

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER CASA DE LA ROSA		STREET ADDRESS, CITY, STATE, ZIP CODE 833 EISENHOWER BLVD LEHIGH ACRES, FL 33974		
(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)	
{A 000}	Initial Comments On _____ a follow-up survey was completed at Casa De La Rosa an Assisted Living Facility (ALF). The following is a description of continued non-compliance:	{A 000}		
A 056	58A-5.0185(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) No prescription drug shall be kept or administered by the facility, including assistance with self-administration of medication, unless it is properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and 2. Identification of each medicinal drug product in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no person other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider shall be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations shall be specified, for example, "as needed for pain, not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the	A 056		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6890

LQV012

If continuation sheet 1 of 6

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A 056	Continued From page 1 health care provider and the signature of the staff who obtained them, shall be noted in the medication record, or a revised label shall be obtained from the pharmacist. (d) Any change in directions for use of a medication for which the facility is providing assistance with self-administration or administering medication must be accompanied by a written medication order issued and signed by the resident's health care provider, or a faxed copy of such order. The new directions shall promptly be recorded in the resident's medication observation record. The facility may then place an "alert" label on the medication container which directs staff to examine the revised directions for use in the MOR, or obtain a revised label from the pharmacist. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed copy of a signed order is acceptable. (f) The facility shall make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 64F-12.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which shall also include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they shall be kept in a container that	A 056	

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A 056	Continued From page 2 bears a label containing the following: 1. Practitioner 's name; 2. Resident 's name; 3. Date dispensed; 4. Name and strength of the drug; 5. Directions for use; and 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident 's health care provider shall provide the resident with a written prescription, or a fax copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to contact the health care provider and request revised instructions for "As needed" medication to include the appropriate indication for use and any limitation of use for 1 (Resident #4) of 4 records reviewed. The findings include: The Medication Observation Record (MOR) for Resident #4 for _____ found two entries for _____ 0.5 mg. The first entry stated, _____ 0.5 mg once a day "As needed." There was no indication on the MOR as needed for what. The entry had 2 scheduled times listed, 8:00 a.m. and 6:00 p.m. The second entry stated, _____ 0.5 mg twice a day. The MOR indicated that the scheduled time of administration is at 8:00 a.m. and 6:00 p.m. There was no indication for use on the entry. On the "As needed" entry it was initialed as being given at 8:00 a.m. on _____ & _____ The second entry on the MOR for the routine _____ 0.5 mg to be given twice a day was also marked as being given at 8:00 a.m. on _____ & _____	A 056			

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A 056	Continued From page 3 Resident #4's record contained a consult report with the medication recommendation of 0.5 mg twice a day and 0.5 mg once a day "As needed." There was no indication on the consult as the indication for use of the as needed On _____ at 12:30 p.m., the Administrator stated that no clarification for the use of the 0.5 mg as needed has been requested or received. Class III		A 056		
(A 181)	58A-5.026(2) FAC Emergency Mgmt - Plan Approval (2) EMERGENCY PLAN APPROVAL. The plan shall be submitted for review and approval to the county emergency management agency. (a) The county emergency management agency has 60 days in which to review and approve the plan or advise the facility of necessary revisions. Any revisions must be made and the plan resubmitted to the county office of emergency management within 30 days of receiving notification from the county agency that the plan must be revised. (b) Newly-licensed facility and facilities whose ownership has been transferred, must submit an emergency management plan within 30 days after obtaining a license. (c) The facility shall review its emergency management plan on an annual basis. Any substantive changes must be submitted to the county emergency agency for review and approval. 1. Changes in the name, address, telephone		(A 181)		

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{A 181}	Continued From page 4 number, or position of staff listed in the plan are not considered substantive revisions for the purposes of this rule. 2. Changes in the identification of specific staff must be submitted to the county emergency management agency annually as a signed and dated addendum that is not subject to review and approval. (d) The county emergency management agency shall be the final administrative authority for emergency management plans prepared by assisted living facilities. (e) Any plan approved by the county emergency management agency shall be considered to have met all the criteria and conditions established in this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have their Emergency Plan approved by the county emergency management agency. The findings include: On _____ at 12:45 p.m., the Administrator stated their Emergency Plan has not been approved. The Administrator stated that she is waiting on the Fire Marshall to sign off on the plan so that she can submit it to the county emergency management agency. The facility had no documentation of having their Emergency Plan approved by the county emergency management agency. Class III	{A 181}		

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State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11968023	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 4/23/2013
Name of Facility CASA DE LA ROSA		Street Address, City, State, Zip Code 833 EISENHOWER BLVD LEHIGH ACRES, FL 33974

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>A0004</u> Reg. # <u>58A-5.016 FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0008</u> Reg. # <u>58A-5.0181(2) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0050</u> Reg. # <u>58A-5.0185(1) FAC</u> LSC _____	Correction Completed
ID Prefix <u>A0054</u> Reg. # <u>58A-5.0185(5) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0085</u> Reg. # <u>58A-5.0191(6) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0093</u> Reg. # <u>58A-5.020(2) FAC</u> LSC _____	Correction Completed
ID Prefix <u>A0162</u> Reg. # <u>58A-5.024(3) 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
Reviewed By _____ State Agency _____	Reviewed By <u>[Signature]</u> CMS RO _____	Date: <u>4-30-13</u>	Signature of Surveyor: <u>[Signature]</u> J. Alter, HFE II	Date: <u>4-30-13</u>	
Followup to Survey Completed on: _____		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO			



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Casa De La Rosa
833 Eisenhower Blvd
Lehigh Acres, FL 33974

Dear Administrator:

This letter reports the findings of a Biennial revisit survey 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 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 (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosures: State Form and Revisit Report

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



Fort Myers Field Office
2295 Victoria Avenue, Room 340
Fort Myers, FL 33901
Phone (239) 335-1315; Fax (239) 338-2372