STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965449	10/16/2013
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)		

Revisit Corrected Tags:
0053-Medication - Administration-10/16/2013

Revisit Repeat Tags:
0000-Initial Comments-
0030-Resident Care - Rights & Facility Procedures-58a-5.0182(6) Fac; 429.28 Fs
0052-Medication - Assistance With Self-Admin-58a-5.0185(3) Fac
0056-Medication - Labeling And Orders-58a-5.0185(7) Fac
N277-Lns - Resident Care Standards-58a-5.031(2) Fac

Revisit New Tags:
0057-Medication - Over The Counter (otc) Products-58a-5.0185(8) Fac
0077-Staffing Standards - Administrators-58a-5.019(1) Fac
0084-Training - Assis Self-Admin Meds & Med Mgmt-58a-5.0191(5) Fac
0152-Physical Plant - Safe Living Environ/other-58a-5.023(3) Fac
0160-Records - Facility-58a-5.024(1) Fac

0000-Initial Comments

A Limited Nursing Services (LNS) revisit survey was conducted at Quality Care of Florida, Inc. on 2013. Deficiencies were identified.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, record review, and interview with staff, 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 #3). The facility also failed to ensure adequate and appropriate health care consistent with established community standards for 1 of 2 sampled residents (Resident #1 and #3).

The findings include:

1. During a tour of the facility on at 10:15 AM, Resident #3's inspected. She had a bed, which had one full-bed rail on the left side of the bed, and one half bed rail on the right side of the bed.

A record review conducted for Resident #3 found there were no physician's orders or written consents for the bed rails, and no hospice services being provided to the resident.

An interview was conducted with the facility manager on at 11:00 am. She confirmed the presence of the bed rails without physician's orders, and that she still had not removed them from the resident's bed. She stated she consulted with a medical supply company for the removal of the rails, however they wanted to charge her $195.00. She acknowledged full bed rails were not permitted in the facility, and stated she would have them removed.

2. Assistance with self-administration of medication was observed on at 9:15 am. Employee #5, a Caregiver, told Resident #1 it was time for her medication. The employee washed her hands, and pushed the

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medication cart to the breakfast table. After dispensing several of Resident #1's medications directly from their unit dose cards into a small medicine cup, the Caregiver retrieved and opened a bottle of Centrum . She poured one of the tablets into her bare hand, then transferred it into the medication cup. She repeated this process, using her bare hand to transfer Resident #1's glimipiride, high potency , and her D3 pills.

At 9:42 am, Resident #3 came to the kitchen table. Employee #5 washed her hands and dispensed several medications from their unit dose cards directly into a small medicine cup. She then poured one tablet into her bare hand from its bottle and transferred it into the medicine cup. She repeated this with Resident #3's D3, using her bare hands to place the pill into the med cup.

An interview was conducted with Employee #5 on at 9:57 am. She acknowledged she should not have used her bare hands to handle medications for Residents #1 and #2.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation of assistance with self-administration of medications, and staff interview, the facility failed to adhere to proper procedures described in Section 429.256 F.S. (Florida Statutes) for 2 of 2 sampled residents who took medications during the survey(Residents #1 and #3).

The findings include:

Assistance with self-administration of medication was observed on at 9:15 am. Employee #5, a Caregiver, told Resident #1 it was time for her medication. Without reading the medication label to the resident, she dispensed the following medications into a medication cup and gave it to Resident #1: Centrum 2.5 milligrams (mg), doc-q-lace capsule, 5 mg, 25 mg, 15 mg, glimipiride 2 mg, high potency 81 mg, and D3. Before the resident finished her medications, Employee #5 left the table to make breakfast for another resident, and then administered medications to Resident #3. Resident #1 remained at the table with her medications in her hand, slowly taking one at a time. She was left unsupervised during this activity, which took over 15 minutes to complete.

At 9:42 am on Resident #3 came to the kitchen table. WIthout reading the medication labels to the resident, Employee #5 dispensed the following into a small cup, and handed it to the resident: B12 , D3, 5 mg, 20 mg, 25 mg, and 2.5 mg.

An interview was conducted with Employee #5 on at 9:57 am. She acknowledged she neglected to read the medication labels to both Residents #1 and #2. She also confirmed she did not directly supervise Resident #1 while she took all of her medication, per the statute.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation, record review and staff interview, the facility failed to obtain a written order clarification or change in directions by the resident ' s health care provider for 1 of 2 sampled residents (Resident #3) who received assistance with the self-administration of medication during the survey.

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The findings include:

An observation of assistance with self-administration of medication for Resident #3 was conducted on at 9:42 am. Employee #5 proceeded to dispense several medications into a small medicine cup for Resident #3. She then retrieved an over-the-counter bottle of 2500 microgram (mcg) tablets. She dispensed one (1) into the small cup, and handed the cup to the resident, who then took her medications independently.

A record review conducted for resident #3 found an AHCA form 1823 (Resident Health Assessment) dated and signed by the examining practitioner. It noted Resident #3 was to receive 5000mcg of every day. In contrast, review of the Medication Observation Record (MOR) indicated Resident #3 was to receive 5000 mcg of on Wednesday, Friday, and Sunday only. There were no clarification or direction change orders for this medication in Resident #3's clinical record.

An interview was conducted with Employee #5 on at 11:15. She confirmed she only dispensed one (1) 2500 mcg B12 tablet to Resident #3 earlier in the morning. She stated she did not realize that the physician's order was for 5000 mcg daily, or that the MOR noted she was to receive the on only three days per week.

Class III

0057-Medication - Over The Counter (OTC) Products 58A-5.0185(8) FAC
Based on an observation of resident medications, and interview with the facility manager, the facility failed to ensure over the counter (OTC) medications, including those prescribed by a licensed health care provider, were labeled with the resident ' s name for 1 of 2 sampled residents (Resident #1).

The findings include:

An observation of Resident #1's medications on at 9:15 am found the following OTC medications stored in the medication cart: centrum , high potency B12 1000 mcg, low dose 81 mg and D3 1000 mg tablets. The medications were in the manufacturer's bottle, however none of the bottles were labeled with the resident's name.

An interview conducted with the facility manager on at 12:10 pm confirmed none of the over-the-counter bottles for Resident #1 were labeled with her name. She stated she would write the resident's name on all of the bottles immediately.

Class III

0077-Staffing Standards - Administrators 58A-5.019(1) FAC
Based on observations, staff interview, and facility and resident record reviews, the Administrator failed to sufficiently supervise the operation and maintenance of the facility including management of staff and provision of care to the residents. This is evidenced by Administration's failure to correct deficient practices cited in the most recent Limited Nursing Services (LNS) survey conducted by a representative of this office on

The findings include:

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A LNS survey was conducted by a representative of this office on , and deficient practice was identified at A0030, A0052, A0056 and AN277.

During the LNS revisit on , at 8:30 am, it was determined corrections had not been made. Interviews conducted with the facility manager on between 8:30 am and 2:00 pm confirmed the findings still had not been corrected.

Class III

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC
Based on observation, employee file review and interview with the facility manager, the facility failed to provide proof of the required training in assistance with self-administered medications for 1 of 4 sampled employees (Employee #5).

The findings include:

An observation of Employee #5 (hired in 2013 as a Caregiver) on at 9:15 am found her assisting Resident #1 with the self-administration of medications. The employee retrieved Resident #1's medication from a locking medication cart, dispensed them into a small cup, and handed them to the resident to take. She documented on the Medication Observation Record (MOR) that she had dispensed the medications for Resident #1. At 9:40 am on , Employee #5 was again observed to repeat this procedure with Resident #3.

There was no personnel file available for review at the time of survey for Employee #5. The facility manager stated in an interview at 1:55 pm on that Employee #5 had been hired in of 2013, and the entire personnel file was at her home for completion. The manager stated she would fax the information to the office by the end of the work week. This information was never received.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observation and interview with the manager, the facility failed to ensure a safe and hazard-free living environment by neglecting to safely store canisters in 1 of 4 resident In addition, the facility failed to ensure the safety of all 6 residents (Residents #1, #2, #3, #4, #5 and #6) by permitting transfilling of portable canisters in a resident care area of the facility.

The findings include:

During an observation of at 10:45 am on , two 45 litre dewers and 6 small canisters were seen sitting on the floor. The small canisters were not in an approved storage rack, nor were they affixed to the wall in any way.

An interview with Resident #5 at 10:53 on found the two large dewars were hers, and she utilized them for refilling her portable tank. She stated she was able to perform this task independently in her

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Review of the 1999 edition of the NPFA (National Fire Protection Association) 99 Health Care Facilities Handbook specifies containers must be kept in place using "stable racks or fastenings to protect them from falling." The guidelines for the indoor storage and transfilling requirements for liquid (revised instruct that transfilling must: be "separated from a patient care area by a one hour fire-rated enclosure with 45-minute self-closing door and ceramic or concrete flooring." The guidelines also specify the be a nonombustable enclosure that is lockable."

An interview was conducted with the Administrator at 1:55 pm on She did not realize it was required to be secured in order to be stored safely. She stated she would have the provider correct the situation.

Class III

0160-Records - Facility 58A-5.024(1) FAC
Based on observation, a review of facility records, and interview with the manager, the facility failed to maintain an up-to-date admission and discharge log which included all required information for 1 unsampled resident (Resident #6) who resided in the facility for respite care.

The findings include:

A tour of the facility on at 10:15 am and concurrent interview with the facility manager found there were 6 residents residing in the facility. She stated Resident #6 was being discharged this same day, and moved into the facility on for a short term, respite stay.

A review of the facility admission and discharge log reflected only 5 residents in the facility (Residents #1, #2, #3, #4 and #5).

An interview with the facility manager was conducted on at 10:45 am. She stated she did not realize she was required to record the required information on the admission and discharge log for Resident #6's respite stay.

Class III

N277-LNS - Resident Care Standards 58A-5.031(2) FAC
Based on record review and staff interview, the facility failed to contract with a nurse(s) for the provision of services as needed by potential Limited Nursing Services (LNS) residents.

The findings include:

A review of facility records revealed the contract with a Registered Nurse for LNS services was not signed by a Registered Nurse (RN).

An interview was conducted with the facility manager on at 1:20 pm. She confirmed that the contract was still not signed. She stated she had not been able to contact the RN to obtain a signature for the contract.

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Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

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

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2013 by a representative of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and new deficiencies identified during the revisit.

All deficiencies shall be corrected no later than , 2013.

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 (904) 798-4201.

Sincerely,

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

LL/KW/sm
Enclosure

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