

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965843	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TRUE TIME HOME CARE CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 2431 SW 127 COURT MIAMI, FL 33175		
(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 visit for a complaint investigation (CCR: 2012012937) was conducted on _____ True Time Home Care Corp had the following deficiency	A 000		
A 054 SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider ' s name, the resident ' s name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known _____ the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical _____, the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by:	A 054		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0009

P2E311

If continuation sheet 1 of 2

Agency for Health Care Administration

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A 054	Continued From page 1 Based on record review and interview the facility failed to maintain an accurate medication observation record. Findings as follow: Record review documented: The facility's 4 residents (#1, #2, #3 and #4) MORs showed residents were given the medications till _____ at 8:00 p.m. (by initializing medication administration till _____ at 8:00 p.m.). Record review documented there was no documentation of medication administration on _____ at 8:00 a.m. On _____ at about 9:30 a.m. staff #2 stated was in charge of assisting residents with medication administration, also stated, already assisted the facility residents to take medications at 8:00 a.m. on this day. On _____ at about 9:30 a.m. staff #2 stated failed to anotate in the medication observation record that facility residents #1, #2, #3 and #4 did take medications at 8:00 a.m. on _____. On _____ at about 10:00 a.m. the facility administrator (staff #1) stated the facility failed to have an accurate MOR for residents #1, #2, #3 and #4 by not documenting medication administration for _____ at 8:00 a.m. Class III	A 054		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
True Time Home Care Corp
2431 Sw 127 Court
Miami, FL 33175

Re: CCR #2012012937

Dear Administrator:

This letter reports the findings of a state complaint survey that was conducted on , 2013 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 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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
XG90

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