STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966815	09/10/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Circle Of Care (the)	4161 Sw Tumble St Fort Pierce, FL 34953	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0083 - 58a-5.0191(4) Fac - Training - First Aid And S-S= D
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0161 - 58a-5.024(2) Fac - Records - Staff S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Relicensure survey was conducted on at The Circle of Care. The facility had deficiencies found at the time of the visit.

0053-Medication - Administration 58A-5.0185(4) FAC
Based on observation and interview, the facility failed to ensure that the orders for medication regarding the timing of administration were followed and failed to compare the medications to the Physician's Order as documented on the Medication Observation Record, for 3 of 5 sampled residents (Resident #5, # 3 and R#4).

Findings include:
1) An observation of the Medication Pass was conducted on starting at 8:25 AM, after the six residents had finished eating their breakfast. The Medication technician removed the prepackaged medications for Resident # 5 from the medication cabinet at 8:25 AM , handed medications including to the resident, who consumed them at 8:33 AM .

The Medication technician then pulled the prepackaged medication packet for Resident # 3 and handed the medications including to the resident at 8:36 am, who consumed them at that time.

The Medication Technician removed the prepacked medication packet labeled for Resident # 4 at 8:44 AM and handed it to the resident.

Review of the Medication Observation Record (MOR) for resident # 5 revealed that the resident was to

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receive 50 mcg daily at 7 am before breakfast. The physician orders for Resident # 3 revealed that she was to receive 50 mcg daily at 7 am before breakfast. The physician's order for Resident # 4 revealed that she was to receive Dr. 500 mg before breakfast daily at 8 am.

At 10 :00 AM, the surveyor conducted an interview with the Administrator and the Medication Technician. The Medication Technician confirmed that she did not compare the prepackaged medications to the MOR to ensure that she was providing the appropriate medications. The Medication Technician confirmed that she should have administered the to Residents # 5 and #3 prior to breakfast at 7 AM and 7:30 AM, as physician ordered and documented on the MOR. The Medication technician also confirmed that she should have administered the to Resident # 4 before and not after breakfast in accordance with the Physician' orders.

The Administrator was present during the interview and stated that the Medication Technician failed to compare the medications to the MOR and then open the prepackaged medication packets in front of the resident. He confirmed that the medications for all 3 residents were not given in accordance with physician orders regarding the timing of the medications.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to ensure that medications were locked and secure when staff were out of sight of the medications during the medication pass observation, for 1 of 1 medication cabinets observed.

Findings include:

The Surveyor arrived the Medication Technician start the Medication Pass at 8:25 AM on She opened the cabinet and placed the box of medications for Resident #5 on the kitchen counter, tore off the prepackaged dose and walked over to the formal dining handed the medications to the resident.

The Technician returned to the unlocked cabinet and put the box of medications for Resident # 5 back in the cabinet and pulled the box of medications for Resident # 3 from the cabinet. The resident had returned to her , so the technician went to the resident to provide her with the medications, leaving the cabinet unlocked and it's contents available to other staff and residents. The resident was

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agitated and refused the medications. The technician returned to the open cabinet and pulled medications for Resident # 2 and handed them to the resident who was still seated at the dining table. The Medication Technician then returned to the kitchen to pull the medications for Resident # 4 at 8:37 AM. The resident had returned to her so the technician left the medication cabinet unlocked and went to the resident's to give her the medications. The technician returned to the kitchen and the unsecured medications to pour the medications for Resident #1.

At 10:00 AM. the Surveyor conducted an interview with the Medication Technician. She confirmed that she should have locked the medication cabinet and not left the box of medications unsecured when she went to the of Residents # 3 and #4. The Administrator was present and confirmed that the medication cabinet should be secured when ever the technician leaves the

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC

Based on observation, record review and interview, the facility failed to ensure that 1 out of 4 employees (Staff D) completed a 1-hour training in Control prior to providing direct care to residents.

The Findings Include:

An observation during the initial tour of the facility on at 8:18 AM was made of a person presumed to be an employee at the facility (Staff D). Staff D was observed sitting in the the live-in staff sleep.

Staff D stated she does not have any direct contact with the residents. When this writer asked what she does with the residents, she stated if Staff A is busy, she will transfer someone to the toilet but will not do anything after that. She stated she does not dispense medications. She stated she has been "helping out" for approximately one week at this facility.

In an interview conducted on at 8:30 AM, the Administrator stated Staff D is a family member and only does housekeeping. The Administrator stated Staff D will walk residents to the toilet but not do anything else. He stated Staff D started "helping out" on and her last day would be

The Administrator acknowledged he had no paperwork for Staff D on file, including Control

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training. According to the Administrator, Staff D's hire date was

Class III

0083-Training - First Aid and 58A-5.0191(4) FAC

Based on record review and interviews, the facility failed to ensure that 3 out of 4 staff members (Staff A, B, and C) hold a current valid card from an accredited organization and that a staff member has completed the training who works in the facility by themselves.

The Findings Include:

Record review of Staff A's employee records indicated she did not have a valid card in her file. Review of the staffing scheduled revealed that Staff A works 24-hour shifts by herself.

Further record review revealed Staff C had a card on file with an expiration date of In an interview conducted on at 9:28 AM, the Administrator acknowledged he did not know that training must be done by an accredited hospital, an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American Association, or National Safety Council, or a provider approved by the Department of Health. He also acknowledged the fact that Staff B's training (dated was not completed by one of the aforementioned organizations. He also confirmed aforementioned staff members work in the facility at various times alone.

Class III

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC

Based on observation, record review, and interview, the facility failed to ensure that 1 out of 4 sampled employees (Staff A) completed a 4-hour initial course on Assistance with Self-Administered Medication and Medication Management.

The Findings Include:

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A review of Staff A's personnel file revealed a 2-hour continuing education course on Self-Administered Medication and Medication Management dated . However, no certificate was found in Staff A's file indicating completion of a 4-hour initial course in the aforementioned topic.
Staff A was observed on dispensing medications to the residents.

In an interview conducted on at 9:28 AM, the Administrator stated there should be a 4-hour certificate in her file but he could not produce it.

Class III

0161-Records - Staff 58A-5.024(2) FAC

Based on observation, record review and interview, the facility failed to ensure that all direct-care staff have a completed employment application on file, for 1 out of 4 sampled employees (Staff D).

The Findings Include:

An observation during the initial tour of the facility on at 8:18 AM was made of a person presumed to be an employee at the facility (Staff D). Staff D was observed sitting in the the live-in staff sleep.

Staff D stated she does not have any direct contact with the residents. When this writer asked what she does with the residents, she stated if Staff A is busy, she will transfer someone to the toilet but will not do anything after that. She stated she does not dispense medications. She stated she has been "helping out" for approximately one week at this facility.

In an interview conducted on at 8:30 AM, the Administrator stated Staff D is a family member and only does housekeeping. The Administrator stated Staff D will walk residents to the toilet but not do anything else. He stated Staff D started "helping out" on and her last day would be

The Administrator acknowledged he had no paperwork for Staff D on file.

Class III

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Circle Of Care (The)
4161 SW Tumble St
Fort Pierce, FL 34953

RE: Abbreviated Relicensure with Limited Nursing Services

Dear Administrator:

This letter reports the findings of a State Licensure Survey that was conducted on 10, 2014 by a representative from 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 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 representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

XG90

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