

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER QUALITY CARE OF FLORIDA, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1261 TUMBLEWEED DRIVE ORANGE PARK, FL 32065		
(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 A Limited Nursing Services survey and revisit was conducted at Quality Care of Florida, Inc. on , 2012. Deficiencies were identified.	A 000			
A 008 SS=D	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 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	A 008			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6026

404U11

If continuation sheet 1 of 13

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER QUALITY CARE OF FLORIDA, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1261 TUMBLEWEED DRIVE ORANGE PARK, FL 32065		
(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 008	Continued From page 1 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 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 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER QUALITY CARE OF FLORIDA, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1261 TUMBLEWEED DRIVE ORANGE PARK, FL 32065		
(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 008	Continued From page 2 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 _____ order for residents who do not wish _____ to be administered in the case of _____ or _____ (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	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER QUALITY CARE OF FLORIDA, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1261 TUMBLEWEED DRIVE ORANGE PARK, FL 32065		
(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 008	Continued From page 3 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 record review and staff interview the facility failed to complete Section 3 of the Agency for Health Care Administration Form 1823 for 3 of 3 residents sampled. Residents #1, #2 and #5) The findings include: A record review for Residents #1, #2 and #3 was conducted and revealed that the Agency for Health Care Administration Form 1823 Section #3 was not completed by facility Administrator on all 3 records. During an interview with the Administrator on : at 11:17 am he acknowledged that section 3 of the Agency for Health Care Administration Form 1823 was not completed for all three residents sampled. Class III	A 008			
A 078 SS=D	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	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER QUALITY CARE OF FLORIDA, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1261 TUMBLEWEED DRIVE ORANGE PARK, FL 32065		
(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 078	Continued From page 4 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 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	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED _____
NAME OF PROVIDER OR SUPPLIER QUALITY CARE OF FLORIDA, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1261 TUMBLEWEED DRIVE ORANGE PARK, FL 32065		
(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 078	Continued From page 5 to each staff member; and 2. Maintain time sheets for all staff. This Statute or Rule is not met as evidenced by: Based on employee record review, the facility failed to ensure that employees were free from evidence of the communicable and in 2 of 3 employee records sampled. (Employee #1 and #2) The findings include: A record review was conducted on and revealed that Employee #1, hired, had no written evidence that she was free of communicable including and that Employee #2, hired, had no evidence that she was free of communicable	A 078			
A 081 SS=D	58A-5.0191(2) FAC Training - Staff In-Service (2) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions, and facility sanitation procedures before providing personal care to residents. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER QUALITY CARE OF FLORIDA, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1261 TUMBLEWEED DRIVE ORANGE PARK, FL 32065		
(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 081	Continued From page 6 the following subjects: 1. Reporting major incidents. 2. Reporting adverse incidents. 3. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility ' s resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility ' s resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED _____
NAME OF PROVIDER OR SUPPLIER QUALITY CARE OF FLORIDA, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1261 TUMBLEWEED DRIVE ORANGE PARK, FL 32065		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1 FIX 3	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 081	Continued From page 7 This Statute or Rule is not met as evidenced by: Based on employee record review, the facility failed to ensure direct care staff received required training for 3 of 3 employee records sampled. (Employees #1, #2 and #3) The findings include: An employee record review was conducted and Employees #1, #2 and #3 did not have evidence of receiving the following training within 30 days of hire. Employee #1 hired, _____ did not have elopement response training, emergency preparedness and evacuation training, incident reporting training, resident rights training, recognizing/reported _____ neglect and _____ training and nutritional & safe food handling in-service. Employee #2, hired _____ did not have elopement response training, emergency preparedness and evacuation training, incident reporting training, resident rights training, recognizing/reported _____ neglect and _____ training and nutritional & safe food handling in-service. Employee #3, hired _____ did not have elopement response training, emergency preparedness and evacuation training, incident reporting training and nutritional & safe food handling in-service. Class III		A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER QUALITY CARE OF FLORIDA, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1261 TUMBLEWEED DRIVE ORANGE PARK, FL 32065		
(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 090 A 090 SS=D	Continued From page 8 58A-5.0191(11) FAC Training - Do Not ... Orders (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding ... within 60 days after the effective date of this rule. (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding ... within 30 days after employment. (c) Training shall consist of the information included in Rule 58A-5.0186, F.A.C. This Statute or Rule is not met as evidenced by: Based on employee record review, the facility failed to ensure that all direct care staff received required ... training within 30 days of hire date for 3 of 3 employee records sampled. (Employees #1, #2 and #3) The findings include: An employee record review was conducted and revealed Employee #1, hired ..., Employee #2, hired ..., and Employee #3, hired ..., did not have evidence of receiving ... training within 30 days of hire. Class III	A 090 A 090			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER QUALITY CARE OF FLORIDA, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1261 TUMBLEWEED DRIVE ORANGE PARK, FL 32065		
(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 162	Continued From page 9	A 162			
A 162	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records shall be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2. . 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance 8. Name, address, and telephone number of next of kin, responsible party, or other person the resident would like to have notified in case of an emergency, and relationship to resident; and 9. Name, address, and phone number of health care provider, and case manager if applicable. (b) A copy of the medical examination described in Rule 58A-5.0181, F.A.C. (c) Any health care provider 's orders for medications, nursing services, therapeutic diets, or other services to be provided, supervised, or implemented by the facility that require a health care provider 's order. (d) A signed statement from a resident refusing a therapeutic diet pursuant to Rule 58A-5.020, F.A.C. (e) The resident record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A weight record which is initiated on admission. Information may be taken from the resident 's health assessment. Residents receiving assistance with the activities of daily living shall have their weight recorded semi-annually. (g) For facilities which will have unlicensed staff assisting the resident with the self-administration	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER QUALITY CARE OF FLORIDA, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1261 TUMBLEWEED DRIVE ORANGE PARK, FL 32065		
(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 162	Continued From page 10 of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract. (h) For facilities which manage a pill organizer, assist with self-administration of medications or administer medications for a resident, the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract, as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, or staff, or representative thereof serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required under Section 429.27, F.S. (k) For any facility which maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required under Section 429.27, F.S. (l) A copy of Alternate Care Certification for Form, CF-ES 1006, 1998, if the resident is an recipient. The absence of this form shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Family Services. (m) Documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required under Rule 58A-5.0181, F.A.C. (o) For apartments, duplexes, quadruplexes, or	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER QUALITY CARE OF FLORIDA, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1261 TUMBLEWEED DRIVE ORANGE PARK, FL 32065		
(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 162	Continued From page 11 single family homes that are designated for independent living but which are licensed as assisted living facilities solely for the purpose of delivering personal services to residents in their homes, when and if such services are needed, record keeping on residents who may receive meals but who do not receive any personal, limited nursing, or extended congregate care service shall be limited to the following: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required under this subsection; 3. The medical examination described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (p) Except for resident contracts which must be retained for 5 years, all resident records shall be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents shall be provided a copy of their resident records upon departure from the facility. (q) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and resident interview the facility failed to inform 1 of 1 sampled	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER QUALITY CARE OF FLORIDA, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1261 TUMBLEWEED DRIVE ORANGE PARK, FL 32065		
(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 162	Continued From page 12 Resident that the Facility may employee non licensed nursing staff to assist residents with medications. (Resident #5) The findings include: During an interview on _____ at 9:26 am, Resident #5 reported that she received assistance with her oral medications from the facility staff. A record review was conducted on _____ and revealed Resident #5 who was admitted _____ did not have a signed consent form, indicating that she had been informed that non licensed staff would be assisting with medications. Class III	A 162			



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Quality Care of Florida, Inc.
1261 Tumbleweed Drive
Orange Park, FL 32065

Dear Administrator:

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 2013 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 this office at 798-4201.

Sincerely,

Keisha Woods
Health Facility Evaluator Supervisor
Div. of Health Quality Assurance

/cw
Enclosures

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



Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone (904) 798-4201; Fax (904) 359-6054