

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES OF NICEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 4268 IDA COON CT NICEVILLE, FL 32578		
(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 On _____ at Bee Hive Home Assisted Living Facility, an unannounced biennial survey was conducted. There were deficiencies found at the time of the visit.	A 000		
A 025 SS=D	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		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6892

OS3Y11

If continuation sheet 1 of 3

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A 025	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on record review and interviews, the Assisted Living Facility failed to document changes in condition resulting in a resident being admitted to the hospital for 1 of 1 resident (#1). Findings include: 1) A review of the resident roster revealed resident #1 was absent from the facility. A review of the resident record reveals the last progress notes dated _____ of resident #1 being observed sleeping a lot and no further documentation. 2) On _____ an interview with the Administrator and Home Manger was conducted about 2:50 PM. The Administrator stated resident #1 went to the hospital because she had a bad _____) and during her hospital visit she had other complications that resulted in a longer stay. She stated resident #1 is now at the Manor and should be back soon. The House Manager, attempted to search for the documentation of resident #1 leaving the facility but could not find any. 3) An interview was conducted at 3:12 PM with the Assistant Director. He stated on the morning of _____ he notice resident #1 declining. He stated she wasn't her usual self and wanted to lay in bed. The Assistant Director stated he contacted her son and told him resident #1 wasn't feeling good and her son took her to the hospital. Later resident #1's son advised him she would have to stay. The Assistant Director stated, " I probably should have documented it in the logs". "It was absolutely my mistake for not documenting".	A 025			

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A 025	Continued From page 2 Class III	A 025	



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Bee Hive Homes Of Niceville
4268 Ida Coon Ct
Niceville, FL 32578

Dear Administrator:

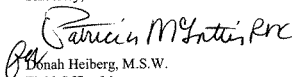
This letter reports the findings of a state licensure survey that was conducted on , 2012 by a representative of this office.

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 , 2013 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 me at 850-412-4540.

Sincerely,


Donah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure
XG90

