

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER AMORE' CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1634 S. KANNER HWY. STUART, FL 34994		
(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 Assisted Living Facility change of ownership (CHOW) licensure survey was conducted on Amore' Care, had licensure deficiencies found at the time of the visit.	A 000		
A 025 SS=D	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	A 025		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6899

9D9K11

If continuation sheet 1 of 8

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER AMORE' CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1634 S. KANNER HWY. STUART, FL 34994		
(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 025	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure notification to the representative and adequate documentation was completed for significant changes, for #1 out of #2 sampled residents' status (R #2). The findings include: On _____ at 11 AM, R #2 was observed in the dining _____ a _____ aid on her right chin and a quarter size _____ on her forehead. Staff #1 was interviewed at 1 PM on this date and stated the resident had "bumped her head on a side rail at night" and had a _____ from her wheelchair on her chin. Record review failed to indicate the details of this incident and notification to the resident's physician and legal guardian. Further record review, revealed a faxed note to the doctor dated _____ stating a "night C.N.A. reported he found the resident with a dark spot on her forehead". The Administrator was interviewed at 2 PM and stated there was no documentation of the resident's injuries yet since "it just happened". She also stated the resident's representative had not been notified. The resident's representative was interviewed by phone on _____ at 4:14 PM and confirmed that she had not been notified of the resident's injuries of unknown origin at the time the facility staff had found them. An "occurrence report" dated 01 _____ that was faxed to the Agency on _____ documented the resident was seen by the ARNP (Advanced Registered Nurse Practitioner) on _____ at 1:30 PM, who "looked at legs and head" and documented "no new orders" for these unwitnessed injuries.	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER AMORE CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1634 S. KANNER HWY. STUART, FL 34994		
(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)	(X6) COMPLETE DATE
A 025	Continued From page 2 Class III	A 025		
A 085 SS=D	58A-5.0191(6) FAC Training - Nutrition & Food Service (6) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. A certified food manager, licensed dietitian, registered dietary technician or health department sanitarians are qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure that staff #4 had obtained, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an ALF. The findings include: The Administrator was interviewed on _____ at approximately 2:45 PM and stated Staff #4 was the designated person responsible for the facility's food service and the day-to-day supervision of food service. Record review of Staff #4's personnel record, failed to indicate the employee had received 2 hours of continuing education regarding nutrition and food in an ALF within the prior or current year by a qualified trainer. Documentation of a minimum of 2 hours continuing education in topics pertinent to	A 085		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER AMORE' CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1634 S. KANNER HWY. STUART, FL 34994		
(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 085	Continued From page 3 nutrition and food service in an ALF for this staff member was requested at this time. The Administrator acknowledged during the interview, that the proper documentation was not present and available for review at this time. Class III	A 085		
A 093 SS=D	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition Board - National Research Council, adjusted for age, _____ and activity, shall be the nutritional standard used to evaluate meals. Therapeutic diets shall meet these nutritional standards to the extent possible. A summary of the Tenth Edition Recommended Dietary Allowances, interpreted by a daily food guide, is available from the DOEA Assisted Living Program. (b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the recommended dietary allowances to be made available to each resident daily by the facility are as follows: 1. Protein: 6 ounces or 2 or more servings; 2. Vegetables: 3 5 servings; 3. Fruit: 2 4 or more servings; 4. Bread and starches: 6 11 or more servings; 5. Milk or milk equivalent: 2 servings; 6. Fats, oils, and sweets: use sparingly; and 7. Water. (c) All regular and therapeutic menus to be used	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER AMORE CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1634 S. KANNER HWY. STUART, FL 34994		
(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 093	Continued From page 4 by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, to ensure the meals are commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date reviewed. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months. (e) Therapeutic diets shall be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items which enable residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility. 2. The facility shall document a resident's refusal to comply with a therapeutic diet and	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER AMORE' _____ CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1634 S. KANNER HWY. STUART, FL 34994		
(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 093	Continued From page 5 notification to the resident ' s health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the resident ' s responsible party refusing the diet is acceptable documentation of a resident ' s preferences. In such instances daily documentation is not necessary. (f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly distributed throughout the day with not less than two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of _____ the time between meals. (g) Food shall be served attractively at safe and palatable temperatures. All residents shall be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, shall be on hand. (h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity. The supply shall consist of dry or canned foods that do not require refrigeration and shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER AMORE' . CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1634 S. KANNER HWY. STUART, FL 34994		
(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 093	Continued From page 6 reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure residents were served meals following a standardized recipe approved by the Dietician, ensuring residents received the RDA (recommended dietary allowances). The findings include: During observation of lunch preparation between 11 AM and 12 PM by Staff #4 on , beef stroganoff with noodles and corn on the cob was served to the residents. Staff #4 was interviewed at 12:15 PM on . and stated he used a recipe he found online. The standardized recipe book approved by the Dietician was reviewed and had a recipe for beef stroganoff with specific ingredients and measurements/portion sizes, including sour cream and 4 ounces of stroganoff to be served to each resident. According to Staff #4, this recipe was not used. He revealed that no sour cream was added to the beef mixture and a regular serving spoon was used to place the stroganoff on to the residents' plates. Staff #4 also revealed, he did not have a way to measure 4 ounces of the mixture and showed this surveyor 2 ice cream type scoops for 1/2 a cup and 1/3 of a cup, which he did not use during serving. Additionally, a small piece of corn on the cob was served instead of 1/2 a cup of carrots that was on the menu for which more than half of the residents (due to) were not able to place in their hands and eat. Therefore, staff had	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER AMORE' CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1634 S. KANNER HWY. STUART, FL 34994		
(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 093	Continued From page 7 to assist them by cutting the corn off the cob which resulted in less than half a cup of this vegetable. Also, 8 ounces of milk was listed to be served on the current menu dated _____ but no milk was offered or served to residents. Observations of the residents during the meal revealed a majority of the residents suffered from _____ and required staff to anticipate their needs. These findings were discussed with the Administrator at 2:45 PM on this date. It was unable to be determined if the RDA was met as standardized recipes (as prepared by the facility's licensed Dietician) were not used as required. Class III	A 093		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Amore' Care
1634 S. Kanner Hwy.
Stuart, FL 34994

Dear Administrator:

This letter reports the findings of a Change of Ownership survey that was conducted on 2013 by a representative from 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 (30) 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,


Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

