

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932571	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER FEEL AT HOME, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 129 WEST 131ST AVENUE TAMPA, FL 33612		
(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 second revisit was conducted on 11 to the complaint survey, CCR# 2012006511, of 1st Revisit conducted 09/13/12. The Feel at Home Inc. assisted living facility had a new deficiency found at the time of the visit.	{A 000}			
A 055	58A-5.0185(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; or in their or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility shall 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	A 055			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0000

IE4013

If continuation sheet 1 of 4

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A 055	Continued From page 1 habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents; or 6. The facility ' s rules and regulations require central storage of medication and that policy has been provided to the resident prior to admission as required under Rule 58A-5.0181, F.A.C. (b) Centrally stored medications must be: 1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and 4. Kept separately from the medications of other residents and properly closed or sealed. (c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident ' s representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident ' s request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked " discontinued medication. " Such medication may be reused if re-prescribed by the resident ' s health care provider. (d) When a resident ' s stay in the facility has ended, the administrator shall return all	A 055			

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A 055	Continued From page 2 medications to the resident, the resident ' s family, or the resident ' s guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident ' s medications are still at the facility, the medications shall be considered abandoned and may be disposed of in accordance with paragraph (e). (e) Medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and disposition shall 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. (f) 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 upon observation and interview, the facility failed to ensure that prescribed medications of 4 residents (# 1, 2 , 3 & 4) were stored in a locked receptacle. Findings include: During the visit of _____ at approximately 10:30am, prescribed medications were observed unlocked in the kitchen refrigerator and small refrigerator of the water cooler in the office. These medications included the following; 2 boxes of Levemir Flex-pens, (inject 14 units sub-q daily at 8pm) and 1 box of Kirkpen 100u/ml) for resident #1	A 055			

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A 055	Continued From page 3 Sol. 10 gr. 2 tbs. (30ml) twice daily. for resident #2. inject 22 units every am and evening for resident #3. 100 u/ml inject 35 units sub-Q every night for 1 month. for resident #4. When told the refrigerated medications also had to be kept in a locked receptacle the administrator said she kept all residents medications in a medication cart. Again it was explained to the administrator that the requirement also applies to medications requiring refrigerator and she claimed she did not know-that no-one had told her that before. She said that she would get a lock for the small refrigerator under the water cooler. In the meantime all medications were transferred to the kitchen refrigerator, although not locked since it was not immediately accessible to residents. Class III Pattern	A 055			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11932571	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
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Name of Facility FEEL AT HOME, INC.	Street Address, City, State, Zip Code 129 WEST 131ST AVENUE TAMPA, FL 33612
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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
ID Prefix <u>A0092</u> Reg. # <u>58A-5.020(1) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0093</u> Reg. # <u>58A-5.020(2) FAC</u> LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By ☒	Reviewed By <i>Paul & Bm</i>	Date: <u>4/15/12</u>	Signature of Surveyor: _____	Date: _____
State Agency	Reviewed By	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By				
CMS RO				

Followup to Survey Completed on: _____	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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RICK SCOTT
GOVERNOR



ELIZABETH DUDEK
SECRETARY

2012

Administrator
Feel At Home, Inc.
129 West 131st Avenue
Tampa, FL 33612

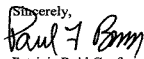
Dear Administrator:

This letter reports the findings of a second state licensure survey revisit 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 deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 deficiency 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 Cauffman
Field Office Manager

PRC/kpr

Enclosures: State Form 3020 & Revisit Report

