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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 A complaint survey, CCR# 2013004529, was conducted on : & , in conjunction with a monitoring visit, see (Aspen Event S36011). The Hillandale, assisted living facility, had deficiencies found at the time of the visit.	A 000		
A 008	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable which is likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual ' s needs can be met in an assisted living facility; and	A 008		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 008	Continued From page 1	A 008		

8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state.
(b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows:
1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment.
a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion.
b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider.
c. Omitted information received verbally must be documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided.
2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 008	Continued From page 2 or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the elements in Section 3. This requirement does not apply for residents receiving: a. Extended congregate care (ECC) services in facilities holding an ECC license; b. Services under community living support plans in facilities holding limited mental health licenses; c. Medicaid assistive care services; and d. Medicaid waiver services. (c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823. (d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule. (f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a do-not- order for residents who do not wish to be administered in the case of or (g) A resident placed on a temporary emergency	A 008		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 008	Continued From page 3 basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility ' s admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review, the facility failed to ensure proper documentation of a Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823), completed by the resident's licensed health care provider, evaluating eligibility and appropriateness of a person for residing in an Assisted Living Facility for 1 (#23) of 24 records. Findings include: AHCA Surveyor conducted a file review of Resident #23 specific to appropriateness and eligibility for residing in an Assisted Living Facility. An AHCA Form 1823 dated : was found in the resident record. The resident was admitted to the facility on ... (discharged). The AHCA Form 1823 was not decipherable due to checkmarks & Xs crossed out, in response to questions, as follows: "Does the individual need help with taking his or her medications (meds)?" Yes is checked; No contains an X; Checkmark placed next to Needs Assistance with Self-Administration of Meds. "In your professional opinion, can this individual's needs be met in an assisted living facility or adult	A 008		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 008	Continued From page 4 family care home, which is not a medical, nursing or , , ' ' ' ' facility?" Yes is checked; No contains an X covering letters or initials (?-indistinguishable). Item F- " Complete for AFCHs only: In your professional opinion, based on this individual's medical profile, can he or she be left without supervision at the adult family care home for up to two hours per 24 hour period without compromising his or her health, safety, security or wellbeing?" Yes contains an X covering letters or initials (?-indistinguishable); No is checked. Note that this Adult Family Care Home section did not need completion if the resident was being evaluated for Assisted Living Facility residence. No signatures or notes accompany the above ambiguously marked items. Class III	A 008		
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 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.	A 030		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 (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 [illegible] 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 [illegible] Hotline " 1(800)96- [illegible] 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, for example, 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 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	A 030		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 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. (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.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 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 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. (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	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 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 observations, interviews, and record review, the assisted living facility failed to ensure residents lived in a safe and decent living environment specifically related to a continued and ongoing bed bug infestation, originally identified , affecting 7 (#1, #2, #10, #12, #14, #15) of 20 current residents and failed to follow all recommended procedures set forth by the County Health Department on to include removing residents from the affected immediately until pest control is complete. Additionally, the facility failed to provide a safe and decent living environment, free from and neglect. The facility failed to provide adequate protection for the health, safety, and welfare of facility residents. Findings include: A. Review of a County Department of Health	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 inspection report dated : revealed "Per conversation with the... administrator, inspector was advised of the presence of the pests (beg bugs) two weeks ago." Review of a County Department of Health inspection report dated : revealed the county identified the presence of bed bugs. The report indicated "Violation #27 Live bedbugs observed in 3 and 8. Residents must be removed from these until problem resolved. Staining on some beds in other may indicate previous or current infestation. All bedding must be thoroughly inspected and situation monitored on ongoing basis." Review of a County Department of Health inspection report dated : revealed the county identified the presence of bed bugs. The report indicated "Violation #27 Active widespread bedbug infestation." Observations of residents waiting for medications on at approximately 7:05 a.m. revealed resident #10 standing in line. He was observed to scratch his back and left shoulder and make a gutteral noise (ugh). When the surveyor asked if he was ok he indicated, "those (deleted word) bugs." Upon request, the resident removed his long sleeve jacket. He was observed to wear a sleeveless t-shirt under the long sleeve jacket. His left arm was observed to have multiple red blotches on the lower half while his shoulder & upper part of his arm were covered with multiple bumps. Observations of # were conducted at 7:40 a.m. on . A size bed was observed up against the west wall with the head of the bed against the north wall. This was the only bed in	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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	A 030		

the . The bed was made. The surveyor pulled the top sheet back. Multiple live insects, which looked like bed bugs, were observed on the top sheet of the bed. The pillow was pulled up and the surveyor viewed the area where the fitted sheet and mattress abutted the head board. Insects were observed to scurry upon exposure. The top sheet was pulled back from the foot of the bed. Two insects were observed on the fitted sheet along the seam. The insects that were observed on this bed were ovoid in shape, flattened, reddish brown in color and many of them were observed to have distended abdomens. Many of the insects were the size of apple seeds. A single insect was picked up by the surveyor from the top sheet, placed on the floor and stepped on with the tip of his right shoe. The bug exploded and red fluid, resembling , spattered on the floor. The above actions were witnessed by employee #A.

Observations of # were conducted at approximately 7:50 a.m on . Two beds were present. One of the beds abutted against the north wall with the head of the bed against the east wall. The bed linens were pulled up to the head of the bed. The bedspread and top sheet were pulled back from the head of the bed. A few small rust colored spots were observed on the pillow and the sheet. Two insects were observed on the southern (long outside) edge of the bed. One bug was the size of an apple seed. It was reddish brown in color with a distended abdomen.

Interview with employee #A after the observations on at approximately 8 a.m. revealed that she would remove resident bed linens and their clothes and wash them as well as spray the beds.

Observation of the spray utilized and concurrent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 11 interview with employee #A on at 9:30 a.m. revealed she had removed bed linens from #7 and #8. According to employee #A the product she used to spray the beds was an ecological friendly product. The main ingredient in this product was listed as 95% d-limonene, per the label that was affixed to the can of spray. She indicated this is the product the pest control company uses. An interview was conducted with a representative of the County Health Department at 11: 40 a.m. She indicated there was a current infestation of bed bugs. She confirmed the insects identified by the surveyor in # and #8 were bed bugs. She indicated that bed bugs are very resistant to poisons so the best methods of extermination are heat or freezing. She also indicated the bugs she observed were well fed. A County Health Department inspection report dated with a begin time of 11:00 a.m. and an end time of 11:50 a.m. documented "Violation #27 Active infestations observed in 1, 7, 8, and 10. Residents must be removed from these until professional pest control is completed. All linens and clothing must be washed and dried on high heat and furniture and mattresses throroughly vacuumed." an interview was conducted at 9:20am resident #10. 10:10am - I meet with resident #10, who resides in #. He was oriented to self, place and date. He stated that he had been getting bitten by bugs in his approximately one month. He stated he informed the administrator and that	A 030		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 12	A 030		

staff #A had sprayed his . He was not sure of the specific date. Observation of his arms, back and lower legs and feet revealed visible small red marks covering his upper back, upper and lower arms and his lower legs including his feet. He indicated he has not seen a doctor for the bites.

An interview was conducted on at 12:45pm with staff #A regarding resident #10 in s in # . She indicated she was not aware of resident #10 bringing to the facility's attention that he was being bitten by bed bugs. She stated that she contacted their pest control company that the facility has contract with to provide pest control. She stated they will come out this Friday and treat for bedbugs. When asked about moving the residents in the infested to uninfested, she indicated she would wash all bed linens in affected in hot water and dry with high heat. She also stated that she is spraying the bedframes with pesticide(95% d-limoneene) which was provided by the pest control company to treat for bedbugs. She confirmed there was an empty (2 beds).

At approximately 12:55pm a telephone interview was conducted with the branch manager of the pest control company. He confirmed that they will be on-site Friday to treat for bedbugs. He stated they are going to all in the facility. He also stated that they will be using liquid nitrogen to provide freezing treatment for bedbugs.

at approximately 1:45pm I was able to interview resident #11. She stated that the bed bugs have affected her. She showed me her lower arms. Observed see small red marks on each arm.

A County Health Department inspection report was reviewed on . The report was dated

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 13 and indicated the "Live adult bedbugs observed in bed on right side of ." B. On at approximately 11:30am, the AHCA Surveyor requested the log of Incident Reports from the facility Administrator. The Administrator responded: "I don't keep a log of the incidents, but I have plenty of Incident Reports. " The Administrator handed the AHCA Surveyor a folder containing 5 Incident Reports dated 2012 plus 11 Incident Reports dated 2011. The AHCA Surveyor made copies of the 2012 reports for review. On at approximately 11:00am, a representative of another state agency observed copies of the reports and provided 2 more reports. They stated that the Administrator had pulled the 2 reports out from under his desk mat. The reports were not included in the file presented to AHCA Surveyor on . AHCA Surveyor reviewed the 7 Incident Reports provided, all reports involved regarded Resident #23. Resident #23 became a resident of Hillandale on . The following events, as documented in Hillandale ' s records, show an escalating pattern of aggression towards others, which the facility failed to redirect: 1. On , "<Resident #23> was upset over	A 030		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 14 relationship break-up ... got aggressive ... wouldn't comply with staff ... : on floor, hit staff." Actions taken: "<Resident #23> called 911. Police came out took report. I spoke to Administrator" Notified Administrator : at "12:30noon" Staff I & B added note at bottom of page: " -spoke with sheriff they stated <Resident #23> was cop shopping to get what s/he wanted. Not Adverse. No one knows how incident happened--She has made wild accusations not supported by witnesses." initialed " JR " (Administrator ' s initials) Nothing is written in the " Follow Up " section at end of report. There was no documentation of efforts made to prevent reoccurrence. 2. : "Assault on Resident-Living I : at 10:15 (am/pm not provided) " "<Resident #23> and <Resident #24> (not listed as current resident) got into a squabble. <Resident #24> thought <Resident #23> was going to hit <Resident #24>. <Resident #24> hit <Resident #23>. " Laceration & Bite--treated by physician: Northbay : at 11 am. "Steps taken to prevent recurrence: <Resident #24> to get evaluated at hospital" Prepared by Staff B at 1:15 (am/pm not provided) ... Note at bottom: "<Resident #23> is having mental lapses." Incident Report faxed to Consult Care & FACT. No additional follow-up provided. There was no documentation of efforts made to prevent reoccurrence. 3. : "Client was outside trying to kill a spider. S/he I trying to kill the spider and twisted ankle." Called 911, Notified <Administrator> : at 4:10pm. Follow Up: "primary care/doctor" (no results provided) 4. : "<Resident #23> signed (out) , 2012 Did not return" "Called 911, filed missing persons Report, I while in community" Notified <Administrator> :	A 030		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 15 (changed to) at 4:00pm--Physician & Case Manager completed by Administrator ... Staff H & C ... Follow Up: "<Resident #23> was the 14th of . S/he is now in treatment at Largo Medical Center in Indian Rocks." This report was dated as written 5 days after the resident signed out from the facility and did not return. 5. undated; ? "<Resident #23> adamantly refuses to cooperate with staff, been aggressive toward other clients and staff, walking around the facility with feces and , refuses to shower." "Talked to FACT Team and <Resident #23> will be ." Notified doctor & Case Manager on at 1:30pm --Attached: "<Resident #23> was " "<Resident #13>, <Resident #21>, and <Resident #8>, also 2 staff members. <Resident #23> is walking around smearing feces on the walls, couches, and people, walking around without clothes and refuses to cooperate, take shower. This is the 3rd time law enforcement have been called. FACT Team member signed form for her to be ." Follow Up: blank -- There was no documentation of efforts made to prevent reoccurrence. There was no documentation of effects of/potential harm caused by being for the 3 residents (Residents #13, #21, and #8). 6. "<Resident #21> went into "<Resident #23> 's get Christmas iPad and "<Resident #23> just started hitting <Resident #21> for no reason." Staff D - Called 911- ; " 8:40"-Notified: blank; Administrator listed--not as being contacted. Follow Up: blank -- There was no documentation of efforts made to prevent reoccurrence. 7. "<Resident #23> was other clients then requested something was wrong. <Resident #23> wanted to cut (own) throat. S/he	A 030		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 16 requested to call 911 and be l." Staff D & E-called 911; Admin & FACT Team notified at 6pm ... Follow Up: blank [Per interview with the Facility Administrator on at approximately 3:00pm, Resident #23 had been discharged on . Resident #23 was listed as admitted to the facility on ; no discharge date or information is recorded on the facility Admission /Discharge log.] There was no documentation of facility efforts to prevent reoccurrence of incidents involving Resident #23 or to provide adequate protection for the health, safety, and welfare of other facility residents. The Agency ' s review of the facility ' s resident records revealed: Resident #13 became a resident on l. A plenary guardian was appointed for Resident #13 on . Resident #13 ' s diagnoses include , gran mal and Resident #21 became a resident of the facility on . A plenary guardian was appointed for Resident #21 on l. Resident #21 ' s diagnoses include affective , ( ), learning and ' s . An evaluation dated l states: " He needs constant redirection ... He appears to have developed aggressive behaviors as a manipulative technique . . . " evaulation states that Resident #21 " has a tendancy to become extremely physically violent . . . " An evaluation of Resident #23 dated , 2013, recounts: " This is a __-year-old female, admitted under BA52 [ ] from the ALF Hillandale, where she had been found with a	A 030		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 17 large amount of and feces on her body, smeared on the walls, aggressive with clients, attempted to another resident with cigarettes, slapped and tow staff members, refusing medications. While in the ER, the patient lunged at the ER nursing staff. She also pushed her fingernails into the arm of another nurse. " Resident interviews conducted (beginning at 11:50am) further confirmed instances of and facility failure to provide adequate protection for the health, safety, and welfare of facility residents: Per AHCA Surveyor interview with resident #9 (at 11:50am), the resident stated: " Staff and residents get into fights. I just stay out of it. <Resident #10> started smacking me on my head. All were on the couch watching tv. " Per AHCA Surveyor interview with resident #17 (at 12:45pm), the resident stated: "<Resident #21> moved out ... won't be coming back ... 2 incidents ... got up in my face and pushed all the time ... Resident #21> moved back home and won't be coming back... got in a fight with <Resident #23> perfume given to my s/he was trying to claim, pushed <resident> down ... <resident> had a water bottle ...water went all over. I pushed <resident> out of my locked my door. I heard <Resident #23> was evicted, not allowed back due to tantrums and running away. <There ' s a> hole in back fence. <Residents> sneak away or slip out when car comes through. " Per AHCA Surveyor interview with resident #5 (at 1:05pm), the resident stated, when asked if he has been or hit by any staff or residents: "<Resident #4 ... not that much ... Staff make threats but don't hit. They say, ' If you	A 030		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 18	A 030		

don't go to bed, I will put you in time out ' ."
Resident stated he likes his freedom and likes to be out walking, wants more privileges at night.
Per AHCA Surveyor interview with resident #11 (, at 1:20pm), the resident stated s/he goes to the Clubhouse during the day because the Adult Day Training program in Tarpon Springs "has been shut down for a while. " Resident # 11 stated: "<Resident #12>, my , stabbed me on the arch of my foot, but there was no , no skin cut, no ... No, I didn't go to the doctor. They <staff> said it was okay."
Per AHCA Surveyor interview with resident #8 (at 1:30pm), the resident stated, when asked about staff treatment of residents: "We ' re treated like doormats & 2nd class citizens here. I believe they <staff> steal things, but I've never seen them. They ' re rude to me and others. "
When asked about resident fighting, resident #8 stated, " I never hit anybody. <Resident #23> got locked up. "
Per AHCA Surveyor interview with resident #14 (at 11:30am), the resident stated: " I don't feel safe. <Resident #12> punched me one time in the back. "
The Incident Reports provided to AHCA Surveyor were all pertaining to Resident #23, named frequently during resident interviews. No Incident Reports were provided pertaining to other residents/incidents mentioned during interviews, and no records were found of facility staff interventions or attempts to protect residents from .

The Pasco Sheriff Department provided a Log of calls to the Hillandale facility from to . Per AHCA Surveyor review of the six calls in the Log, two (&) had written Incident Reports per above review. Following are the 4 additional incidents involving police

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 19 intervention: 1. " Missing person <Resident #19> left facility 2 days ago and has not returned, does not have meds with her -- staff said " Because she leaves so frequently it is normally not reported right away " -reported missing 4 times in the past year. " There was no documentation of facility interventions to provide adequate protection for the health, safety, and welfare of Resident #19. 2. " at 6:57pm dispatched to facility regarding runaway/missing person <Resident #19> <Staff D> reported that resident escaped out of facility on 3pm by climbing through a hole in the fence. " (Clearwater Police picked up resident and transported to Morton Plant Hospital) There was no documentation of the elopement and no documentation of the 4/2 report; there was no evidence of concern regarding the 20 days that passed between elopement and police dispatch. 3. " simple battery <Resident #21> Suspect <Resident #23> <Resident #21> standing in line for medicine when <Resident #23> <Resident #21>. <Staff F> said <Resident #23> started to slap and scratch <Resident #21> on neck, face, and back. <Resident #21> said s/he was standing in line for meds; Staff <F> said it happened when <Resident #23> came out of <own >. <Resident #23> said <Resident #21> <Resident #23> & hit <Resident #23> in the face--case transferred to State Attorney ' s Office. " A facility incident report dated was provided--referencing Resident #23 " other clients, " but no documentation of the incident. There was no documentation of facility interventions to provide adequate protection for the health, safety, and welfare of either Resident #21 or #23. On , Resident #23 said she knew something was wrong, wanted	A 030		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 20 to cut (own) throat, and requested facility staff call 911 to be [illegible]. There was no evidence of staff concern for resident welfare. 4. [illegible] 7:20pm Responded in reference to [illegible] threats, reported by Staff F - <Resident #18> harming himself-upset that he lost game charger-threw picture frame- " began bashing his head into the wall, causing a laceration on his forehead. <Staff F> brought <Resident #18> into office and attempted to calm down. <Resident #18> then began bashing his head into the wall, causing a laceration on his forehead. <Staff F> immediately called the Pasco Sheriff ' s Office to report the incident and have <Resident #18> [illegible] for safety. " Transported to Trinity Hospital to be treated for injury; [illegible] form completed while at Trinity. On [illegible] & two AHCA Surveyors were approached multiple times (2-3 times each) by Resident #18 regarding needing a charger for his game. There were no documented attempts by the facility to assist the resident with concern causing him considerable distress and documented [illegible] threat. There was no documentation of efforts by facility to prevent reoccurrence of resident self-harm. Class I	A 030		
A 054	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (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 directions for use.	A 054		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 054	Continued From page 21 (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 staff and resident interviews, observation and record review, the facility failed to ensure the Medication Observation Record (MOR) was accurate for one (#3) of four residents (#2, 3, 21 and 23) selected for review. Specifically, two medications were documented as taken or utilized,which were not in stock, and reflected the facility failed to follow the physician orders. Failure to ensure that medication orders are followed may result in adverse outcomes for the resident. Findings include: Review of resident #3's records revealed she was admitted per the contract signed and dated by the resident and the administrator on . The Resident Health Assessment, AHCA Form	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 054	Continued From page 22 1823, signed by a physician and the administrator on indicated diagnosis that included 295.74, 314.01 and past 304.10. Page 4 of the form indicates the resident needs assistance with self-administration of medications. The website http://www.findacode.com/ -9 revealed the diagnosis code 295.74 is " , chronic with acute exacerbation" and 314.01 is " with ". Employee #C was interviewed at 7:00 a.m. on . A copy of the MOR that was provided by employee #A was used to review the medication in the medication cart. Employee #C was asked to show the surveyor the medications that were in the cart that were for resident #3 as he compared them to the copy of the MOR for 2013. Of the medications listed on the MOR, two were not present in the medication cart. There was no cream 5% nor was there 20 mg (milligram) predisone tablets. Employee #C confirmed that the medications she presented to the surveyor for review were the only medications for resident #3. There were no other(1) cre 5%, apply to skin from chin to feet, remove by washing after 8 to 14 hours was listed on the MOR. The 2013 MOR documented that this medication was applied at 7 a.m. on - then through . For the MOR documented resident #3 was absent, "A". (2) Presnisone tab 20 mg (milligrams), take 2 tablets by mouth once daily for 3 days was listed on the MOR. The MOR documented this medication was provided to the resident at 7 a.m. on - , , and . The MOR documented that the medication was	A 054		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 054	Continued From page 23 held ("HD") on , , and . For the MOR documented resident #3 was absent. "A". Review of resident #3's record revealed "Patient Education Instructions" from a local hospital emergency department to include the following medications; (1) " (5% Cream) 1 app One time only apply to skin (chin to feet), remove by washing after 8 to 14 hours" and (2) " (20 mg oral tablet) 40 mg By Mouth once a day 3 days(s)". An interview was conducted with employee #A on at 9:25 a.m. regarding the discrepancies in the physician order and the documentation that the facility continued to provide the two medications. Employee #A indicated the medication should be discharged. She also indicated that the initials the surveyor had difficulty identifying belonged to employee #G. An interview with resident #3 was conducted on at 11:15 a.m. She indicated the one of the reasons she is in the facility is help with her medications. Review of the website http://www.drugs.com/pro/ .html the drug is a . Additionally, there is a warning to patients that prolonged use may cause insufficiency and make patients dependent on . Review of the website http://www.webmd.com revealed that unless the doctor recommends it should not be used more than once. Overuse of this medicine can irritate the skin and may increase the risk of side effects.	A 054		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 054	Continued From page 24	A 054		
	Class III			
A 093	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition Board - National Research Council, adjusted for age, and activity, shall be the nutritional standard used to evaluate meals. Therapeutic diets shall meet these nutritional standards to the extent possible. A summary of the Tenth Edition Recommended Dietary Allowances, interpreted by a daily food guide, is available from the DOEA Assisted Living Program. (b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the recommended dietary allowances to be made available to each resident daily by the facility are as follows: 1. Protein: 6 ounces or 2 or more servings; 2. Vegetables: 3 5 servings; 3. Fruit: 2 4 or more servings; 4. Bread and starches: 6 11 or more servings; 5. Milk or milk equivalent: 2 servings; 6. Fats, oils, and sweets: use sparingly; and 7. Water. (c) All regular and therapeutic menus to be used by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, to ensure the meals are	A 093		

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
	AL11968321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 093	Continued From page 25 commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date reviewed. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months. (e) Therapeutic diets shall be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining or family style dining are not required to document what is eaten unless a health care provider ' s order indicates that such monitoring is necessary. However, the food items which enable residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility. 2. The facility shall document a resident ' s refusal to comply with a therapeutic diet and notification to the resident ' s health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the resident ' s responsible party refusing the diet is	A 093		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 093	Continued From page 26 acceptable documentation of a resident ' s preferences. In such instances daily documentation is not necessary. (f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly distributed throughout the day with not less than two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food shall be served attractively at safe and palatable temperatures. All residents shall be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, shall be on hand. (h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity. The supply shall consist of dry or canned foods that do not require refrigeration and shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.	A 093		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 093	Continued From page 27 This Statute or Rule is not met as evidenced by: Based on record review, interview with staff and residents and observations, the facility failed to provide meals in accordance with the Registered Dietician's approved menu, failed to have a substitution menu/options and log substitutions in the menu. Failure to follow menus may affect the nutrition and health of residents. Findings include: Observations of the facility on at 10:00 a.m. failed to find a posted menu. Employee #A provided a menu to the surveyor on . On 8:20 a.m. she confirmed the menu that the facility was following was on week 4 of the 4 week menu she provided on . Review of the menu revealed that Monday lunch was to be; 2 oz. (ounce) luncheon meat, 1 oz. cheese sandwich, 1 small cucumber salad, 1/2 c. (cup) peaches 1 c. low fat milk, 1 c. of punch or lemonade and for NCS (no concentrated sweets) uns (unsweetened) peaches. Monday dinner was listed as; 3 oz. swedish meatballs, 1 medium baked potatoe, 1 c. italian mixed vegetables, 1 peice of garlic bread, 1/2 cup banana pudding with banana slices, 1 c. low fat milk, punch or lemonade, and NCS - unsweetened pudding with bananas. The Tuesday breakfast menu was listed as; 3/4 c. orange juice, 3/4 c. choice of cereal, 1/2 c. sausage gravy on 1 biscuit, 1 c. low fat milk, coffee/tea. The Tuesday lunch menu listed; 3 oz. sliced ham, 1/2 c. macaroni salad, 1 c. assorted vegetables, 1/2/ c. tapioca pudding, 1 c. low fat milk, 1 c. punch or lemonade and NCS - unsweetened pudding.	A 093		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 093	Continued From page 28 Observations of residentes in the dining area on at 11:30 a.m. revealed they were eating a tortilla wrap with meat & cheese in it and a colored beverage. Interview with resident #17 on as she was leaving the dining area revealed lunch was a wrap with lemonade to drink. Interview with employee #C on at approximately 11:30 a.m. revealed lunch was a meat & cheese wrap (soft tortilla shell) with beverage. Observations of residents in the dining area on beginning at 4:40 p.m. revealed they were served 2 meatballs with gravy, a medium baked potatoe, green beans, garlic bread, and a flavored beverage for dinner. Observations of residents in the dining area on at 6:20 a.m. revealed they were served and were eating, toast with butter, scrambled eggs, 2 sausage links, and a liquid beverage for breakfast. Observation of residents in the diling area on at 11:30 a.m. revealed they were served and were eating a sandwich with meat and cheese, carrot sticks, green jello and juice for lunch. Interview with employee #C at 11:45 a.m. on confirmed the residents were served a turkey & cheese sandwich, carrot sticks, jello and juice for lunch. Review of the facility policy and procedure manual, undated, revealed a form for documenting substitutions on. The form was	A 093		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 093	Continued From page 29 blank. The surveyor was unable to locate a policy on substitutions. Interview with employee #A on at approximately 11:50 a.m. revealed that there was no substitution policy, menu or log kept by the facility. Resident #14 stopped the surveyor as he was exiting the facility on at 12:05 p.m. She indicated that dinner the previous evening was great but the facilty had never provided this before. Discussion of breakfast revealed that the residents normally do not get butter for their toast. Class III	A 093		
A 160	58A-5.024(1) FAC Records - Facility Records. The facility shall maintain the following written records in a form, place and system ordinarily employed in good business practice and accessible to Department of Elder Affairs and Agency staff. (1) FACILITY RECORDS. Facility records shall include: (a) The facility ' s license which shall be displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident ' s: 1. Date of admission, the place from which the resident was admitted, and if applicable, a notation the resident was admitted with a pressure ; and 2. Date of discharge, the reason for discharge, and the identification of the facility to which the resident is discharged or home address, or if the	A 160		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 160	Continued From page 30 person is _____, the date of Readmission of a resident to the facility after discharge requires a new entry. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intends to return pursuant to Rule 58A-5.025, F.A.C. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) An up-to-date record of major incidents occurring within the last 2 years. Such record shall contain a clear description of each incident; the time, place, names of individuals involved; witnesses; nature of injuries; cause if known; action taken; a description of medical or other services provided; by whom such services were provided; and any steps taken to prevent recurrence. These reports shall be made by the individuals having first hand knowledge of the incidents, including paid staff, volunteer staff, emergency and temporary staff, and student interns. (e) The facility ' s emergency management plan, with documentation of review and approval by the county emergency management agency, as described under Rule 58A-5.026, F.A.C., which shall be located where immediate access by facility staff is assured. (f) Documentation of radon testing conducted pursuant to Rule 58A-5.023, F.A.C.; (g) The facility ' s liability insurance policy required under Rule 58A-5.021, F.A.C.; (h) For facilities which have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C. (i) The admission package presented to new or prospective residents (less the resident ' s contract) described in Rule 58A-5.0182, F.A.C.	A 160		

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
	AL11986321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 160	Continued From page 31 (j) If the facility advertises that it provides special care for persons with _____ or related _____, a copy of all such facility advertisements as required by Section 429.177, F.S. (k) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C. (l) All food service records required under Rule 58A-5.020, F.A.C., including menus planned and served; county health department inspection reports; and for facilities which contract for catered food services, a copy of the contract for catered services and the caterer ' s license or certificate to operate. (m) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last two (2) years. (n) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (o) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (p) Additional facility records requirements for facilities holding a limited mental health, extended 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. (q) The facility ' s resident elopement response policies and procedures. (r) The facility ' s documented resident elopement response drills.	A 160		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 160	Continued From page 32	A 160		

This Statute or Rule is not met as evidenced by:
Based on observation, record review, and staff interview, the facility failed to ensure that an up-to-date facility admission and discharge log is maintained as required, failed to maintain an up-to-date record of major incidents occurring within the last 2 years, and failed to maintain food service records as required.
1. Based on observation, record review, and staff interview, the facility failed to ensure that an up-to-date facility admission and discharge log is maintained as required.
Findings include:
Upon entrance to the facility on at approximately 9:30am, AHCA Surveyor requested the facility ' s current census and a list of current residents. Staff A provided a hand-printed list of residents by first names. AHCA Surveyor requested the Facility Admission /Discharge log (beginning at approximately 10:00am); Staff A provided 7 pages of logs, some hand-printed and some typed. AHCA Surveyor observed duplicate entries (Residents #15 & 23), residents on list not on Admission /Discharge log (Resident #20), and resident discharge information (final 3 columns: Date, Reason, Place Discharged To) not completed for at least 3 former residents (Residents #21, 22, & 23).
On the facility Admission /Discharge log, Resident #21 is listed as having been admitted on ; no discharge date or information is recorded. Per interview with the Facility Administrator on at approximately 11:00am, he did not update the facility Admission /Discharge log documenting Resident #21 ' s discharge because he believes the resident may come back. The Facility Administrator stated that Resident #21 ' s mother " picked him up last Thursday night

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 160	Continued From page 33	A 160		

< >, and he has been with her since then. "
Resident #21 ' s mother stated she personally discharged Resident #21 from the facility on . Per interview with Staff on , Resident #21 ' s mother removed the rest of his belongings from his former Thursday, .

Per continued interview with the Facility Administrator on , the Administrator stated that Resident #22 is out with parents, will not be returning, and is being discharged. Resident #22 was listed on the facility census provided . When AHCA Surveyor was matching with the resident census/listing on , Staff A stated that Resident #22 had been discharged from the facility. Resident #22 ' s former (double) is occupied by residents #14 & #15. Resident #22 was listed on the facility Admission /Discharge log as admitted on ; no discharge date or information is recorded.

Per interview with the Facility Administrator on at approximately 3:00pm, Resident #23 had been discharged on . Resident #23 was listed as admitted to the facility on ; no discharge date or information is recorded on the facility Admission/Discharge log.

The census/resident list provided by Staff A on contained a resident (#20) who was not listed on the facility Admission /Discharge log. Per interview with Staff A on , Resident #20 was admitted on . Staff A acknowledged that the resident had not been added to the Log.

AHCA Surveyor also observed three additional residents listed on the facility Admission /Discharge log who are not current residents of the facility. Admission dates of , and are individually recorded; no discharge date or information is recorded on the facility Admission /Discharge log.

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 160	Continued From page 34 2. Based on observation, record reviews, and interviews, the facility failed to maintain an up-to-date record of major incidents occurring within the last 2 years. Findings include: On at approximately 10:30am, AHCA Surveyor requested the log of Incident Reports from Staff A. Staff A did not know of any Incident Log being kept. She stated, "We don't document all incidents unless they're bad enough." On at approximately 11:30am, AHCA Surveyor requested the log of Incident Reports from the facility Administrator. The Administrator responded: "I don't keep a log of the incidents, but I have plenty of Incident Reports." The Administrator handed AHCA Surveyor a folder containing 5 Incident Reports dated 2012 plus 11 Incident Reports dated 2011. On at approximately 11am, Douglas Thomas, Adult Protective Investigator, DCF, observed copies of the reports and provided 2 more reports-He stated that the Administrator had pulled the 2 reports out from under his desk mat. The reports were not included in the file presented to AHCA Surveyor on . On at 4:41pm, the Pasco County Sheriff Department provided a Log of 6 calls to the Hillandale facility dated from to . Two of the 6 calls corresponded with written Incident Reports; there was no documentation at the facility pertaining to 4 of the 6 calls. AHCA Surveyor observed 7 facility Incident Reports dated during 2012. 3. Failed to maintain food service records required under Rule 58A-5.020, F.A.C., including menus planned and served, and a Substitution Log. AHCA Surveyors observed preparation and/or provision of 5 meals served at the facility on (lunch & dinner) and (breakfast,	A 160		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 160	Continued From page 35 lunch & dinner). An approved menu was posted (with alternating 4-week meal schedules). None of the meals served matched any of the meals listed on the alternating schedule for the day of any week 1-4. AHCA Surveyor requested the facility ' s food Substitution Log on · at approximately 11:40am. Staff A stated that there is no food substitution list. AHCA Surveyor requested the facility ' s food Substitution Log on · at approximately 4:00pm. Staff B (preparing the dinner meal on) responded: " What ' s that? " When told by the Surveyor what the food substitution log is, Staff B acknowledged that the facility does not keep such a log. Class III	A 160		
A 165	429.23 FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, " adverse incident " means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in:	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 165	Continued From page 36 1. _____; 2. or spinal damage; 3. Permanent _____; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident. (6) , neglect, or must be reported to the Department of Children and Family Services as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11986321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 165	Continued From page 37 involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within one (1) business day after the incident on AHCA Form 3180-1024, Assisted Living Facility Initial Adverse Incident Report-1 Day, 2006, and incorporated by reference. The form shall be submitted via electronic mail to riskmgmtps@ahca.myflorida.com; on-line at http://ahca.myflorida.com/reporting/index.shtml; by facsimile to (850)922-2217; or by U.S. Mail to	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 165	Continued From page 38 AHCA, Florida Center for Health Information and Policy Analysis, 2727 Mahan Drive, Mail Stop 16, Tallahassee, Florida 32308-5403, telephone (850)412-3731. AHCA Form 3180-1024 is available from the Florida Center for Health Information and Policy Analysis at the address stated above. The Initial Adverse Incident Report is in addition to, and does not replace, other reporting requirements specified in Florida Statutes. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported under subsection (1) above, the facility shall submit a full report within fifteen (15) days of the incident. The full report shall be submitted on AHCA Form 3180-1025, Assisted Living Facility Full Adverse Incident Report-15 Day, dated 2006, and incorporated by reference. The methods for obtaining and submitting the form are set forth in subsection (1) of this rule. This Statute or Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to provide preliminary and 15-day reports to the agency on all adverse incidents; specifically, events reported to law enforcement or its personnel for investigation and resident elopement if the elopement places the resident at risk of harm or injury. Findings include: On at approximately 11:30am, AHCA Surveyor requested the log of Incident Reports from the facility Administrator. The Administrator responded: "I don't keep a log of the incidents, but I have plenty of Incident Reports." The Administrator handed AHCA Surveyor a folder containing 5 Incident Reports dated 2012 plus 11	A 165		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 165	Continued From page 39 Incident Reports dated 2011. On : at approximately 11:00am, an Adult Protective Investigator from the Department of Children & Families observed copies of the reports and provided 2 more reports. The Investigator stated that the Administrator had pulled the 2 reports out from under his desk mat. The reports were not included in the file presented to AHCA Surveyor on . AHCA Surveyor reviewed the 7 Incident Reports provided, all written regarding Resident #23, and found that 3 of the 7 reports are deemed "adverse incidents;" all 3 events resulted in being reported to law enforcement for investigation, and 1 involved resident elopement: 1. On ..., "<Resident #23> was upset over relationship break-up ... got aggressive ... wouldn't comply with staff ... on floor, hit staff." Actions taken: "<Resident #23> called 911. Police came out took report. I spoke to Administrator" Notified Administrator : at "12:30noon" Staff I & B added note at bottom of page: " -spoke with sheriff they stated <Resident #23> was cop shopping to get what s/he wanted. Not Adverse. No one knows how incident happened--She has made wild accusations not supported by witnesses." initialed " JR " (Administrator ' s initials) Nothing is written in the " Follow Up " section at end of report. 2. ..."<Resident #23> signed (out) , 2012 Did not return" "Called 911, filed missing persons Report, ! while in community" Notified <Administrator> ... : (changed to :) at 4:00pm--Physician & Case Manager completed by Administrator ... Staff H & C ... Follow Up: "<Resident #23> was : the 14th of . She is now in treatment at Largo Medical Center in Indian Rocks." This report was dated as written 5 days after the resident signed out from the facility and	A 165		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 165	Continued From page 40 did not return. [Elopement places the resident at risk of harm or injury.] 3. undated; ? "<Resident #23> adamantly refuses to cooperate with staff, been aggressive toward other clients and staff, walking around the facility with feces and , refuses to shower." "Talked to FACT Team and <Resident #23> will be ." Notified doctor & Case Manager on at 1:30pm --Attached: "<Resident #23> was "<Resident #13>, <Resident #21>, and <Resident #8>, also 2 staff members. <Resident #23> is walking around smearing feces on the walls, couches, and people, walking around without clothes and refuses to cooperate, take shower. This is the 3rd time law enforcement have been called. FACT Team member signed form for her to be ." Nothing is written in the " Follow Up " section at end of report. On at 4:41pm, the Pasco County Sheriff Department provided a Log of 6 calls to the Hillandale facility dated from to . Following are 4 additional incidents involving police intervention, including 2 incidents of elopement placing the resident at risk of harm or injury: 1. " Missing person <Resident #19> left facility 2 days ago and has not returned, does not have meds with her -- staff said " Because she leaves so frequently it is normally not reported right away " -reported missing 4 times in the past year. " There was no documentation of facility interventions to provide adequate protection for the health, safety, and welfare of Resident #19. [Elopement places the resident at risk of harm or injury.] 2. " at 6:57pm dispatched to facility regarding runaway/missing person <Resident #19> <Staff D> reported that resident escaped out of facility on 3pm by climbing	A 165		

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
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 165	Continued From page 41 through a hole in the fence. " (Clearwater Police picked up resident and transported to Morton Plant Hospital) There was no documentation of the elopement and no documentation of the 4/2 report; there was no evidence of concern regarding the 20 days that passed between elopement and police dispatch. [Elopement places the resident at risk of harm or injury.] 3. " simple battery <Resident #21> Suspect <Resident #23> <Resident #21> standing in line for medicine when <Resident #23> <Resident #21>. <Staff F> said <Resident #23> started to slap and scratch <Resident #21> on neck, face, and back. <Resident #21> said s/he was standing in line for meds; Staff <F> said it happened when <Resident #23> came out of <own >. <Resident #23> said <Resident #21> <Resident #23> & hit <Resident #23> in the face--case transferred to State Attorney ' s Office. " A facility incident report dated was provided--referencing Resident #23 " other clients, " but no documentation of the incident. There was no documentation of facility interventions to provide adequate protection for the health, safety, and welfare of either Resident #21 or #23. On , Resident #23 said she knew something was wrong, wanted to cut (own) throat, and requested facility staff call 911 to be . There was no evidence of staff concern for resident welfare. 4. 7:20pm Responded in reference to threats; reported by Staff F - <Resident #18> harming himself-upset that he lost game charger-threw picture frame- " began bashing his head into the wall, causing a laceration on his forehead. <Staff F> brought <Resident #18> into office and attempted to calm down. <Resident #18> then began bashing his head into the wall, causing a laceration on his forehead. <Staff F>	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966321	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLANDALE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

(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 165	Continued From page 42 immediately called the Pasco Sheriff ' s Office to report the incident and have <Resident #18> for safety. " Transported to Trinity Hospital to be treated for injury; form completed while at Trinity. On & two AHCA Surveyors were approached multiple times (2-3 times each) by Resident #18 regarding needing a charger for his game. There were no documented attempts by the facility to assist the resident with concern causing him considerable distress and documented threat. There was no documentation of efforts by facility to prevent reoccurrence of resident self-harm. Class III	A 165		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Hillandale
6333 Langston Avenue
New Port Richey, FL 34652

Re: CCR # 2013004529

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2013 by representative(s) 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.

The Agency for Health Care Administration is imposing a directed plan of correction (DPOC). Should Hillandale fail to comply with the DPOC, submit an acceptable plan of correction, and/or achieve substantial compliance, the Agency for Health Care Administration may take administrative action including termination of its Assisted Living license.

You are directed to perform the following:

1. Residents located in infested will be relocated to an uninfested relocated per the County Department of Health's recommended action.

2. The entire facility must be treated in the appropriate manner, with temperature or a pesticide of the appropriate strength to kill/remove bed bugs.

3. The County Health Department must confirm, after treatment, the facility is free of bed bugs.

4. An approved plan of correction must be submitted to the Agency for Health Care Administration that outlines how the facility will monitor, on a daily basis, and maintain an environment free of bed bugs. The plan of correction must be submitted within 7 days of receipt of this letter.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Paul Brown at (727) 552-2000.

Sincerely,

Brian Stevens, for

Reid Caufman
Field Office Manager

PRC/brn
Enclosure(s)