STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968121	07/23/2015
NAME OF PROVIDER OR SUPPLIER R AND C ULTIMATE CARE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2660 SE WESTSIDE AVE PALM BAY, FL 32909	

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

0000 Initial Comments

The biennial re-licensure survey was conducted on . . . . R & C Ultimate Care, LLC had deficiencies found at the time of the visit

0052 Medication - Assistance with Self-Admin

Based on observation and interview the facility failed to ensure when unlicensed staff provided assistance with the self-administration of medications, the staff followed the appropriate procedure at all times for 1 of 9 sampled residents (#4)

Findings:

Observation of the medication pass on / at approximately 8:06 am was completed by Staff C, she washed her hands and took the medication, in its previously dispensed, properly labeled container from the locked file cabinet. Staff C checked the medication against the MOR (Medication Observation Record). Staff C then popped all the pills in the bubble package into a small silver cup. Staff C then handed the cup to resident #4 and said "here is your medication". Staff did not read the label to the resident.

In an interview with the administrator on / at approximately 2:45 pm she stated she did not realize the staff was not following the correct procedure for assistance with self-administration of medication.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
R And C Ultimate Care, LLC
2660 Se Westside Ave
Palm Bay, FL 32909

RE: Relicensure

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representative(s) 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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(s). Should you have any questions please call Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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