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
	AL11967884	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHIDS HOME	2960 MEADOWS OAKS DR S CLEARWATER, FL 33761

(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 Assisted Living Facility A biennial state licensure survey with limited nursing services (LNS) and limited mental health (LMH) was conducted on . Orchids Home assisted living facility had deficiencies found at the time of the visit.	A 000		
A 008	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable which is likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual ' s needs can be met	A 008		

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A 008	Continued From page 1 in an assisted living facility; and 8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state. (b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows: 1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment. a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion. b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider. c. Omitted information received verbally must be documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided. 2. The facility administrator, or designee, must	A 008		

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A 008	Continued From page 2	A 008		

complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the elements in Section 3. This requirement does not apply for residents receiving:
a. Extended congregate care (ECC) services in facilities holding an ECC license;
b. Services under community living support plans in facilities holding limited mental health licenses;
c. Medicaid assistive care services; and
d. Medicaid waiver services.
(c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823.
(d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).
(e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule.
(f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a do-not- order for residents who do not wish
to be administered in the case of
or

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A 008	Continued From page 3 (g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility ' s admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure the health assessment AHCA Form 1823 was completed by a licensed health care provider during a face to face visit (as required) and failed to assure all components including what type of help would be needed for the residents medication/treatment management for 2 (Resident #1 and #2) of 2 sampled residents which could lead to [redacted] and incorrect care being given to the residents. Findings include: A review of Resident #1's current health assessment (form 1823) dated [redacted] revealed a different handwriting style than the licensed provider who signed it. Further review revealed in the area that asked for what type of help was needed for taking medications, it was checked yes but did not document what type of help was needed, assistance or administration. Another form titled, Authorization for Medication	A 008		

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A 008	Continued From page 4 Administration was signed by the same provider and was checked off indicating that the resident required medication administration by a validated medication administration assistant (required by the other State program that the resident is followed by). It was further documented on the assessment that the resident needed [illegible] 24 hours a day but did not indicate the liter requirement. A review of the medication orders attached to the assessment revealed several incomplete orders that needed dose and timeframe and indications for use. Examples included: [illegible] 0.5mg 2, twice by [illegible] (listed how many times but did not say to use twice per day or how it was supplied (vial). An order for [illegible] 0.83% four times by [illegible] was missing how it was supplied (vial?) and did not indicate what the 4x timeframe was (such as 4x day). An order for [illegible] (Q-[illegible]) 500mg, instructed 2 tab (no timeframe or indication for use), Propoxy-napap [illegible], give 1/2 tab prn (no indication for use), [illegible] 90 mcg, 2 puffs prn (no indication for use listed). After reviewing the health assessment/orders, it could be determined that a licensed provider would not likely write such incomplete orders. Review of the current [illegible] MORs revealed clarification had been obtained for some of the orders. A review of Resident #2's current health assessment (form 1823) dated and signed by a licensed health care provider on [illegible]. Further review revealed the assessment was written with the same handwriting as Resident #1's above which was different than the provider's signature. The assessment was incomplete and was missing the resident's weight. Under Section A where activities of daily living were addressed,	A 008		

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A 008	Continued From page 5 all areas were checked off in 2 places instead of indicating the most appropriate column as asked for in the directions, not both supervision and assistance, for instance. Under toileting, independent, supervision and assistance were blank but to the side was written, "pull-ups". Transferring was left blank although in the area of physical or sensory limitations was written: one leg drags on ground. The medication orders had the same information missing as Resident #1 including how the medication was supplied, timeframes and indication for use for as needed meds (prns). Section B (medication management)indicated the resident needed help in the form of medication administration. Interviews with the administrator and one (Staff A) of two live in caregivers acknowledged that neither of them were licensed health care providers and therefore were not qualified to complete the residents health assessments including writing the medication orders which the provider then signed. They further acknowledged the incomplete orders on the assessments. Attempts to speak to either the administrator or (Staff A) via phone 2 x in the am on (at approximately 9:30 and 10:40 a.m. for more clarification as to who had actually written the assessments was unsuccessful. Class III Widespread	A 008		
A 052	58A-5.0185(3) FAC Medication - Assistance with Self-Admin (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) For facilities which provide assistance with	A 052		

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A 052	Continued From page 6 self-administered medication, either: a nurse; or an unlicensed staff member, who is at least , trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. (b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container. (c) Staff shall observe the resident take the medication. Any concerns about the resident ' s reaction to the medication shall be reported to the resident ' s health care provider and documented in the resident ' s record. (d) 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 which coincides with the resident ' s presence in the facility; 2. The medication container may be given to the resident or 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	A 052		

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A 052	Continued From page 7	A 052		

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;
(e) Pursuant to Section 429.256(4)(h), 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.
(f) Pursuant to Section 429.256(4)(i), F.S., the terms " judgment " and " discretion " mean interpreting vital signs and evaluating or assessing a resident ' s condition.
(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 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 through intermittent positive pressure breathing machines or a .
(d) Administration of medications by way of a tube inserted in a cavity of the body.
(e) Administration of preparations.
(f) Irrigations or debriding agents used in the treatment of a skin condition.
(g) , , or preparations.
(h) 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

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A 052	Continued From page 8	A 052		

preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident.
(i) 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.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interviews, the facility failed to obtain clarification of medication orders including whether they were to be given scheduled or on an as needed basis, what the frequency was or obtain discontinue orders for the if no longer necessary, orders to include frequency and orders including a range of liter/minute use which would force non licensed medication trained techs to use judgement in determining how much or how often to assist, which could have negative outcomes if not given correctly.

Findings include:

A record review revealed Resident #1 the health assessment included the following diagnoses: ( ) and . Just above the physician's signature was written, "she is on 24 hours/day". There was no actual order found in the resident file. Review of the medication observation record (MOR) revealed the order transcribed as: 2-3 liters via nasal canula x 24 hours (parameters are not allowed). Observation revealed no available for the resident

A further review of the health assessment revealed orders for .5mg/2 twice

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A 052	Continued From page 9 daily by and an order for 0.083% IH sol, use 1 vial via 4x day as needed for and An interview with Staff A (live in caregiver/med tech) on at approximately 11:00 a.m. revealed the resident was no longer on because the insurance company would not cover it based on a test they did on her. This was confirmed by the administrator on at approximately the same time however no documentation stating this was shown to the surveyor. The administrator then proceeded to call the primary provider and obtained a discontinue order for the . A further interview with staff A (who is not a licensed health care provider and therefore not qualified to administer or treatments told the surveyor that she had administered and monitored the and gave both treatments together, although the order did not mention anywhere to combine them). During the survey, the resident was observed to be able to put the vial into the chamber with the assistance of Staff A and held the apparatus to her face via mask without difficulty. She did not combine the treatments during the observation. Continued interview with the administrator revealed she would speak with the resident's family and primary physician to address these issues raised above. Observation of the resident during the morning and afternoon revealed no breathing difficulty. Class III Pattern	A 052		

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A 053	58A-5.0185(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities which provide medication administration a staff member, who is licensed to administer medications, must be available to administer medications in accordance with a health care provider ' s order or prescription label. (b) Unusual reactions or a significant change in the resident ' s health or behavior shall be documented in the resident ' s record and reported immediately to the resident ' s health care provider. The contact with the health care provider shall also be documented in the resident ' s record. (c) Medication administration includes the conducting of any examination or testing such as glucose testing or other procedure necessary for the proper administration of medication that the resident cannot conduct himself and that can be performed by licensed staff. (d) A facility which performs clinical laboratory tests for residents, including glucose testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Part I of Chapter 483, F.S. A valid copy of the State Clinical Laboratory License and the CLIA Certificate must be maintained in the facility. A state license or CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents ' own equipment. Information about the State Clinical Laboratory License and CLIA Certificate is available from the Clinical Laboratory Licensure Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail	A 053		

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A 053	Continued From page 11	A 053		

Stop 32, Tallahassee, FL 32308; telephone (850)487-3109.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to assure only qualified licensed staff provided medication administration that including the conducting of twice daily glucose testing, treatments and administration for 1 (Resident #1) of 1sampled residents who had orders for glucose monitoring, treatments and administration; additionally, the facility failed to assure that the facility held a CLIA Certificate (State Clinical Laboratory License) in order for licensed staff to obtain the glucose levels (which requires a finger stick) thereby placing all 5 residents at risk of receiving testing and treatments inaccurately by unqualified staff. which could lead to adverse results.

Findings include:

A record review revealed Resident #1, admitted to the facility on / had diagnoses of behavior, mental and (non) listed on the health assessment, form 1823 dated . Further review revealed orders for 2x daily glucose testing, 4 x day treatments and 24 hour/day administration. Review of the glucose levels log dated revealed the testing was done 2 x day, before breakfast and 2 hours after dinner. The results ranged from 77-152 before breakfast to 65-157 after dinner.

An interview with the caregiver (Staff A), a trained medication technician on at approximately 10:30 a.m. revealed she had been

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A 053	Continued From page 12 trained by a registered nurse on how to obtain glucose levels and therefore thought she was qualified to obtain them. She further stated the resident could not or would not be able to obtain them herself due to her mental capacity. A further review also did not reveal an order to either self administer the glucoses, treatments or An interview with the administrator on at approximately 11:00 a.m. revealed she also thought that if staff had been trained by a registered nurse in obtaining glucoses, they were qualified to do them. During the tour of the facility on beginning at 9:30 a.m., there was no CLIA certificate observed. An interview via phone with the administrator on at 4:45 p.m. revealed she was not aware of what the CLIA license was and acknowledged the resident could not obtain her own glucose levels and that the facility was not licensed to provide CLIA services. She further told the surveyor that she would either have the resident's family members who were very involved and visited every night to do the necessary glucose testing and treatments would also speak to them about contracting with home health nursing to fill in any gaps. A further observation of the facility revealed no . Staff A and the administrator on at approximately 12:00 p.m. stated that insurance would not cover the and an order from the primary provider was received to discontinue it during the survey. Observation during the noon med pass revealed the resident	A 053		

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A 053	Continued From page 13 was able to pour the vial and hold the mask to her face while receiving a treatment. Class III	A 053		
A 054	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall 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 shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication.	A 054		

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	AL11967884	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHIDS HOME	2960 MEADOWS OAKS DR S CLEARWATER, FL 33761

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A 054	Continued From page 14 This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to correctly transcribe as needed (prn) orders onto the medication observation records (MORs) for 1 (Resident #1) of 2 sampled residents which could make it difficult to determine if the order was scheduled or as needed (prn) which could lead to either giving to much or too little medication which could result in an adverse outcome. Finding include: A review of Resident #1's health assessment dated had a diagnosis of and and orders for 0.83% solution to use 1 vial via 4 x (missing whether it was scheduled 4 x day or prn) for / . Review of the 06 and MORs had the following order transcribed as an as needed medication but was scheduled 4 x day at 8:00am, 12:00noon, 4:00pm and 8:00pm. The back of the MOR should not have included scheduled times because the medication may not necessarily be needed as often as it can be given (4x day). It was signed off as being given every 4 hours during the hours of 8:00am and 8:00pm. An interview with the med tech (staff A) acknowledged that the order did state, "as needed" and said the resident did need it every 4 hours during the day but that it should not have been scheduled. She further stated she documented each time it was given on the back of the MOR correctly as one would for an as needed medication used. An interview with the administrator on at approximately 12:45 p.m. acknowledged the	A 054		

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A 054	Continued From page 15 order should not have been scheduled on the MOR even though the resident did need it every 4 hours. She further said she would discuss the order with the provider to determine if it should be scheduled or remain as needed. Class III	A 054		
A 078	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Newly hired staff shall have 30 days to submit a statement from a health care provider, based on a examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable including . Freedom from must be documented on an annual basis. A person with a positive test must submit a health care provider ' s statement that the person does not constitute a risk of communicating . Newly hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in service. If any staff member is later found to have, or is suspected of having, a communicable , he/she shall be removed from duties until the administrator determines that such condition no longer exists. (b) All staff shall be assigned duties consistent with his/her level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff shall exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate	A 078		

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A 078	Continued From page 16 resident ' s record, and to report the observations to the resident ' s health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of Rule 58A-5.0191, F.A.C. (d) Staff provided by a staffing agency or employed by a business entity contracting to provide direct or indirect services to residents must be qualified for the position in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor shall specifically describe the services the staffing agency or contractor will be providing to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility shall: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and 2. Maintain time sheets for all staff. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 (Staff B) employed more than 30 days had been trained in the facility's policies regarding Do Not Recussitate orders ( ) as required placing residents at risk of having their honored and also did not have evidence of general information/training regarding for Staffs A and B which could lead to inappropriate care and services given to residents whose diagnoses might include . Findings include: A review of live in caregiver (Staff A)'s personnel file revealed a hire date of and . Further review revealed no evidence of training. Interview with	A 078		

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A 078	Continued From page 17 Staff A on acknowledged she had not received training in the subject at the facility. A review of live in caregiver (Staff B)'s personnel file revealed a hire date of / . Further review of the file revealed no evidence of training in the facility's policy. Further review revealed no training in . An interview with Staff B during the survey revealed she did understand what meant and was able to correctly explain it to the surveyor. She then indicated she was aware that one resident did had a . An interview with the administrator on at approximately 12:00 p.m. revealed she was not aware of the training requirement in and asked where to obtain the information. She said she sure Staff B had been trained in but acknowledged there was no verification of it in the personnel file. Class III	A 078		
A 093	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition Board - National Research Council, adjusted for age, and activity, shall be the nutritional standard used to evaluate meals. Therapeutic diets shall meet these nutritional standards to the extent possible. A summary of the Tenth Edition Recommended Dietary Allowances, interpreted by a daily food guide, is available from the DOEA	A 093		

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A 093	Continued From page 18 Assisted Living Program. (b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by 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 recommended dietary allowances to be made available to each resident daily by the facility are as follows: 1. Protein: 6 ounces or 2 or more servings; 2. Vegetables: 3 5 servings; 3. Fruit: 2 4 or more servings; 4. Bread and starches: 6 11 or more servings; 5. Milk or milk equivalent: 2 servings; 6. Fats, oils, and sweets: use sparingly; and 7. Water. (c) All regular and therapeutic menus to be used by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, to ensure the meals are commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date reviewed. 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 to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be	A 093		

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A 093	Continued From page 19	A 093		

encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months.
(e) Therapeutic diets shall 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 which enable residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility.
2. The facility shall document a resident ' s refusal to comply with a therapeutic diet and notification to the resident ' s health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the resident ' s responsible party refusing the diet is acceptable documentation of a resident ' s preferences. In such instances daily documentation is not necessary.
(f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly distributed throughout the day with not less than two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals.
(g) Food shall be served attractively at safe and

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A 093	Continued From page 20 palatable temperatures. All residents shall 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, shall be on hand. (h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity. The supply shall consist of dry or canned foods that do not require refrigeration and shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall 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, review of the dietician's emergency food menu and interviews, the facility failed to have on hand the required 3 day emergency food supply and had expired dry goods in the pantry placing all 5 residents at risk for receiving expired foods and an inadequate amount of nutrition should an emergency occur when it would be needed. Findings include: During a tour of the facility's pantry where it was indicated the emergency supply was kept, there was not a 3 day supply of non perishable foods	A 093		

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A 093	Continued From page 21 available. There was a very limited number of canned vegetables, an expired box of dry mild (expiration date 2009) and 2 boxes of expired crackers. Further observation revealed 3 large containers of water that were dated over An interview with Staff A on at approximately 9:45 a.m. who had accompanied the surveyor on the tour acknowledged the expired foods and revealed no prior knowledge of the expired food or water products. An interview with the administrator on at approximately 1:15 p.m. revealed she was not aware of the expired foods/water and said they used fresh produce most of the time but acknowledged there needed to be a minimum of a 3 day supply. She acknowledged the current menus signed by the contracted licensed dietician supplied a 5 day emergency menu and would use that to obtain the necessary products. Class III Widespread	A 093		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Orchids Home
2960 Meadows Oaks Dr S
Clearwater, FL 33761

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with limited mental health (LMH) and limited nursing services (LNS) that was conducted on , 2012, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

For Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

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