

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER SAM'S ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1 PEBBLEWOOD LANE PALM COAST, FL 32164
---	--

(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 An unannounced biennial licensure survey, was conducted at Sam's Assisted Living Facility on , 2013. Sam's Assisted Facility had deficiencies at the time of the visit.	A 000		
A 052	58A-5.0185(3) FAC Medication - Assistance with Self-Admin (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least . . . , trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. (b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container. (c) Staff shall observe the resident take the medication. Any concerns about the resident ' s reaction to the medication shall be reported to the resident ' s health care provider and documented in the resident ' s record. (d) When a resident who receives assistance with	A 052		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6899

3NFK11

If continuation sheet 1 of 11

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/08/2013
NAME OF PROVIDER OR SUPPLIER SAM'S ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1 PEBBLEWOOD LANE PALM COAST, FL 32164		
(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)	(X6) COMPLETE DATE	
A 052	Continued From page 1 medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule which coincides with the resident's presence in the facility; 2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident's medication record; 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record; or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging; (e) Pursuant to Section 429.256(4)(h), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. (f) Pursuant to Section 429.256(4)(i), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (4) Assistance with self-administration does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications through _____	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SAM'S ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1 PEBBLEWOOD LANE PALM COAST, FL 32164		
(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 052	Continued From page 2 intermittent positive pressure breathing machines or a _____ (d) Administration of medications by way of a tube inserted in a cavity of the body. (e) Administration of _____ preparations. (f) Irrigations or debriding agents used in the treatment of a skin condition. (g) _____ or _____ preparations. (h) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (i) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure unlicensed staff does not give physician ordered as needed medication that required judgment on the part of the unlicensed staff member for 2 of 3 sampled residents. (#3, #4) Findings include: 1. Observation and interview with resident #3 on _____ at approximately noon, found the resident is alert to self only. Review of the labels on the medications for resident #3 found a bottle of W/A _____ Elixir dated _____ with instructions on the label to take 1 tablespoon every 8 hours as needed for pain. Review of the _____ 2013	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SAM'S ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1 PEBBLEWOOD LANE PALM COAST, FL 32164		
(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 052	Continued From page 3 Medication Observation Record (MOR) for resident #3 found the medication recorded as Q/A Elixir take 15 milliliters every 8 hours as needed for pain. Further review of the 2013 MOR found Resident #3 was given the W/A Elixir at 6:00 a.m. and 6:00 p.m. on 013 through 8, 2013 at 6:00 a.m. Review of the 2013 MOR found the medication was given at 6:00 a.m. and 6:00 p.m. every day in . Review of the resident's record could not locate physician orders for the medication. Further review of the labels of medication for resident #3 found a bottle of . dated with instructions on the label to take 1 to 2 tablets daily. Review of the 2013 MOR for Resident #3 found the medication recorded as . 2 tabs at 7:00 a.m. Further review of the 2013 MOR found Resident #3 was given two tablets of . at 7:00 a.m. on 2013 through 8, 2013. Review of the 2013 MOR found two tablets of the . was given to the resident at 7:00 a.m. every day in . During an interview with the caregiver at the facility on . at 1:15 p.m., she stated the resident can sometimes say she is in pain. During an interview with the Administrator of the facility on . at 1:30 p.m., she stated she did not have physician orders for the resident's medication. She further stated they should be in the resident's hospice file. She looked and could not locate them. 2. Observation of resident #4 on . at 9:00 a.m. found she is not able to make her needs known.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SAM'S ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1 PEBBLEWOOD LANE PALM COAST, FL 32164		
(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 052	Continued From page 4 Review of the labels on the medications for resident #4 found bottle of _____ W/A _____ Elixir dated _____ with instructions written on the label to take 7.5 milliliters every 6 hours as needed for pain. Review of the _____ 2013 Medication Observation Record (MOR) for resident #3 found the medication recorded as Q/A _____ Elixir take 7.5 milliliters every 6 hours as needed for pain. Further review of the _____ 2013 MOR found the medication was given on _____ at 6:00 p.m., _____ at 6:00 a.m. and 6:00 p.m., _____ at 6:00 a.m. and 6:00 p.m. and on _____ at 6:00 a.m. Review of the labels on the medications for Resident #4 found a bottle _____ 1 milligram tablets dated _____ with instructions on the label to take one tablet every four hours as needed. Further review of the _____ 2013 MOR found the resident is receiving the medication at 7:00 a.m. and 7:00 p.m. Further review of the labels on the medications for resident #4 found a bottle of _____ Liquid dated _____ with orders on the label to take two tablespoons three times a day for two days and then three a day as needed. Review of the MOR for _____ for resident #4 found the _____ was given at 6:00 a.m., 12:00 p.m. and 6:00 p.m. on _____ On _____ at 6:00 a.m. and 12:00 p.m. On _____ and _____ at 6:00 a.m. and 6:00 p.m. and again at 6:00 a.m. on _____ During an interview with the administrator on _____ at 1:24 p.m. she was asked about the as needed medications. She stated they give the medications as directed by the hospice nurse and that she would check with Hospice about the orders.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/08/2013
NAME OF PROVIDER OR SUPPLIER SAM'S ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1 PEBBLEWOOD LANE PALM COAST, FL 32164		
(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 052	Continued From page 5 Class III	A 052			
A 056	58A-5.0185(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) No prescription drug shall be kept or administered by the facility, including assistance with self-administration of medication, unless it is properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and 2. Identification of each medicinal drug product in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no person other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider shall be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations shall be specified; for example, "as needed for pain, not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, shall be noted in the medication record, or a revised label shall be obtained from the pharmacist. (d) Any change in directions for use of a medication for which the facility is providing	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SAM'S ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1 PEBBLEWOOD LANE PALM COAST, FL 32164		
(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 056	Continued From page 6 assistance with self-administration or administering medication must be accompanied by a written medication order issued and signed by the resident's health care provider, or a faxed copy of such order. The new directions shall promptly be recorded in the resident's medication observation record. The facility may then place an "alert" label on the medication container which directs staff to examine the revised directions for use in the MOR, or obtain a revised label from the pharmacist. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed copy of a signed order is acceptable. (f) The facility shall make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 64F-12.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which shall also include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they shall be kept in a container that bears a label containing the following: 1. Practitioner's name; 2. Resident's name; 3. Date dispensed; 4. Name and strength of the drug; 5. Directions for use; and	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965709	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SAM'S ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1 PEBBLEWOOD LANE PALM COAST, FL 32164		
(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 056	Continued From page 7 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider shall provide the resident with a written prescription, or a fax copy of such order. This Statute or Rule is not met as evidenced by: Based on staff interview, and record review, the facility failed to obtain physician orders to discontinue medications and failed to obtain physician orders for new medications 2 of 2 sampled residents. (Resident #3 and #4) The findings include: Review of the labels on the medications for resident #3 found she is receiving W/A Elixir take 1 tablespoon every 8 hours as needed for pain, take 1 to 2 tablets daily, 20 milligrams, 1 tablet each day, 10 milligrams, 1 tablet twice a day, CL Meq 1 tablet a day, 81 milligrams 1 tablet a day, and 0.5 milligrams take 1 tablet in the a.m. and 2 tablets in the p.m. Review of record for resident #3 found physician orders for 25 milligrams each day, 5 milligrams each day, 125 milligrams each day, 40 milligrams each day, 20 milligrams each day, 10 mec each day, Mirtazipine 15 milligrams at the hour of sleep, 3 milligrams each day and and 0.5 milligrams each day. During interview with the Administrator on at 1:49 p.m., she stated all the medications for the resident have changed. She further she did not get new orders and that once in Hospice she thought Hospice would take	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SAM'S ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1 PEBBLEWOOD LANE PALM COAST, FL 32164		
(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 056	Continued From page 8 care of everything. Review of the labels on the medications for resident #4 found she is receiving 1 milligram tablets take one tablet every four hours as needed, Liquid take two tablespoons three times a day for two days and then three a day as needed, Polyethylene Mirilax power 17 grams in pureed diet twice a day, 500 milligrams twice a day, 25 milligrams 3 tablet twice a day and 2 tablets midday, 20 milligrams 1 tablet a day, 10 meq 1 table a day and Natural take two tablets twice a day. Review of the record for resident #4 found physician orders for 500 milligrams twice a day and Thorazine 25 milligrams twice a day During an interview with the Administrator on at 1:00 p.m., she stated she thought because the resident is in Hospice that they take care of all the physician orders. She stated the resident's medications have changed and she did not have any other physician orders for the resident. Class III	A 056			
A 161	58A-5.024(2) FAC Records - Staff (2) STAFF RECORDS. (a) Personnel records for each staff member shall contain, at a minimum, a copy of the original employment application with references furnished and verification of freedom from communicable including In addition, records shall contain the following, as applicable: 1. Documentation of compliance with all staff	A 161			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SAM'S ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1 PEBBLEWOOD LANE PALM COAST, FL 32164		
(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 161	Continued From page 9 training required by Rule 58A-5.0191, F.A.C.; 2. Copies of all licenses or certifications for all staff providing services which require licensing or certification; 3. Documentation of compliance with level 1 background screening for all staff subject to screening requirements as required under Rule 58A-5.019, F.A.C.; 4. A copy of the job description given to each staff member pursuant to Rule 58A-5.019, F.A.C., for facilities with a licensed capacity of seventeen (17) or more residents; and 5. Documentation of facility direct care staff and administrator participation in resident elopement drills pursuant to paragraph 58A-5.0182(8)(c), F.A.C. (b) The facility shall not be required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by a business entity contracting to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 58A-5.019, F.A.C. (c) The facility shall maintain the facility's written work schedules and staff time sheets as required under Rule 58A-5.019, F.A.C., for the last 6 months. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain verification 1 of 3 employees were free from communicable (Employee #3) The findings include:	A 161			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/08/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER SAM'S ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1 PEBBLEWOOD LANE PALM COAST, FL 32164
---	--

(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 161	Continued From page 10 Record review of the employee file for Employee #3 (hired) could not locate a statement from a health care provider that Employee #3 was free from communicable . During an interview with the Administrator on she was able to provide a consult report dated with the impression: no acute and a LabCorp result that stated there were negative results meaning there is no . During further interview with the Administrator she stated they employee went to the health department and they told her because she was from the Philippines she needed these tests. She stated she did not have any other paperwork to show the Employee #3 was free from communicable Class III	A 161		

RICK SCOTT
GOVERNOR



ELIZABETH DUDEK
SECRETARY

2013

Administrator
Sam's Assisted Living Facility
1 Pebblewood Lane
Palm Coast, FL 32164

Dear Administrator:

This letter reports the findings of a state biennial licensure survey that was conducted on 2013 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after 2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at

Sincerely,

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

KW/sm
Enclosure

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



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