

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963865	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED _____
NAME OF PROVIDER OR SUPPLIER EMERITUS AT SPRINGTREE			STREET ADDRESS, CITY, STATE, ZIP CODE 4201 SPRINGTREE DRIVE SUNRISE, FL 33351		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	Initial Comments Complaint Surveys: CCR #2012004289 - One of three allegations was substantiated. CCR #2012004929 - The allegation was not substantiated. CCR #2012005987 - The allegations were not substantiated. These complaint surveys were conducted on _____ Emeritus at Springtree had a licensure deficiency found at the time of the visit related to the allegations reviewed.	A 000			
A 056 SS=D	58A-5.0185(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) No prescription drug shall be kept or administered by the facility, including assistance with self-administration of medication, unless it is properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident 's name; and 2. Identification of each medicinal drug product in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no person other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are " as needed " or " as directed, " the health care provider shall be contacted and requested to provide revised instructions. For an " as needed " prescription,	A 056			

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0000

2FYH11

If continuation sheet 1 of 4

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963865	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER EMERITUS AT SPRINGTREE			STREET ADDRESS, CITY, STATE, ZIP CODE 4201 SPRINGTREE DRIVE SUNRISE, FL 33351		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 056	Continued From page 1 the circumstances under which it would be appropriate for the resident to request the medication and any limitations shall be specified; for example, "as needed for pain, not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, shall be noted in the medication record, or a revised label shall be obtained from the pharmacist. (d) Any change in directions for use of a medication for which the facility is providing assistance with self-administration or administering medication must be accompanied by a written medication order issued and signed by the resident's health care provider, or a faxed copy of such order. The new directions shall promptly be recorded in the resident's medication observation record. The facility may then place an "alert" label on the medication container which directs staff to examine the revised directions for use in the MOR, or obtain a revised label from the pharmacist. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed copy of a signed order is acceptable. (f) The facility shall make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 64F-12.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging,	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963865	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER EMERITUS AT SPRINGTREE		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 SPRINGTREE DRIVE SUNRISE, FL 33351		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 056	Continued From page 2 which shall also include the practitioner 's name, the resident 's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer 's labeled package, they shall be kept in a container that bears a label containing the following: 1. Practitioner 's name; 2. Resident 's name; 3. Date dispensed; 4. Name and strength of the drug; 5. Directions for use; and 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident 's health care provider shall provide the resident with a written prescription, or a fax copy of such order. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide physician ordered medications for 1 of 5 sampled residents (#1). The findings are: Resident #1 's record was reviewed. The resident 's Health Assessment documented that the resident was a Dislipidemia, ASHD, and . There was a progress note dated . that the facility received word from the pharmacy that resident has not paid the pharmacy bill in months and so they would not be able to send the medications. The family was notified. On . the facility instructed the pharmacy to send the medications and send the bill to the facility. The Medication Observation Record (MOR) for 2012 was reviewed. All the resident 's medications were	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963865	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER EMERITUS AT SPRINGTREE			STREET ADDRESS, CITY, STATE, ZIP CODE 4201 SPRINGTREE DRIVE SUNRISE, FL 33351		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 056	Continued From page 3 circled for _____ and all of the morning doses were circled for _____. The medications included _____ 500 mg three times a day before meals, Amlodopine _____ 10 mg once a day, _____ 100 mg once a day, _____ 5 mg every morning, _____ 20 mg once a day, _____ 100 mg once a day, _____ 0.4 mg once a day and _____ 20 mg once a day. The back of the MOR documented that the medications were not given due to waiting for pharmacy to deliver. On _____ at 1:55 p.m. an interview was conducted with the DON. She said when the pharmacy contacted the facility about the unpaid bill, she called the family, but they told her they could not pay. The DON advised the family that the facility would cover the cost of the medications and bill the family. The DON was not able to explain why pharmacy did not notify the facility in a timely manner that the medications would not be refilled, and was not able to explain why facility staff were not aware that the medications were running out. Class III	A 056			



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Emeritus at Springtree
4201 Springtree Drive
Sunrise, FL 33351

Re: CCR #2012004289, #2012004929, & #2012005987

Dear Administrator:

This letter reports the findings of three complaint surveys conducted on _____, 2012 by a representative of this office. Attached is the provider's copy of the State Form 3020, which indicates the deficiencies identified on the day of the visit. Section 408.811(4), Florida Statutes, requires you correct these deficiencies within **thirty (30) days** of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after _____ 2012 to verify 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 this agency's representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

A.C. Ayres, H&E Supervisor
for Arlene Mayo-Davis
Field Office Manager

AMD/hl
Enclosure

