facility record conducted on [redacted], revealed on [redacted] at 1:35am, a pharmacy made a delivery of a [redacted] medication for Resident #2. The pharmacy shipping notice revealed Staff D, an unlicensed outside agency staff person, signed that she received the medication from the pharmacy. Staff D failed to follow the appropriate protocol for accepting medications for residents and did not notify anyone at the facility that the medication were delivered. The medication was never logged into Resident #2's medication inventory. The record	A 055		

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A 055	Continued From page 12 showed that the facility spoke with Staff D on and she stated that she put the received medication in with Resident 2's medications on the medication cart. The record showed that the facility looked for the medication on the medication cart and it was not there, and when they realized it was missing, the record showed that they called the local law enforcement agency. Record review conducted on revealed that a statement from Staff D was taken, Staff D's stated she did sign the pharmacy shipping record as receiving medications just after 1:00am on . She stated that since she was new (to working in the facility) and didn't know any better, she just put all the medications on the medication cart, never having been told that the medications needed to be kept separately locked up or that the inventory count sheets should be put in the record book. An interview Administrator conducted at 10:40am on , she stated that the facility had been, and currently was still using, outside agency staff personnel to supplement its staffing shortage issues. She stated that Staff D did work for an outside agency and was not an employee of the facility and that she was new to working at the facility and had been scheduled to work as a medication technician on the overnight shift the night of - . She stated the facility had no knowledge that the pharmacy had delivered Resident #2's medication to the facility until 5 days later. A review of the facility's policy and procedure regarding medications, on , revealed the following for receiving medications: medication personnel receiving a drug delivery must verify	A 055		

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A 055	Continued From page 13 receipt of each prescription and quantity of the drug delivery slip before signing the drug delivery slip, and the drug delivery slip must be crossed referenced to drug orders pending delivery, to track the receipt of all drugs ordered from pharmacy. The policy and procedure also stated that in order to ensure that quality standards are maintained, all staff handling medications should complete the medication training program. In an interview with the Administrator at 3:30pm on , she said that the facility did not check the medication technician training credentials of outside agency staff, that they would just rely on what the agency told them. They did not provide and medication technician training to outside agency personnel. Therefore, they would not have knowledge of any , certifications of the medication technicians that the facility employed from outside agencies. Photographic evidence obtained. Class III	A 055		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee	A 081		

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A 081	Continued From page 14 completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents,	A 081		

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A 081	Continued From page 15	A 081		

other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement.
(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Reporting adverse incidents.
2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.
(c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Resident rights in an assisted living facility.
2. Recognizing and reporting resident , , neglect, and , . The facility must use its prevention policies and procedures when offering this training.
(d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects:
1. Resident behavior and needs.
2. Providing assistance with the activities of daily

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A 081	Continued From page 16 living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that staff who provided direct care to residents had at least 1 hour of training in the area of elopement, within 30 days of employment, for 2 of 3 staff members whose records were reviewed (Staff B and Staff C), and failed to ensure that all facility staff were able to demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. Findings Included: A review of Staff B's record on revealed that Staff B was employed with the facility on . There was 1 training certificate in Staff B's record for elopement training, only 0.5 of an hour on .	A 081		

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A 081	Continued From page 17 A review of Staff C's record on revealed that Staff C was employed with the facility on . There was 1 training certificate in Staff C's record for elopement training, only 0.5 of an hour training. A review of the facility's elopement drill log revealed drills on , , and . An interview with the Administrator at 3:15pm on was conducted and she acknowledged that the facility elopement drill log had only one genuine elopement training listed, on . The other 2 notations were and , which were actual elopements, not drills. She stated that the facility's policy for elopement drills was to conduct them quarterly. She acknowledged that they had not been conducting elopement drills quarterly. She said that she thought elopement policy was just the protocol on what to do in case someone eloped and was not sure of a policy and procedure of how to actually prevent elopement. She stated she was not aware that elopement in-service training was to be for one whole hour, as opposed to only 0.5 of an hour as some of the staff had. Photographic evidence obtained. Class III	A 081		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed	A 084		

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A 084	Continued From page 18 persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , and dosage forms;	A 084		

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A 084	Continued From page 19 b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , , rate, temperature, and , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have	A 084		

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A 084	Continued From page 20 successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on records review and interview, the facility failed to ensure that all staff handling medications completed the required medication training for one (Staff D) of one record reviewed. Findings Included: A review of a facility record conducted on , revealed that on the night of at 1:35am, a	A 084		

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A 084	Continued From page 21 pharmacy made a delivery of a medication for a resident. The pharmacy shipping record, in the record, showed that Staff D, an unlicensed outside agency staff person, signed that she received the medication from the pharmacy. Staff D failed to follow the appropriate protocol for accepting medications for residents, and did not notify anyone at the facility that the medication was delivered, therefore the medication was never logged into the resident's medication inventory. The record showed that the facility spoke with Staff D on and she stated that she put the received medication on the medication cart. The record showed that the facility looked for the medication on the medication cart and it was not there, and when they realized it was missing, the record showed that they called the local law enforcement agency. Record review conducted on revealed that a statement from Staff D was taken, as part of their internal investigation into the matter of the missing medication. According to Staff D's statement, she did sign the pharmacy shipping record as receiving medications just after 1:00am on . She stated that since she was new (to working in the facility) and didn't know any better, she just put all the medications on the medication cart, never having been told that the medications needed to be kept separately locked up or that the inventory count sheets put in the record book. An interview with the facility Administrator 10:40am on was conducted. In the interview, she stated that the facility had been, and currently was still using, outside agency personnel to supplement its staffing shortage issues. She stated that Staff D did work for an	A 084		

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A 084	Continued From page 22 outside agency and was not an employee of the facility and that she was new to working at the facility and had been scheduled to work on the overnight shift the night of - in the role of a medication technician. She stated the facility had no knowledge of the missing medication until 5 days later. A review of the facility's policy and procedure regarding medications, on , revealed a statement that said that in order to ensure that quality standards are maintained, all staff handling medications should complete the medication training program. In an interview with the Administrator at 3:30pm on , she said that the facility did not check the training credentials of outside agency staff, that they would just rely on what the agency told them about receiving medication technician training and that the facility provided no further medication technician training to the agency personnel. Therefore, they would not have knowledge of any , certifications of the medication technicians that the facility employed from outside agencies. Photographic evidence obtained. Class III	A 084		