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 |
|---|---|---|---|
| | AL11965627 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAFE AND SECURE RESPITE CARE, LLC | 3091 SKYLINE DRIVE CRESTVIEW, FL 32539 |

| (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<br><br>Complaint investigation CCR#2012009109 was conducted on . The facility was found to not be in compliance with state regulations for Assisted Living Facilities at the time of this survey. | A 000 | | |
| A 052 SS=D | 58A-5.0185(3) FAC Medication - Assistance with Self-Admin<br><br>(3) ASSISTANCE WITH SELF-ADMINISTRATION.<br>(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.<br>(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.<br>(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. | A 052 | | |

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 |
|---|---|---|---|
| | AL11965627 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAFE AND SECURE RESPITE CARE, LLC | 3091 SKYLINE DRIVE CRESTVIEW, FL 32539 |

| (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<br><br>(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:<br>1. The health care provider may prescribe a medication schedule which coincides with the resident ' s presence in the facility;<br>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;<br>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<br>4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging;<br>(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.<br>(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.<br>(4) Assistance with self-administration does not include:<br>(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.<br>(b) The preparation of syringes for injection or the administration of medications by any injectable route. | A 052 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965627 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAFE AND SECURE RESPITE CARE, LLC | 3091 SKYLINE DRIVE CRESTVIEW, FL 32539 |

| (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<br><br>(c) Administration of medications through intermittent positive pressure breathing machines or a<br>(d) Administration of medications by way of a tube inserted in a cavity of the body.<br>(e) Administration of preparations.<br>(f) Irrigations or debriding agents used in the treatment of a skin condition.<br>(g) , , or preparations.<br>(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.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observations, record review and interview the facility failed to provide qualified personnel to administer medications to 1 of 1 residents (#1) who require administration of medications; and failed to ensure that unlicensed staff followed proper procedure for assistance with self-administration of medication for 2 of 2 residents (#2 and 4) who require assistance with self-administration of medication.<br><br>The findings are:<br><br>Observations of medication pass on beginning at 12:15 PM revealed the med tech as she unlocked the med cart; removed resident #1 ' s bin from the cart; removed a prescription bottle of 25 milligrams (mg) from the bin; | A 052 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965627 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAFE AND SECURE RESPITE CARE, LLC | 3091 SKYLINE DRIVE CRESTVIEW, FL 32539 |

| (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 | A 052 | | |

dispensed 1 tablet into a med cup; returned the prescription bottle to the bin and the cart; took the med cup and a cup of water to the resident in the living [illegible]; stated " I ' ve got your medicine here " , and handed the med cup and water to the resident. Interview with this resident immediately following med pass revealed she was not able to name or describe her meds, was not aware of how many pills she is supposed to take at this time of day, nor what the medication is for. Record review for this resident revealed a resident assessment Form 1823 dated with the comment "Administer meds" under the section titled "Nursing/treatment/ service requirements" on page 1 of the form. Page 3 of the form was marked "yes" in response to the question "Does the individual need help with taking his or her medications (meds)?" A checkmark was placed beside the box "Needs assistance with self-administration of meds". The form also noted as a diagnosis, and the comment " ." under the section "[illegible] or behavioral status". Due to the discrepancy between these sections on the 1823, a phone interview was conducted on with a nurse at the resident's physician's office. The nurse was asked to clarify the resident's ability to self-administer her medication. She stated "She would have to have her meds administered. [illegible], she isn't able to self-administer".

Observations at 12:20 PM during med pass revealed the med tech as she removed the med bin for resident #4 from the med cart; removed a prescription bottle of 1mg from the bin; dispensed 1 tablet into a med cup; removed a bottle of 100mg from the bin; dispensed 1 tablet into the med cup; returned

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965627 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAFE AND SECURE RESPITE CARE, LLC | 3091 SKYLINE DRIVE CRESTVIEW, FL 32539 |

| (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 4<br>the bottles to the bin; took the med cup and a cup of water to the resident at the dining ; handed the resident the med cup and water and stated " here is your medicine, (resident's name) " . The tech did not show the resident the prescription bottles and did not identify the meds to the resident. She returned to the med cart and signed the meds off on the Medication Observation Record (MOR). Interview with resident #4 at this time revealed he was able to name his medications and briefly describe what he was taking them for. Review of the resident assessment Form 1823 for this resident revealed the physician has assessed the resident to be capable of self-administering medication with assistance.<br><br>During med pass observation at 1:55 PM, the med tech unlocked the med cart; removed the med bin for resident #2; removed a prescription bottle of 30mg; dispensed 1 tablet into a med cup; returned the bottle to the bin and the cart; took the med cup and a cup of water to the resident in the living ; stated " here is your medicine " ; handed the med cup and water to the resident, who swallowed the pill. The tech returned to the med cart and signed the med off on the MOR. She did not show the resident the prescription bottle or dispense the med in the presence of the resident and did not identify the med to the resident. Review of Form 1823 for this resident revealed the physician has assessed her to be capable of self-administering medication with assistance.<br><br>An interview was conducted with the med tech on at 4:15 PM and she was asked to briefly describe the procedure she has been trained to use when assisting residents with | A 052 | | |

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 |
|---|---|---|---|
| | AL11965627 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAFE AND SECURE RESPITE CARE, LLC | 3091 SKYLINE DRIVE CRESTVIEW, FL 32539 |

| (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 5<br>self-administration of medication. She immediately stated "I know I should have identified the medication for the residents, I forgot to do that". She stated she has been trained to use hand sanitizer, and to go to the resident and tell them what their pills are and what they are for, and hand them the medication. She did not state that her training had taught her to take the medication container to the resident and dispense the medication in the presence of the resident When asked further about this, she stated "Yes, I should have done that, I usually do. I usually take the med cart to the living take the meds out right there in front of them". | A 052 | | |

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Safe And Secure Respite Care, Llc
3091 Skyline Drive
Crestview, FL 32539

Dear Administrator:

Re: CCR #2012009109

This letter reports the findings of a state licensure survey 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 after 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(s). Should you have any questions please call me at (850) 412-4540.

Sincerely,

for Donah Heiberg, M.S. W.
Field Office Manager

DH/kb
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone 850-412-4540; Fax (850) 922-9162