RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Family Connect Life Inc
7969 Pinehurst Drive
Spring Hill, FL 34606

RE: CCR #2016009074

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) of this office.

Enclosed 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** 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 Chuck Bory at 386-462-6201.

Sincerely,

Charles Bory

Kriste J. Mennella
Field Office Manager

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KJM/CB
Enclosure
XG90

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967453	10/28/2016
NAME OF PROVIDER OR SUPPLIER **FAMILY CONNECT LIFE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **7969 PINEHURST DRIVE** **SPRING HILL, FL 34606**	

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

0000 Initial Comments

An unannounced complaint survey (CCR#2016009074) was conducted at Family Connect Life, Inc. (facility license number 11521). Deficiencies were identified.

0030 Resident Care - Rights & Facility Procedures

Based on observation, record review and interview, the facility failed to provide access to adequate and appropriate health care for 3 of 4 residents (Resident #1, #2 and #3).

Findings:

During the interviews with Residents #1, #2 and #3, on beginning at 8:10 AM, they stated the Administrator decided to change physicians. They denied requesting a change. They did not know who their physician was going to be. They like the Nurse Practitioner whose services were just canceled by the Administrator. Resident #1 showed this surveyor his shoulders which had a small round -Aid just below his neck. The area was dry with no pinkness and a small hard area like a scab, could be seen through the -Aid. He stated he had a pimple which grew to a boil, and was lanced at the hospital emergency . There was no other issue.

During an interview with the Patient Care Coordinator with the Case Management Group who makes the decisions about Resident #1, on at approximately 11:00 AM, she confirmed they were removing the residents in the home which were under their caseload. The only resident, from their caseload, left in the home was Resident #1. They stated his processing was complete and he would move /// (in 4 more days). They stated he had been informed . They confirmed the reason was lack of proper attention/understanding/response to the resident's medical needs by the Administrator. She stated the Administrator was informed.

During an interview with the Registered Nurse Practitioner, on at 9:00 AM, she stated the Administrator had ignored doctor's orders for keeping a dressing on the boil which had been lanced on Resident #1's back. She stated Resident #1's kidney is becoming worse. While the resident goes to a nephrologist, the Nurse Practitioner stated she does not believe the Administrator understands the gravity of the situation. She stated she had to spend time showing her how to keep the Medication Observation Record current. She said she had to explain the recommendations and doctor's orders to her repeatedly. She stated the Administrator decides if she is going to follow the orders. She did not provide any documentation of any of these conversations. She said either last week or the week before, the Administrator complained to her agency and asked to have the Nurse Practitioner removed from her facility. The contract between the agency and the home was canceled at that time.

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Review of Resident #1, #2 and #3's records revealed new applications had been completed, but not signed for, for a new physician service. The applications had not been turned into the physician's office.

During an interview with the Administrator, on at 10:45 AM, she stated the Nurse Practitioner cannot come back to her house. She said she was afraid she would be fined. She said she does not trust the Nurse Practitioner. She denied not following orders. She repeated several times about conflicts between nursing recommendations that were slightly different, but she did not discuss how Resident #1's pimple became a boil. She said she makes the decisions about who is providing the physician's services in this home. She had no response about giving the resident choices. The Administrator denied Resident #1 was moving out of the home. She denied any problems with the case management group overseeing his circumstances.

Class III

0054 Medication - Records

Based on observation, record review and interview, the facility failed to maintain a current Medication Observation Record for 1 of 2 residents taking medications in the facility (Resident #1).

Findings:

During an interview with Resident #1 on at 9:35 AM, he stated he received all his medications before 8:00 AM. He stated there are only 2 residents of the 4, who get medications in the facility.

Review of Resident #1's 2016 Medication Observation Record (MOR), revealed it was completed only through . The medication given to Resident #1, before 8:00 AM on , 0.4 mg, was not documented/initialed as given on the MOR.

During an interview with the Administrator, who was present during the review on /16 at 9:30 AM, she took the MOR immediately from the surveyor and insisted on filling the empty blanks before allowing it to be reviewed again. This Administrator stated she had been told again by the Nurse Practitioner she just fired , how to complete the MOR . She said they discussed the importance of the documentation.

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0055 Medication - Storage and Disposal

Based on observation and interview, the facility failed to maintain all medications in a secured manner for 2 of 4 residents (Resident #1 and #3).

Findings:

An observation was conducted on at 8:00 AM, of the area where medications are dispensed for 2 of 4 residents in the facility who receive medications, revealed a loose white pill on top of a desk. The 's door was open to anyone. The pill was visible from the hallway in front of the door. The pill had a 4 on it and was scored if there was a need to split the pill in half . There was no name on the pill (Picture taken).

During an interview with the Administrator on at 8:05 AM, she stated medication passage was over about an hour earlier. She grabbed the white pill off the desk when it was pointed out to her. Initially, she did not say who the medication was for or the name/kind of medication. A short time later, she stated it was hers. She said it was . She had no response as to why her medications were in the same the residents. She provided no policies for medications storage. She provided no bottle for the pill or label.

Class III