



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

2012

Administrator  
Chambrel At Pinecastle  
1801 SE 24th Road  
Ocala, FL 34471

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2012 by representative(s) 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 2012 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 Anna Lopez at 386-462-6201.

Sincerely,

  
Kriste J. Mennella  
Field Office Manager

KJM/al  
Enclosure State Form 3020

XC90



Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910267</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                      |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CHAMBREL AT PINECASTLE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1801 SE 24TH ROAD<br/>OCALA, FL 34471</b> |                                                                                                                          |                                               |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                | ID<br>PREFIX<br>TAG                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                      |
| (A 000)                                                           | Initial Comments<br><br>An unannounced follow-up to the Compliance Survey was conducted at Chambrel At Pinecastle located in Ocala, FL on _____ to determine if the facility was in compliance with Chapters 429, Part I & 408, Part II, Florida Statutes and 58A-5 Florida Administrative Code. The facility was not in compliance.<br><br>A 056 58A-5.0185(7) FAC Medication - Labeling and Orders<br>SS=D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                | (A 000)                                                                               |                                                                                                                          |                                               |
|                                                                   | (7) MEDICATION LABELING AND ORDERS.<br>(a) No prescription drug shall be kept or administered by the facility, including assistance with self-administration of medication, unless it is properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container:<br>1. The resident's name; and<br>2. Identification of each medicinal drug product in the container.<br>(b) Except with respect to the use of pill organizers as described in subsection (2), no person other than a pharmacist may transfer medications from one storage container to another.<br>(c) If the directions for use are "as needed" or "as directed," the health care provider shall be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations shall be specified; for example, "as needed for pain, not to exceed 4 tablets per day." The revised instructions, |                                                                                | A 056                                                                                 |                                                                                                                          |                                               |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

9899

GCG812

If continuation sheet 1 of 4

Agency for Health Care Administration

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| A 056                                                             | Continued From page 1<br><br>including the date they were obtained from the health care provider and the signature of the staff who obtained them, shall be noted in the medication record, or a revised label shall be obtained from the pharmacist.<br>(d) Any change in directions for use of a medication for which the facility is providing assistance with self-administration or administering medication must be accompanied by a written medication order issued and signed by the resident's health care provider, or a faxed copy of such order. The new directions shall promptly be recorded in the resident's medication observation record. The facility may then place an "alert" label on the medication container which directs staff to examine the revised directions for use in the MOR, or obtain a revised label from the pharmacist.<br>(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed copy of a signed order is acceptable.<br>(f) The facility shall make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.<br>(g) Pursuant to Section 465.0276(5), F.S., and Rule 64F-12.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which shall also include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled | A 056                                                                                 |                                                                                                                          |                                               |

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| A 056                                                             | <p>Continued From page 2</p> <p>package, they shall be kept in a container that bears a label containing the following:</p> <ol style="list-style-type: none"> <li>1. Practitioner ' s name;</li> <li>2. Resident ' s name;</li> <li>3. Date dispensed;</li> <li>4. Name and strength of the drug;</li> <li>5. Directions for use; and</li> <li>6. Expiration date.</li> </ol> <p>(h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident ' s health care provider shall provide the resident with a written prescription, or a fax copy of such order.</p> <p>This Statute or Rule is not met as evidenced by: Based on review of the medication observation record (MOR) and interview the facility failed to ensure that medications were ordered in a timely manner for 5 (#1 #2, #3, #9, #14) of 16 residents in the sample.</p> <p>Finding:</p> <ol style="list-style-type: none"> <li>1. Review of resident #1's 2012 MOR revealed the resident was out of the 75 milligrams (mg) medication from 2012 thru 2012.</li> <li>2. Review of resident #2's 2012 MOR revealed the resident was out of the Gris 250 mg that was to be taken daily from 23-26, 2012.</li> <li>3. Review of resident #3's 2012 MOR revealed the resident was out of the 50 mg medication from 1-3, 2012.</li> <li>4. Review of resident #9's 2012 MOR revealed the resident was out of the 50 mg medication from 7-10, 2012.</li> </ol> |                                                                                | A 056                                                                                 |                                                                                                                          |                                               |

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| A 056                                                             | <p>Continued From page 3</p> <p>5. Review of resident : MOR<br/>revealed the resident was out of the<br/>100 mg medication from 7-9, 2012.</p> <p>Interview with the Administrator on _____ at<br/>1:10 PM she stated that she was not aware that<br/>the residents were out of the medications.</p> <p>Class: III</p> | A 056                                                                                 |                                                                                                                          |