STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965449	08/01/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Quality Care Of Florida, Inc.	1261 Tumbleweed Drive Orange Park, FL 32065	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

"Revised Copy"

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - N277 - 58a-5.031(2) Fac - Lns - Resident Care Standards S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Limited Nursing Services (LNS) licensure survey was conducted at Quality Care of Florida, Inc. in Orange Park, Florida on 2013. Licensure deficiencies were identified as a result of the survey.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, record review and staff interview, the facility failed to ensure that were limited to half-bed rails, and only upon the written order of the resident's physician for 1 of 2 sampled residents. (Resident #6) The facility also failed to ensure resident access to adequate and appropriate health care consistent with established and recognized standards within the community for 1 of 1 sampled residents. (Resident #1)

The findings include:

During a tour of the facility on at approximately 9:30 AM Resident #6 was observed with a full-bed rail on the left side of her bed. There was also a partial bed rail on the right side of her bed.

A review of Resident #6's clinical record revealed no orders for bed rails.

An interview with the administrator on at approximately 10:15 AM confirmed that there were no orders for Resident #6's bed rails. The administrator said that the rails were on the bed when she received it, and that she would have them removed right away. She said that she was unaware that a resident could not have full side rails in an assisted living facility.

At approximately 12:00 PM on during medication pass, Employee C was observed sitting on the floor beside the medication cart with the medication observation record (MOR) also on the floor. She was observed leafing through the MOR with her bare hands as well as touching the floor. She opened the bottom drawer of the medication cart, and pulled a pack of pills out. She popped a pill from the pack directly into her bare hand that had just touched the MOR and the floor before placing it in a medication cup for a resident.

An interview with Employee C on at approximately 12:00 PM revealed that she was unaware that she could not use her bare hands to handle medication as she had just sanitized them. When reminded that she had touched the MOR and the floor after sanitizing, she acknowledged that her hands had been soiled, and that she should not have handled the medication. She disposed of the pill, sanitized her hands, and popped a new pill directly into a medication cup without touching it.

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0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation and resident interview, the facility failed to assist residents with self-administered medications in accordance with procedures described in Section 429.256 F.S. (Florida Statutes) for 2 of 2 sampled residents (Residents #1 and #3), and failed to ensure that administration of medication through a was completed by licensed staff for 1 of 1 sampled residents. (Resident #1)

The findings include:

On at approximately 9:20 AM a clear plastic cup containing seven pills and labeled with Resident #3's name was observed sitting on a table in the sun the facility beside a clear plastic cup of water. Resident #3 was sitting at the table completing her glucose test. At approximately 9:45 AM the same plastic cup with the pills in it and the plastic cup of water were observed sitting on the same table. No one was in the

An interview with Resident #3 at approximately 9:20 AM confirmed that the medications belonged to her and that she was going to take them "in just a minute".

An interview with Employee B on at approximately 9:45 AM revealed that she had poured the medication for Resident #3. She acknowledged that she did not stay to watch the resident take her medication. During the interview, Employee B handed the cup of medication for Resident #3 to Employee C and asked her to deliver the medication to the resident. Employee C took the medication to Resident #3 and watched her take the medication.

An interview with the administrator on at approximately 10:15 AM revealed that she was aware that the staff assisting with medications were supposed to watch each resident take their medication.

At approximately 12:00 PM on Employee C was observed during medication pass. When she entered Resident #1's take him his medication, she handed him the souffle cup containing the pill, but she did not read the medication label to the resident or tell the resident what the medication was for. Employee C simply said, "It's time for your pill, Resident Name. Could you sit up and take it?"

An interview with Employee C on at approximately 12:05 PM revealed that she was unaware that she was supposed to explain the medications to the residents when assisting with self-administration of medication.

At approximately 12:10 PM on Employee C was observed during medication pass. She entered Resident #1's picked up his took the top of it off, opened the vial of medication, and poured it into the She replaced the top and handed the to Resident #1. She had to instruct Resident #1 to "put on your breathing treatment" several times before he complied.

An interview with Employee C on at approximately 12:15 PM revealed that she was unaware that she was not supposed to dispense Resident #1's medication into the his

Class III

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0053-Medication - Administration 58A-5.0185(4) FAC
Based on observation, staff interview and record review, the facility failed to ensure that the conducting of glucose testing was performed by a licensed nurse for 1 of 1 sampled residents. (Resident #1)

The findings include:

Observation of medication pass on at approximately 12:00 PM revealed that Resident #1 was unable to independently perform his glucose test. Employee C was observed placing her right hand over the resident's right hand assisting him to prick the index finger on his left hand. Employee C then handed Resident #1 a test strip for the on his left index finger. Resident #1 sat holding the test strip and looking at Employee C. He did not speak. Employee C then placed her right hand over Resident #1's right hand and guided the test strip to the on the resident's left index finger. Employee C took the test strip and placed it in the glucometer. She told Resident #1 what his result was and handed him an wipe to clean the from his left index finger. Employee C had to instruct Resident #1 to wipe off his finger.

A review of the personnel file for Employee C revealed that she was a Caregiver/Med Tech and not a licensed nurse.

An interview with Employee C on at approximately 12:15 PM confirmed that she was not a licensed nurse. When asked, Employee C acknowledged that she was assisting the resident with his glucose test, and that she knew he was supposed to do it himself.

An interview with the administrator on at approximately 12:15 PM confirmed her understanding that unlicensed personnel were not to assist with glucose testing.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation and staff interview, the facility failed to ensure that a prescription drug was kept in a customized, patient-labeled medication package for 1 of 2 residents sampled. (Resident #1)

The findings include:

During observation of medication pass for Resident #1 on at approximately 12:00 PM, the resident's vial was pulled out of an unmarked packet. The packet accurately identified the medication inside, however there was no label on the packet indicating who the medication was prescribed for.

A review of Resident #1's MOR on confirmed that was ordered for this resident.

An interview with Employee C on at approximately 12:00 PM revealed that the medication was prescribed for Resident #1, and Employee C knew this because it was in Resident #1's medication drawer. When asked, Employee C said that the facility no longer had the box that the medication came in, and the box was what was labeled. Employee C acknowledged that the labeled box should have been kept.

Class III

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N277-LNS - Resident Care Standards 58A-5.031(2) FAC
Based on record review and staff interview the facility failed to employ or contract with a nurse(s) who shall be available to provide such services as needed by all potential Limited Nursing Services residents.

The findings include:

A review of the Limited Nursing Services (LNS) file on revealed a contract with a registered nurse for LNS services which was not signed by the registered nurse.

An interview with the administrator on at approximately 10:30 AM revealed that she was unaware that the contract was not signed. She acknowledged that a contract must be signed in order to be binding.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

REVISED COPY

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

Dear Administrator:

This letter reports the findings of a state licensure Limited Nursing Services survey that was conducted on 2013 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) 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

Sincerely,

Keisha Woods, MPH
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JV/KW/sm
Enclosure

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