



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Rose Manor
14180 Amero Lane
Spring Hill, FL 34609

Dear Administrator:

This letter reports the findings of a revisit survey conducted on _____ 2012 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references the uncorrected deficiencies and/or new deficiencies, identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than _____ 2012.**

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 this office at (386) 462-6201.

Sincerely,

Kriste J. Mennella
Field Office Manager

KJM/amw

Enclosure



State Form: Revisit Report

(Y1) Provider / Supplier / CLIA /
Identification Number
AL11967880

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
8/9/2012

Name of Facility
ROSE MANOR

Street Address, City, State, Zip Code
14180 AMERO LN
SPRING HILL, FL 34609

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
	Correction Completed		Correction Completed		Correction Completed
ID Prefix A0008		ID Prefix A0030		ID Prefix	
Reg. # 58A-5.0181(2) FAC		Reg. # 58A-5.0182(6) FAC; 429.28		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By
State Agency
Reviewed By
CMS RO

Reviewed By

Reviewed By

Date:
08/30/12
Date:

Signature of Surveyor:
cf. Lpy HBS for S. BACUT, HFEIT
Signature of Surveyor:

Date:
08/30/12
Date:

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967880	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER ROSE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 14180 AMERO LN SPRING HILL, FL 34609		
(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 An unannounced follow-up to the Biennial Licensure survey was conducted on _____ at Rose Manor located in Spring Hill, FL to determine if the facility was in compliance with Chapters 429, Part I & 408, Part II, Florida Statutes and 58 A-5 Florida Administrative Code. The facility was not in compliance. Since the facility received an uncorrected Class II deficiency in medications, the facility is being required to employ the consultant services of a licensed pharmacist or a licensed registered nurse to address the concerns with the medications.	{A 000}		
{A 052}	58A-5.0185(3) FAC Medication - Assistance with SS=G Self-Admin (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) For facilities which provide assistance with 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,	{A 052}		

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0890

TYL212

If continuation sheet 1 of 6

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967880	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 14180 AMERO LN SPRING HILL, FL 34609		
(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 052}	Continued From page 1 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 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		{A 052}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967880	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 14180 AMERO LN SPRING HILL, FL 34609		
(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 052}	Continued From page 2 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 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 interview and record review, the facility failed to ensure that medication was being administered to resident #1 by licensed personnel. Finding: Review of resident #1's _____, 2012		{A 052}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967880	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 14180 AMERO LN SPRING HILL, FL 34609		
(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 052}	Continued From page 3 medication observation record (MOR) revealed that the resident's 7:00 am _____ had been signed off as being assisted with by K. M. During the interview with the resident on _____ at 10:20 am, he pointed to the owner and stated that she gives him his _____ During the interview with the administrator on _____ at 10:30 am, she stated that her daughter who is a licensed practical nurse (LPN) pre-fills the syringes and initial the medication record that the pharmacy sends the facility. Continued interview with the administrator revealed that her daughter is contracted to work for the facility however there was no record or background screening for the LPN who's initial are A.B. Review of the hand written MOR that the facility uses to document the medication did not reveal the _____ medication that is suppose to be assisted every day at 8:00 am. Continued interview with the administrator revealed that the _____ medication is listed with the Pill Organizer. The section that is documented as Pill Organizer does not list the name and dose of the medications just a list of times. The administrator stated that the 7:00 am medication was for the _____ Review of the resident's clinical record revealed that he is receiving hospice services. Review of the care plan revealed that the resident needs the _____ injections on a daily basis, but the skilled nurse is only scheduled to come out to the facility two times a week. During the interview with the administrator on _____ at 11:30 am, she stated that hospice informed her that they would not come out on a daily basis to give _____ Class II		{A 052}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967880	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 14180 AMERO LN SPRING HILL, FL 34609		
(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 161 SS=D	58A-5.024(2) FAC Records - Staff (2) STAFF RECORDS. (a) Personnel records for each staff member shall contain, at a minimum, a copy of the original employment application with references furnished and verification of freedom from communicable including . In addition, records shall contain the following, as applicable: 1. Documentation of compliance with all staff training required by Rule 58A-5.0191, F.A.C.; 2. Copies of all licenses or certifications for all staff providing services which require licensing or certification; 3. Documentation of compliance with level 1 background screening for all staff subject to screening requirements as required under Rule 58A-5.019, F.A.C.; 4. A copy of the job description given to each staff member pursuant to Rule 58A-5.019, F.A.C., for facilities with a licensed capacity of seventeen (17) or more residents; and 5. Documentation of facility direct care staff and administrator participation in resident elopement drills pursuant to paragraph 58A-5.0182(8)(c), F.A.C. (b) The facility shall not be required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by a business entity contracting to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 58A-5.019, F.A.C. (c) The facility shall maintain the facility's written work schedules and staff time sheets as required under Rule 58A-5.019, F.A.C., for the last 6 months.		A 161		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967880	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 14180 AMERO LN SPRING HILL, FL 34609		
(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 161	Continued From page 5		A 161		
	This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure it maintained a record for 1 of 1 licensed practical nurse (LPN) working at the facility. Findings: During the interview with the administrator on at 10:30 am, she stated that her daughter who is a licensed practical nurse (LPN) pre-fills the syringes and initial the medication record that the pharmacy sends the facility. Continued interview with the administrator revealed that her daughter is contracted to work for the facility however there was no record or background screening for the LPN who's initial are A.B. Class: III				