

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TORIA'S ASSISTED LIVING FACILITY II		STREET ADDRESS, CITY, STATE, ZIP CODE 613 FOREST HILLS BRANDON, FL 33510		
(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 monitoring visit was conducted on The Toria's Assisted Living Facility II had deficiencies found at the time of the visit.	A 000		
A 054	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.	A 054		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0000

VPFC11

If continuation sheet 1 of 8

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/12/2013
NAME OF PROVIDER OR SUPPLIER TORIA'S ASSISTED LIVING FACILITY II			STREET ADDRESS, CITY, STATE, ZIP CODE 613 FOREST HILLS BRANDON, FL 33510		
(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 054	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow proper procedures for assistance with self-administration for one of one sampled residents requiring glucose testing and injection of (Resident #1). Specifically, the facility assigned unlicensed staff to assist Resident #1 with daily testing of sugar, the required units of for the sugar level and then provide the resident with a corresponding pre-drawn syringe of to the resident. Findings include: On at approximately 1:15 p.m., during a tour of the facility, the surveyor found plastic bags labeled with numbers containing syringes of liquid stored in the refrigerator. The administrator then opened a box stored in the refrigerator and showed the surveyor more bags with numbers on them and confirmed that they were syringes of, prepared by home health staff. During a follow-up interview conducted at 1:30 p.m. on the same date, the administrator stated that a home health nurse prepares the syringes of and places them in plastic bags labeled according to the number of units. The administrator said that when Resident #1 checks her sugar, the unlicensed facility staff checks the sugar reading and gives Resident #1 a syringe corresponding to the number of units of required. At 2:00 PM on that same date, Resident #1 was asked to demonstrate how she checks her sugar and administers her. Resident #1 was observed to pick up the glucometer to prick her finger and test her sugar. The unlicensed	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TORIA'S ASSISTED LIVING FACILITY II		STREET ADDRESS, CITY, STATE, ZIP CODE 613 FOREST HILLS BRANDON, FL 33510		
(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 054	Continued From page 2 caregiver took the testing strip and inserted it into the glucometer for the resident. After pricking her finger and getting a reading, the unlicensed caregiver then took a syringe of _____ out and handed it to Resident #1, who indicated she would go into the _____ inject it. When asked how many units of _____ were in the syringe, Resident #1 did not answer. On that same date, a review of Resident #1's health assessment indicated her medical provider had said she required assistance with self-administration of medication. The health assessment also indicated that Resident #1 is diagnosed with _____ and mental _____. On that same date, during a review of the notes from the home health agency, the surveyor noted that the entry for _____ stated, in part: "Sliding scale teaching needed to avoid complication - teaching began with one staff member who already seemed _____." Class III	A 054		
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	A 055		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TORIA'S ASSISTED LIVING FACILITY II			STREET ADDRESS, CITY, STATE, ZIP CODE 613 FOREST HILLS BRANDON, FL 33510		
(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 055	Continued From page 3 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 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.	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TORIA'S ASSISTED LIVING FACILITY II			STREET ADDRESS, CITY, STATE, ZIP CODE 613 FOREST HILLS BRANDON, FL 33510		
(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 055	Continued From page 4 (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 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 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 on observation and interview, the facility failed to insure that expired medications were properly disposed of within 30 days of the expiration date for 4 of 4 sampled residents.	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TORIA'S ASSISTED LIVING FACILITY II			STREET ADDRESS, CITY, STATE, ZIP CODE 613 FOREST HILLS BRANDON, FL 33510		
(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 055	Continued From page 5 (Residents 1, 2, 3 and 4.) The facility also failed to insure that _____ belonging to one of one residents (Resident #1) was stored in a locked refrigerator and was not accessible to residents. Findings include: During a tour of the facility conducted on _____, resident medications were observed stored in a locked cabinet and were separated into individual containers. Medications prescribed "as needed" (PRN) were stored in separate containers in the cabinet. The PRN medications for Residents 1, 2 3 and 4 contained medications that had expired more than 30 days ago, including _____ prescribed for Resident #3 that expired in _____ and _____ for Resident #4 that expired in _____. Later in the tour of the facility conducted on the same date, the refrigerator was observed in the kitchen of the facility near the table where the residents sat. The kitchen was open and accessible to the residents. The refrigerator had a lock but was not locked. No staff were in the kitchen and the surveyor approached the refrigerator, opened it and observed _____ stored in the door of the refrigerator, unlocked and accessible. The administrator was interviewed on _____ at approximately 3:15 p.m. The administrator stated that she kept discontinued medications in case they were needed again and also stated some of her residents had PRN medications that they did not take often. The administrator said she would need to audit her medications. The administrator further demonstrated that the refrigerator had a lock and she would need to	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TORIA'S ASSISTED LIVING FACILITY II			STREET ADDRESS, CITY, STATE, ZIP CODE 613 FOREST HILLS BRANDON, FL 33510		
(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 055	Continued From page 6 remind staff to lock it. Class III	A 055			
A 078	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 an examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable _____ 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	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TORIA'S ASSISTED LIVING FACILITY II		STREET ADDRESS, CITY, STATE, ZIP CODE 613 FOREST HILLS BRANDON, FL 33510		
(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 7 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 to each staff member; and 2. Maintain time sheets for all staff. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to insure that one of three sampled employees (Employee C) provided documentation from their medical provider indicating they were free of communicable Findings include: On , the surveyor reviewed the employee record for Employee C. The record did not contain documentation from a medical provider indicating Employee C was free of communicable The administrator was interviewed that same day at approximately 3:00 p.m. The administrator confirmed that Employee C provided care to the residents and said she did not know where the communicable statement was. Class III	A 078		

RICK SCOTT
GOVERNOR



ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Toria's Assisted Living Facility II
613 Forest Hills
Brandon, FL 33510

Dear Administrator:

This letter reports the findings of a monitoring visit that was conducted on , 2013, 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 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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

