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 |
|---|---|---|---|
| | AL11910478 | A. BUILDING: _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| INN AT THE FOUNTAINS | 1255 PASADENA AVENUE, S. SAINT PETERSBURG, FL 33707 |

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| A 000 | Initial Comments<br><br>A complaint survey, CCR# 2013000154, was completed in conjunction with an abbreviated biennial state licensure survey with limited nursing services (LNS), see separate (Aspen Event 8PRV11).<br><br>The Inn at the Fountains, assisted living facility, had deficiencies found at the time of the visit. | A 000 | | |
| A 052 | 58A-5.0185(3) FAC Medication - Assistance with Self-Admin<br><br>(3) ASSISTANCE WITH SELF-ADMINISTRATION.<br>(a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least , trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S.<br>(b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container.<br>(c) Staff shall observe the resident take the medication. Any concerns about the resident ' s | A 052 | | |

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| A 052 | Continued From page 1 | A 052 | | |

reaction to the medication shall be reported to the resident ' s health care provider and documented in the resident ' s record.
(d) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule which coincides with the resident ' s presence in the facility;
2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident ' s medication record;
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident ' s medication record; or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging;
(e) Pursuant to Section 429.256(4)(h), F.S., the term " competent resident " means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.
(f) Pursuant to Section 429.256(4)(i), F.S., the terms " judgment " and " discretion " mean interpreting vital signs and evaluating or assessing a resident ' s condition.
(4) Assistance with self-administration does not include:
(a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.

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| A 052 | Continued From page 2<br>(b) The preparation of syringes for injection or the administration of medications by any injectable route.<br>(c) Administration of medications through intermittent positive pressure breathing machines or a [illegible].<br>(d) Administration of medications by way of a tube inserted in a cavity of the body.<br>(e) Administration of [illegible] preparations.<br>(f) Irrigations or debriding agents used in the treatment of a skin condition.<br>(g) [illegible], or [illegible] preparations.<br>(h) Medications ordered by the physician or health care professional with prescriptive authority to be given " as needed, " unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident.<br>(i) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed ensure that the resident received the correct dosage of a medication for 2 (Resident #2 and #8) of 5 residents sampled, who were prescribed controlled medications, which could have affected the resident's health.<br><br>Findings include:<br><br>Review of Resident #2 ' s medication observation records (MORs) revealed that he was prescribed the medication [illegible] 40mg, which was used to manage high [illegible], with directions to take ½ tablet (20mg) at bedtime. | A 052 | | |

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| A 052 | Continued From page 3<br><br>Observation of the tablets in the bottle on at approximately 12:20pm revealed un-scored tablets. There were tiny fragments along with whole and halved tablets in the bottle. Un-scored medications are not permitted to be cut in half and placed the resident at risk of receiving too much or too little medication. Instead, the proper dosage of the medications should be requested from a residents' pharmacy.<br><br>Review of Resident #8 ' s MORs revealed that he was prescribed the medication 20mg, which was used to manage high , with directions to take ½ tab=10mg at bedtime.<br><br>Observation of the medication in the bottle on at approximately 11:30am revealed that the medication was un-scored.<br><br>In the interview with Staff C on at approximately 11:45am, she stated that the medication technician working during the timeframe the medication was due would split the tablets to give to the resident.<br><br>Class III | A 052 | | |
| A 054 | 58A-5.0185(5) FAC Medication - Records<br><br>(5) MEDICATION RECORDS.<br>(a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider ' s name, the resident ' s name, the date dispensed, the name and strength of the drug, and the | A 054 | | |

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directions for use.
(b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered.
(c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication.

This Statute or Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to assure qualified staff correctly documented on the daily medication observation records (MORs) and control sheets and failed to transcribe the medication orders onto the controlled drug use record (control log) for 1 (Resident #2) of 5 residents sampled, who were prescribed controlled medications.
Findings include:
Record review revealed Resident #2 had diagnoses listed on his health assessment dated including chronic back pain. Further review revealed an order dated for -Acetamenophen 10-325 take 1 tab by mouth every 6 hours as needed for severe pain. The staff failed to document every time this medication was given in the MORs, and used the

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| A 054 | Continued From page 5<br><br>control log instead to document the doses given, and transcribed the prescription orders incorrectly onto the control log which made it impossible to determine when the last dose was given, increasing the chance that the resident received the medication too early.<br>Further medication record review revealed that Resident #2 ' s control logs which covered doses given between to noted that the resident had been given 11 doses of , , 10-325 (a controlled drug used to treat pain) between / to , but the MORs only note 1 dose, which was given on . The controlled drug use record that was used by the facility staff to record when this controlled medication was given to the resident, also had the prescription orders for the medication transcribed incorrectly. The MORs and physician orders read: Take 1 tablet by mouth every 6 hours as needed for severe pain. The controlled drug use log read: Take 1 tablet by mouth every 4 hours as needed for severe pain.<br><br>Interview with Resident #2 on at approximately 11:05am, revealed that he received his ~Acetominophen 3 times a day and has not had any problems getting the medication from the staff.<br><br>Class III | A 054 | | |
| A 055 | 58A-5.0185(6) FAC Medication - Storage and Disposal<br><br>(6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both | A 055 | | |

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prescription and over-the-counter, in their possession both on or off the facility premises; or in their or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if:

1. The facility administers the medication;
2. The resident requests central storage. The facility shall maintain a list of all medications being stored pursuant to such a request;
3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;
4. The resident fails to maintain the medication in a safe manner as described in this paragraph;
5. The facility determines that because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents; or
6. The facility ' s rules and regulations require central storage of medication and that policy has been provided to the resident prior to admission as required under Rule 58A-5.0181, F.A.C.

(b) Centrally stored medications must be:
1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is

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located locked;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and
4. Kept separately from the medications of other residents and properly closed or sealed.
(c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident ' s representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident ' s request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked " discontinued medication. " Such medication may be reused if re-prescribed by the resident ' s health care provider.
(d) When a resident ' s stay in the facility has ended, the administrator shall return all medications to the resident, the resident ' s family, or the resident ' s guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident ' s medications are still at the facility, the medications shall be considered abandoned and may disposed of in accordance with paragraph (e).
(e) Medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and disposition shall be documented in the resident ' s record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.
(f) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed

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| A 055 | Continued From page 8<br><br>medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation and interview, the facility failed to keep medications separate for each resident which made it difficult to determine which medications were available for residents and increased the chance of one resident's medication being used for another resident; the facility also failed to remove discontinued medications from the current medications ordered for 2 (Resident #2 and #6) of 5 residents sampled, who were prescribed controlled medication.<br><br>Findings include:<br><br>Observation on at approximately 2:00 p.m. of a medication cart used to give late night and early morning medications to residents that normally receive their medications in their that only a few residents' medications were separated by name cards. The majority of the medication in the cart was not separated for each individual resident. Different residents ' medications were placed back to back and even on the side of each other.<br><br>In the interview with the DON on at approximately 2:20 p.m., she acknowledged that the residents' medications should be kept separate from other residents ' medications in the medication drawer referenced in the facility's Assisted Living Medication Manual, WRC-AL-MOO#, p58 Quality Improvement Medication Pass Review (administration of medications).<br><br>Observation of Resident #6's available | A 055 | | |

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| A 055 | Continued From page 9<br><br>medications on at approximately 12:10 p.m. revealed 1 medication that was not one of the current medications on the medication observation records (MORs), 50mg (for pain). The resident resided in the memory care unit and due to limitations, an interview was not deemed reliable. She refused to speak with the surveyor.<br><br>In the interview with med tech, staff #B, on at approximately 12:15 p.m., he stated he was not sure why the medication was not removed from the resident's current medications.<br><br>Observation of Resident #2's available medications on at approximately 12:40 p.m. revealed 2 medications that were not current medications on the MORs, 10mg (for symptoms) ordered as a one time medication for a procedure and 100mg (for mood and sleep).<br><br>Interview with Resident #2 via phone on at approximately 11:05 a.m. revealed he had no concerns with these medications.<br><br>Class III | A 055 | | |
| A 056 | 58A-5.0185(7) FAC Medication - Labeling and Orders<br><br>(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 | A 056 | | |

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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, 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

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| A 056 | Continued From page 11<br><br>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.<br>(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.<br>(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, 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:<br>1. Practitioner ' s name;<br>2. Resident ' s name;<br>3. Date dispensed;<br>4. Name and strength of the drug;<br>5. Directions for use; and<br>6. Expiration date.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation during the noon medication pass, record review and interviews, the facility failed to assure changes to prescribed medication orders were promptly and accurately transcribed or clarified for 2 (Resident #1 and #2 ) of 5 sampled residents (whose medications were | A 056 | | |

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| A 056 | Continued From page 12 | A 056 | | |

reconciled) which resulted in labeled medications not matching the medication observation records (MORs) and caused residents to potentially not receive accurate doses of prescribed medications that could have resulted in adverse outcomes; additionally the facility failed to order a medication for 1 (Resident #6) of the same sampled residents.

Findings include:

Review of Resident #1's health assessment (form 1823) dated following return from rehab revealed diagnoses of ( ) and ( ). The same 1823 had treatments every 6 hours (p.1). Review of the most recently signed signed physician's order sheet dated had the following order: Iprat-Albut 0.5-3 (2.5) mg/3ml, inhale 3 ml via every 6 hours as needed (prn), no indication for use was given.

Review of the and MORs revealed the following orders: Iprat-Albut 0.5-3 (2.5) mg/ml, inhale 3ml via every 6 hours as needed. The indication for use was missing. It was not documented as being needed or administered during the month of .

Observation of the medication on hand revealed a dispense date of and was labeled: Iprat-Albut 0.5-3 (2.5) mg/ml, inhale 3 ml via every 6 hours. There were 2 boxes of the medication both labeled as a routine scheduled treatment to be used every 6 hours.

Record review revealed no documentation that staff had tried to obtain clarification of the

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|---|---|---|---|
| | AL11910478 | A. BUILDING: _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| INN AT THE FOUNTAINS | 1255 PASADENA AVENUE, S. SAINT PETERSBURG, FL 33707 |

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| A 056 | Continued From page 13<br><br>treatment to determine if it was needed routinely or as needed (prn) and what the indication for use was.<br><br>Review of the MOR revealed the following transcribed order: 50mg tab, take 1 tab 3 x daily as needed for severe pain. It also had "order changed " handwritten next to the order. Review of the MOR did not have the order change on it and the computer generated MOR continued to read: 50mg, take 1 tablet 3x daily as needed prn for severe pain. There was documentation that the medication had been requested or used one time in ( ) and not used at all during the month of to today's date .<br><br>Observation of the medication label on hand read: 50mg, take 1 tablet 3 x daily as needed for severe pain. The facility used 2 of 3 pill packages (30 pills each) dispensed on ). The available pill package had not been opened.<br><br>Record review revealed an order change dated to decrease to 50mg every 12 hours prn for severe pain only. A physician's order sheet signed on (9 days after the order to decrease the frequency) by a different practitioner than the one who had decreased the order on changed the order back to 3x day. Further record review did not show any attempts by staff to clarify the order.<br><br>Review of the and MORs revealed the following transcribed order: 100mg capsule, take 1 cap at bedtime, hold for . It was scheduled at | A 056 | | |

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| A 056 | Continued From page 14<br><br>9:pm.<br>Observation of the available medication label read: 100mg capsule, take 1 capsule 2x day.<br><br>Observation of the medication on hand revealed: 2 pill packs of 30 each dispensed on , labeled: 100mg, take 1 capsule 2 x day. There was no alert sticker on any of the pill packs alerting of the order change. Record review revealed the order was changed from 1 cap/day to 2x day on and then a physician's order sheet signed on (9 days later) had it scheduled back to 1x day.<br><br>Record review revealed the physician order sheet was signed on by a different practitioner than the practitioner who increased the order on (9 days earlier). Further review did not show that the facility staff attempted to obtain clarification of the order.<br><br>Record review revealed Resident #1 had an order dated ) for 250mg, take 1 tablet every am. (scheduled at 9am) and another order for 500mg, give 1 daily at 8pm. Review of the and MORs noted the orders were transcribed accurately. Observation of what was available that did not match the order included: 500mg, take 1 tab at 2pm and 1 1/2 at 8pm (dispense date was - from a previous order). There were no alert stickers to notify staff of dosing/order changes.<br><br>Interview on at approximately 1:00pm with the LPN (Staff B) in the memory care unit unit where Resident #1 resided revealed he did not know why the labeled Iprat- treatment, the , and | A 056 | | |

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| A 056 | Continued From page 15 | A 056 | | |

on hand for Resident #1 did not match the orders transcribed onto the MOR and said it was all of the facility's nurses responsibility to make sure the orders/order changes matched the MORs, that labels matched the orders and if not clarification was to be obtained. Additionally, he said the incorrectly labeled medications needed alert stickers to identify dosage/frequency order changes. He acknowledged the labeled medications did not have alert stickers.

Further review of the resident's MOR revealed the indication for use was missing for another order: Suspension- give 30ml once daily as needed. There was no documentation that the resident requested the medication during the month of .

Observation of Resident #1 on at approximately 1:30 p.m. revealed a well nourished male appropriately dressed using a wheelchair to propell himself around the memory care unit. He was heard vocalizing in a somewhat aggressive manner to no one in . He was not observed to be in any distress, had no labored breathing and was not heard to complain of any pain or upset. Later during the survey he was observed up walking using a walker. He was not deemed to be a reliable interview due to limitations. He was redirected by staff several times during the observation.

Interview with the Director of Nurses on at approximately 2:30 p.m. revealed it was the responsibility of the facility nurses to accurately transcribe orders and order changes onto the MORs, obtain clarification when needed and to place alert stickers on medications to show either dose or frequency changes had been

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| A 056 | Continued From page 16<br><br>made per facility policy (see WRC Assisted Living Medication Manual- section 4 regarding records and documentation ). She stated a nurse (LPN) is on duty at all times and that only nurses give medications in the memory care unit while trained med techs provide medications assistance with monitoring from the nurses on staff. She went on to describe a monthly medication pass review (part of the facility's quality improvement program) that is completed by a facility LPN and an unlicensed but qualified medication tech . Review of the last 5 of these monthly audits (form WRC-Q1-F006-Rev. ) included 2 different LPNs and 5 med techs. None of the med pass reviews identified which residents were observed and none of them identified medication labels not matching orders or MORs. The dates on the forms were marked over making it difficult to determine exactly when the med passes reviews were completed. The DON further stated that the facility's consulting pharmacy had not completed a cart/MOR audit for approximatley 9 months. The DON further acknowledged it was her responsibly as the DON to provide the necessary oversight to the medication management at the facility and said she monitored approximately 1x month using the facility's medication pass audit tool.<br><br>Review of Resident #2 's MORs revealed 4 medications with medication labels that did not match the MORs or physician orders. His records indicated he was taking for his stomach ( ), for , and and Plus for . The label on the bottle read 20mg capsule, take 2 capsules by mouth every morning and the MORs and physician orders read 40mg capsule, | A 056 | | |

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| A 056 | Continued From page 17<br><br>take 1 capsule by mouth every morning. Another bottle label read 100mg capsule, take 1 capsule by mouth 3 times a day and the MORs and physician orders read 100mg capsule, take 200mg=2 capsules by mouth 3 times daily. The and Plus came to the facility as a combination pill, but they are listed on the MORs as 2 separate medications. The bottle label read 50mg/ 8.6mg, take 2 tablets by mouth twice daily, but the MORs and physician orders included, 50mg capsule, take 2 capsules by mouth twice daily and Plus tablet, take 2 tablets by mouth twice daily.There was a note on the MORs for the which read "ORDER REPEAT". The was not signed out for the resident on the MORs, but the Plus was signed out for the combination pill.<br>In the interview with Staff B on at approximately 1:50 p.m., he stated that he follows the directions on the MORs, when the medication labels do not match the MORs, but also stated he needed to check the records to verify which one was correct, the MORS or the bottle's label.<br>Review of Resident #6's medication observation records revealed an order for , - , 5-500, take 1 tablet by mouth twice daily as needed for pain.<br><br>In the interview with the Director of Nursing on at approximately 12:00 p.m., she stated that Resident #6's medication was not available at the facility. She stated she contacted the resident's doctor to have the medication discontinued due to non-use and she was waiting for a response.<br><br>Interview with the Administrator on at approximately 4:0 p.m. revealed she was unaware of the above identified medication | A 056 | | |

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| A 056 | Continued From page 18<br><br>issues and added that the pharmacy would be contacted right away to come on sight and provide the necessary review/cart audit.<br><br>Class III | A 056 | | |

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Inn at the Fountains
1255 Pasadena Avenue, S.
Saint Petersburg, FL 33707

Dear Administrator:

Re: **CCR# 2013000154** & LNS Monitoring Visit

This letter reports the findings of a complaint survey and a limited nursing services (LNS) monitoring visit that were conducted on , 2013, by representatives 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 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 surveyors. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosures: State Forms 3020

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