

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER INN ON THE POND			STREET ADDRESS, CITY, STATE, ZIP CODE 2010 GREENBRIAR BLVD CLEARWATER, FL 33763		
(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 Assisted Living Facility An extended congregate care (ECC) monitoring visit was conducted on . . . The Inn on the Pond, assisted living facility, had a deficiency found at the time of the visit.	A 000			
A 162	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records shall be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2.; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance; 8. Name, address, and telephone number of next of kin, responsible party, or other person the resident would like to have notified in case of an emergency, and relationship to resident; and 9. Name, address, and phone number of health care provider, and case manager if applicable. (b) A copy of the medical examination described in Rule 58A-5.0181, F.A.C. (c) Any health care provider's orders for medications, nursing services, therapeutic diets,, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) A signed statement from a resident refusing a therapeutic diet pursuant to Rule 58A-5.020, F.A.C. (e) The resident record described in paragraph	A 162			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0000

TP5Z11

If continuation sheet 1 of 5

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER INN ON THE POND			STREET ADDRESS, CITY, STATE, ZIP CODE 2010 GREENBRIAR BLVD CLEARWATER, FL 33763		
(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 162	Continued From page 1 58A-5.0182(1)(e), F.A.C. (f) A weight record which is initiated on admission. Information may be taken from the resident ' s health assessment. Residents receiving assistance with the activities of daily living shall have their weight recorded semi-annually. (g) For facilities which will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident ' s contract. (h) For facilities which manage a pill organizer, assist with self-administration of medications or administer medications for a resident, the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident ' s contract with the facility, including any addendums to the contract, as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, or staff, or representative thereof serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required under Section 429.27, F.S. (k) For any facility which maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required under Section 429.27, F.S. (l) A copy of Alternate Care Certification for () Form, CF-ES 1006, 1998, if the resident is an recipient. The absence of this form shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER INN ON THE POND			STREET ADDRESS, CITY, STATE, ZIP CODE 2010 GREENBRIAR BLVD CLEARWATER, FL 33763		
(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 162	Continued From page 2 Department of Children and Family Services. (m) Documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required under Rule 58A-5.0181, F.A.C. (o) For apartments, duplexes, quadruplexes, or single family homes that are designated for independent living but which are licensed as assisted living facilities solely for the purpose of delivering personal services to residents in their homes, when and if such services are needed, record keeping on residents who may receive meals but who do not receive any personal, limited nursing, or extended congregate care service shall be limited to the following: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required under this subsection; 3. The medical examination described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (p) Except for resident contracts which must be retained for 5 years, all resident records shall be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents shall be provided a copy of their resident records upon departure from the facility. (q) Additional resident records requirements for facilities holding a limited mental health, extended	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER INN ON THE POND			STREET ADDRESS, CITY, STATE, ZIP CODE 2010 GREENBRIAR BLVD CLEARWATER, FL 33763		
(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 162	Continued From page 3 congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure that residents provide written informed consent for assistance with self-administration of medications by unlicensed staff. Findings include: Per interview at the facility with the Administrator on _____ at approximately 9:30am, the facility is moving toward having all medications done by Licensed Practical Nurses and is "about 80 percent there, but currently Certified Nursing Assistants/Medication Technicians with the required training to assist with self-administration of medications do meds." The Resident Care Director/Extended Congregate Care Supervisor verified (_____ at approximately 1:30pm) that at least 8 of 20 CNAs listed on employee "Nursing" roster are responsible for assisting residents with self-administration of medications. Review of the resident record for the one resident (#1) receiving Extended Congregate Care services at the facility conducted _____ at approximately 10:00am revealed no Consent for Unlicensed Staff to Assist with Self-Administration of Medications. The resident's most recent medical assessment (AHCA Form 1823) completed by a physician on _____ indicated resident's need for assistance with self-administration of medications. Per review conducted _____ at approximately 11:00am of one ECC resident record (Medication	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER INN ON THE POND			STREET ADDRESS, CITY, STATE, ZIP CODE 2010 GREENBRIAR BLVD CLEARWATER, FL 33763		
(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 162	Continued From page 4 Administration Record in use by facility to document self-administration), 3 Certified Nursing Assistants/Medication Technicians (Staff #A, B, & C) provided the resident (#1) assistance with self-administration of medications during the months of _____ & _____, 2013. Per interview with the Administrator (_____ at 12:30pm) and observation of her "To Do" list for _____ 2013, she had previously noted the need to use forms for Informed Consent for Unlicensed Staff to Assist with Self-Administration of Medications. The Administrator stated she became aware of this need as a result of attending the Assisted Living Facility Core Training Program. The Administrator became employed as the facility Administrator on _____ and became Core certified on _____. Per review of the one ECC resident (#1) record containing admission information (contract, releases, etc.) and interview with the facility Administrator on _____ at approximately 1:45pm, no form for, or mention of, Informed Consent for Unlicensed Staff to Assist with Self-Administration of Medications is included in the standard Resident Admission package/Resident Record. Class III	A 162			



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUKE
SECRETARY

, 2013

Administrator
Inn on the Pond
2010 Greenbriar Blvd
Clearwater, FL 33763

Dear Administrator:

This letter reports the findings of an extended congregate care (ECC) monitoring visit that was conducted on , 2013, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiency 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 **Paul Brown, HFES**, at 727-552-2000.

Sincerely,

For 
Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

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



St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161