Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963806	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMOND IN THE PINES	101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174

(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 Two unannounced licensure complaint surveys, CCR# 2012005981 and CCR# 2012006819, was conducted on 2012. Ormond in the Pines had deficiencies found at the time of the visit related to CCR# 2012006819.	A 000		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963806	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMOND IN THE PINES	101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174

(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 025	Continued From page 1	A 025		

This Statute or Rule is not met as evidenced by:
Based on resident record review and staff interviews, the facility failed to offer appropriate supervision to 3 of 3 sampled residents (Residents #1, #2 and #4) by neglecting to notify the appropriate party when a change in condition necessitated additional services and treatment.

The findings include:

1. A record review conducted for Resident #1 revealed she was admitted , 2010. Per the AHCA Form 1823 (Resident Health Assessment) dated , 2010, her diagnoses included Fibrilation, Event,and generalized Resident #1 received hospice services for

Further record review found a referral to the on-site licensed psychologist for evaluation and treatment. The form was dated 2012 and noted the following problems: , family issues, and adjustment to health issues. The referral was signed and approved by the physician on this date. Progress notes from the on-site psychologist dating back to 2011 were located in Resident #1's record.

A power of attorney notification form dated 1, 2012 and signed by the psychologist noted Resident #1's Power of Attorney (POA) and other family participated in her treatment during her hospice period; however, there was no indication that the POA had been notified of the need for services, nor was signed consent for the treatment located in Resident #1's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963806	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMOND IN THE PINES	101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174

(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 025	Continued From page 2	A 025		

An interview was conducted with Resident #1's daugter (POA) at 1:20 pm on , 2012. The POA expressed surprise and concern over the discovery last year that her mother was receiving services from the on-site psychologist. She said her mother was seen for up to 6 months without her knowledge; the facility never informed her, nor obtained written consent as Resident #1's POA, for treatment. She did not know why her mother was being treated.

2. A record review was conducted for Resident #2, admitted , 2011. An AHCA Form 1823 (Resident Health Assessment) dated 2011 revealed she had diagnoses including Hyposmolian Type II, , and Chronic .
Further record review found a referral to the on-site psychologist for and family issues which was dated , 2012. The form had been stamped as being "faxed" to the physician; however, no physician signature or approval was observed. The resident's record reflected numerous visits by the on-site psychologist, with the most recent documented visit on , 2012. There was no signed consent for treatment by the POA in the resident's record.

3. A review of Resident #4's closed record revealed she was admitted , 2011. An AHCA Form 1823 (RHA) dated 2011 (no day specified) noted diagnoses including: , A-fib, and .

Resident #4 received hospice services while residing in the facility. A progress note by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963806	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMOND IN THE PINES	101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174

(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 025	Continued From page 3 on-site psychologist dated 2011 reflected a 20 minute visit. Further review of the resident record found no signed referral by the physician, and no signed consent for treatment by the POA. During a telephone interview at 8:45 am on 2012, Resident #4's POA stated she had never beed consulted about or authorized her mother's treatment by the psychologist, and requested it cease immediately once she discovered it had been initiated. She stated she saw no need for treatment since her mother already received counseling and support through Hospice. An interview was conducted with the Administrator at 4:00 pm on , 2012. She stated that the licensed psychologist directly obtained written consent for treatment from residents and/or their POAs. The Administrator insisted the consents were maintained by the psychologist rather than in the resident's records. When facsimile copies of the consents for Residents #1, #2 and #4 were requested for review, the Administrator changed her statement and said she was certain the psychologist did not have written consent. Class III Correction Date: 2012	A 025		
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963806	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMOND IN THE PINES	101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174

(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 030	Continued From page 4 Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida Hotline " 1(800)96 or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents. (e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements. (f) Residents may not be required to perform any work in the facility without compensation, except	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963806	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMOND IN THE PINES	101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174

(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 030	Continued From page 5 that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law. (g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside. (h) Pursuant to Section 429.41, F.S., the use of physical . . . shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963806	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMOND IN THE PINES	**101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174**

(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 030	Continued From page 6 (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a [redacted] his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963806	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMOND IN THE PINES	101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174

(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 030	Continued From page 7 (k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. This Statute or Rule is not met as evidenced by: Based on resident records review and staff interviews, the facility failed to honor the residents' rights to make informed, independent and personal decisions regarding treatment necessitated by a change in condition for 3 of 6 sampled residents (Resident #1, #2 and #4). The facility also failed to protect 2 of 6 sampled residents (#5 and #6) right to privacy and	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963806	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMOND IN THE PINES	101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174

(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 030	Continued From page 8	A 030		

confidentiality by posting health information in a common area visible to all residents that used the dining .....

The findings include:

1). Record review for Resident #1 revealed she received hospice services for .

A pysician's referral was made on . 2012 to the on-site Licensed psychologist for evaluation and treatment. Identified problems included . family issues, ... and adjustment to health issues. Progress notes from the on-site Psychologist dating back to . 2011 were located in Resident #1's record.

A power of attourney notification form dated . 2012 and signed by the Psychologist, noted Resident #1's Power of Attorney (POA) and other family participated in her treatment during her hospice period; however, there was no indication that the POA had been notified of a change in condition necessitating the need for treatment. In addition, there was no acknowledgement or consent for treatment by the resident or the POA located in the resident's record.

An interview was conducted with Resident #1's daugter (POA) at 1:20 pm on . 2012 in the resident's apartment. The POA expressed surprise and concern over the discovery last year that her mother had been receiving services from the Psychologist. She said her mother was seen for up to 6 months without her knowledge; the facility never informed her, nor obtained written consent as Resident #1's POA, for treatment. She added she did not know why her mother was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963806	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMOND IN THE PINES	101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174

(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 030	Continued From page 9 being seen by the Psychologist. 2). Record review for Resident #2 revealed a referral to the on-site Psychologist dated , 2012 for problems including and family issues. The form had been stamped as being faxed to the physician, however no physician signature or approval was present. The resident's record reflected visits by the Licensed on-site psychologist as recent as , 2012. There was no signed acknowledgement or consent for treatment by the resident or her POA in the resident's record. 3). A review of Resident #4's closed record revealed she received hospice services while residing in the facility. A progress note for a 20 minute visit by the on-site Psychologist dated , 2011 was located in Resident #4's record. Further review of the resident record found there was no signed acknowledgement or consent for treatment by the resident or her POA. An interview was conducted with the Administrator at 4:00 pm on , 2012. She stated that the Licensed Psychologist obtained written consent for services and treatment from residents and their POA's. The Administrator insisted the consents were maintained by the Psychologist, and not in the facility or resident's records. When asked to request facsimile copies of the consents from the Psychologist for Residents #1, #2 and #4, the Administrator changed her statement and said she was certain the Psychologist did not have written consent. 4. A tour of the third floor dining , 2012 at 11:15 am revealed a cork board with a handwritten note on an 8 1/2 X 11 inch piece of paper. The note listed two residents by their first	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963806	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMOND IN THE PINES	101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174

(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 030	Continued From page 10 and last names (Residents #5 and #6), and reported food .next to their names. Any resident dining in the dining . . . . . l access to this personal information. During an interview with the administrator on , 2012 at 4:30 pm, she acknowledged the facility failed to protect these individuals' right to privacy. Class III Correction Date: . 2012	A 030		
A 092	58A-5.020(1) FAC Food Service - General Responsibilities Food Service Standards. (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator or a person designated in writing by the administrator shall: (a) Be responsible for total food services and the day to day supervision of food services staff. (b) Perform his/her duties in a safe and sanitary manner. (c) Provide regular meals which meet the nutritional needs of residents, and therapeutic diets as ordered by the resident ' s health care provider for resident ' s who require special diets. (d) Maintain the in-service and continuing education requirements specified in Rule 58A-5.0191, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation of the holding kitchen	A 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963806	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMOND IN THE PINES	101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174

(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 092	Continued From page 11	A 092		

refrigerator and interviews with food service staff, the facility failed to store food in a safe and sanitary manner.

The findings include:

During a tour of the facility on , 2012 at 11:08 am, observation of the third floor holding kitchen revealed two loaves of bread in open containers, and four containers of breakfast cereal without dates. Observation of the reach-in holding kitchen refrigerator on 2012 at 2:40 pm found a dessert cup that was without covering/packaging, and was without a date. An observation of the main kitchen walk in refrigerator at 3:04 pm revealed four blocks of cheese wrapped loosely in plastic wrap. The cheese was making direct contact with the refrigerator shelf, and was not labeled with dates. One package of lunch meat and another package of cheese were observed to be open and with out dates.

During an interview with Cook #1 on 2012 at 3:08 pm, he acknowledged the facility failed to date opened cheeses and meat, and to store the cheese in a sanitary manner.

During an interview with Executive Chef/Dietary Manager on 012 at 3:09 pm, he acknowldged the facility failed to store foods in a sanitary manner in the third floor holding kitchen. He reported the 4 storage containers of breakfast cereal were without dates because he knew "the cereal only lasts about 4 days with how much the residents eat it".

Class III
Correction Date: , 2012

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Ormond in The Pines
101 Clyde Morris Blvd.
Ormond Beach, FL 32174

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2012 by a representative of this office.

Attached is the provider's copy of the State (3020) 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 , **2012** 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 surveyor. Should you have any questions please call this office at

Sincerely,

Keisha Woods

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

KW/sm
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone (904) 798-4201; Fax (904) 359-6054