

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	Initial Comments Assisted Living Facility A complaint survey, CCR# 2013004707, was conducted on 1/1/13. The Serenity House, assisted living 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	A 052			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0000

9X9E11

If continuation sheet 1 of 34

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 1 resident ' s health care provider and documented in the resident ' s record. (d) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule which coincides with the resident ' s presence in the facility; 2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident ' s medication record; 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident ' s medication record; or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging; (e) Pursuant to Section 429.256(4)(h), F.S., the term " competent resident " means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. (f) Pursuant to Section 429.256(4)(i), F.S., the terms " judgment " and " discretion " mean interpreting vital signs and evaluating or assessing a resident ' s condition. (4) Assistance with self-administration does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the		A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669	
(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 administration of medications by any injectable route. (c) Administration of medications through 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 record review and interview, the facility failed to ensure that 4 of 4 staff who provide assistance with self-administration of medications have successfully completed the initial 4-hour training on providing assistance with self-administration of medications and safe medication practices in an assisted living facility. Findings include: AHCA Surveyor conducted a review of the facility _____ Record and Medication Observation Record on _____ (beginning at approximately 10:30am). The _____ Record review confirmed that Staff B was providing assistance with self-administration of medications on or before _____ and Staff C was providing	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 assistance with self-administration of medications on or before . The medication records review confirmed that Staff A, B, C, & D had all assisted residents with self-administration of medications during the month of , 2013. Per interview with the facility Administrator on / at approximately 11:15am, the facility has no records of staff training and could not verify that staff providing residents with assistance with self-administration of medications completed the initial 4-hour training on providing assistance with self-administration of medications and safe medication practices in an assisted living facility. Widespread	A 052			
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. (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	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 4 medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure proper maintenance of a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications, recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. Findings include: AHCA Surveyor review of the facility Record conducted at the facility (beginning at approximately 10:30am) revealed errors as follows (Resident #1-Medication: Hydrocone- 5-500 TAB - Take 1 tablet by mouth 2 times a day as needed for pain): -count went from 57 minus 1=55, then entry from (55 changed to 56) 56-1=55; entry 54-1=53; entry 53-1=52. There was one med not accounted for during that time period-Staff B & Staff C signatures. / -count went from 52 minus 1=51, then / at 12 N entry from 52 minus 1=51 and a 2nd / at 12 N entry from 51 minus 1=50 (Staff B). / -count went from 34 minus 1=33, then next entry is dated //13-count went from 25 minus 1=24. No counts were documented from / to / -8 meds not accounted for during that time period. The last entry was / -count: 24. Surveyor verified count with the Administrator: 24 as of / at	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 5 11:30am. AHCA Surveyor conducted further review of Resident #1 Medication Observation Records: Hydrocone- 5-500 TAB was initiated as given by "RL" on [redacted] & [redacted]; There is no indication of who has those initials; the count sheet only has a [redacted] entry by Staff B-no [redacted] entry. MORs for the months of [redacted] & [redacted] 2013 show no Hydrocone given during those months-- [redacted] Record indicates 4 meds given during [redacted] During [redacted] 2013, this med was initiated as given by Staff B on [redacted] and noted on reverse as given; also initiated as given by Staff B on [redacted]-med, reason, & result not noted on reverse. There is no entry on the MOR for med given on [redacted] / [redacted]; one was given on [redacted] / [redacted] according to Record. Surveyor reviewed Resident #1's records for the month of [redacted] 2013, observed additional errors/omissions as follows: [redacted] 5 MG Tablets - Take 1 tablet by mouth every 8 hours as needed for muscle spasms Initiated and noted on reverse as given by Staff B on [redacted] & [redacted] Staff C initiated as given on [redacted] & [redacted]-med, reason, & result not noted on reverse. [redacted] 150mg - Take 1 tablet by mouth twice a day-8am & 5pm: Not initiated as given at 8am on [redacted] & [redacted] / [redacted]; Not initialed as given at 5pm on [redacted] & [redacted] / [redacted] [redacted] 5mg- Take 1 tablet by mouth daily-8am: Not initialed as given at 8am on [redacted] & [redacted] / [redacted] [redacted] 10mg - Take 1 tablet by mouth at bedtime-8pm: Not initialed as given at 8pm on [redacted] & [redacted] / [redacted] [redacted] 5mg C-4 -- Take 1 tablet by mouth twice a day at 8am & 8pm: Not initialed as given at 8pm on [redacted] & [redacted] / [redacted]	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 6 Levothyrox 25mcg - Take 1 tablet by mouth daily-8am: Not initialed as given at 8am on _____, & _____. 20mg -Take 1 capsule by mouth daily-8am: Initialed as given on _____, with a line drawn through remainder of the month. MOR states start _____ -stop _____ -There is no indication of this med having been discontinued. Metoprolol 25mg - Take 1 tablet by mouth daily in the morning and 1&1/2 in the evening-8am & 5pm: Not initialed as given at 8am on _____, & _____. Not initialed as given at 5pm on _____, & _____. 325mg- Take 1 tablet by mouth daily-8am: Not initialed as given at 8am on _____, & _____. Ferrex 150mg -Take 1 capsule by mouth twice a day-8am & 5pm: Not initialed as given at 8am on _____, & _____. Not initialed as given at 5pm on _____, & _____. 667mg-Take 1 capsule by mouth three times a day with meals-8am, noon, & 5pm: Not initialed as given at noon & 5pm on _____, Not initialed as given at any time (8am, noon, & 5pm) on _____, & _____. Polyethylene _____ PWD-Dissolve 17 grams in 8oz of water and drink daily-8am: Not initialed as given at 8am on _____, & _____. 48mg - Take 1 tablet by mouth daily-8am: Not initialed as given at 8am on _____, & _____. The facility Administrator stated that the medications had been given and acknowledged that the Medication Observation Records had not been properly documented (_____ at 11:15am). Widespread	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 077	Continued From page 7	A 077		
A 077	58A-5.019(1) FAC Staffing Standards - Administrators Staffing Standards. (1) ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429, F.S., and this rule chapter. (a) The administrators shall: 1. Be at least _____; and 2. If employed on or after _____, 1990, have a high school diploma or general equivalency diploma (G.E.D.), or have been an operator or administrator of a licensed assisted living facility in the State of Florida for at least one of the past 3 years in which the facility has met minimum standards. Administrators employed on or after _____, 1995, must have a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening standards pursuant to Section 429.174, F.S.; and 4. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C. (b) Administrators may supervise a maximum of either three assisted living facilities or a combination of housing and health care facilities or agencies on a single campus. However, administrators who supervise more than one facility shall appoint in writing a separate "manager" for each facility who must: 1. Be at least _____; and 2. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C. (c) Pursuant to Section 429.176, F.S., facility owners shall notify both the Agency Field Office and Agency Central Office within ten (10) days of	A 077		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 077	Continued From page 8 a change in a facility administrator on the Notification of Change of Administrator, AHCA Form 3180-1006, 2006, which is incorporated by reference and may be obtained from the Agency Central Office. The Agency Central Office shall conduct a background screening on the new administrator in accordance with Section 429.174, F.S., and Rule 58A-5.014, F.A.C. This Statute or Rule is not met as evidenced by: Based on record the review and interview, the facility failed to ensure that the Administrator has completed the core training required by the State of Florida for all Assisted Living Facility Administrators. Failure to ensure proper facility operation and staff management/supervision places residents at risk of improper care, with the potential for adverse medical consequences. Findings include: Per interview conducted on 1/1 at approximately 11:30am, the Administrator acknowledged having become the facility Administrator on and acknowledged not having taken the CORE training required of facility Administrators. The Administrator acknowledged being responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents. Facility business card names advertise the present Administrator as Owner/ Administrator of the facility.	A 077			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 078	Continued From page 9		A 078		
A 078	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Newly hired staff shall have 30 days to submit a statement from a health care provider, based on an examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable including . Freedom from . must be documented on an annual basis. A person with a positive test must submit a health care provider's statement that the person does not constitute a risk of communicating . Newly hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in service. If any staff member is later found to have, or is suspected of having, a communicable , he/she shall be removed from duties until the administrator determines that such condition no longer exists. (b) All staff shall be assigned duties consistent with his/her level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff shall exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of Rule 58A-5.0191, F.A.C. (d) Staff provided by a staffing agency or employed by a business entity contracting to provide direct or indirect services to residents must be qualified for the position in accordance with this rule chapter. The contract between the		A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 078	Continued From page 10 facility and the staffing agency or contractor shall specifically describe the services the staffing agency or contractor will be providing to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility shall: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and 2. Maintain time sheets for all staff. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all staff have submitted, within 30 days of beginning employment, a statement from a health care provider, based on examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable _____ including _____. Failure to ensure staff are free from communicable _____ places resident at risk of adverse medical consequences. Findings include: Per interview with the facility Administrator on ____/____/____ at approximately 11:15am, the facility has not been maintaining employee records – 2 job applications and 1 CNA certificate were the only items available at the time of visit. There was no evidence of _____ testing and no documentation of freedom from communicable _____ for 4 of 4 current facility employees. Employee start dates available for 3 of 4 employees include _____, on or before _____, and on or before _____. Widespread	A 078			
A 080	58A-5.0191(1) FAC Training - Core & Competency Test	A 080			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 080	Continued From page 11 Staff Training Requirements and Competency Test. (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training requirements established by the department pursuant to Section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to , 1997, and managers who attended the core training program prior to , 1998, shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with Part II of Chapter 468, F.S., are exempt from this requirement. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years as provided under Section 429.52, F.S. (d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must:	A 080			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 080	Continued From page 12 1. Retake the assisted living facility core training; and 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed \$200. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by: Based on record the review and interview, the facility failed to ensure that the Administrator has completed the core training requirements within 3 months from the date of becoming a facility administrator and passed the required competency test. Failure to ensure required training and certification of facility administration places residents at risk of improper care, with the potential for adverse medical consequences. Findings include: Per interview conducted on 1/1/13 at approximately 11:30am, the Administrator acknowledged having become the facility Administrator on 1/1/13 and acknowledged not having taken the CORE training required of facility Administrators. Facility business card names advertise the present Administrator as Owner/ Administrator of the facility. 	A 080			
A 081	58A-5.0191(2) FAC Training - Staff In-Service (2) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 081	Continued From page 13 facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions, and facility sanitation procedures before providing personal care to residents. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to _____ borne _____, may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting major incidents. 2. Reporting adverse incidents. 3. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and _____. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 081	Continued From page 14 taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all staff have completed a minimum of 1 hour in-service training in control, including universal precautions, and facility sanitation procedures before providing personal care to residents; a minimum of 1 hour in-service training within 30 days of employment that covers reporting major incidents and adverse incidents, facility emergency procedures, including emergency evacuation, resident rights in an assisted living facility, and recognizing and reporting resident, neglect, and ; 3 hours of in-service training within 30 days of employment covering resident behavior and needs and providing assistance with the activities of daily living; and in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. Failure to ensure staff are trained in all of these concerns places	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 081	Continued From page 15 residents at risk of potential for neglect, and and adverse medical consequences. Findings include: Per interview with the facility Administrator on / / at approximately 11:15am, the facility has not been maintaining employee records -- 2 job applications and 1 CNA certificate were the only items available at the time of visit. There was no evidence of in-service training in control, including universal precautions and facility sanitation procedures for 3 of 4 current facility employees. There was no evidence of in-service training in reporting major incidents and adverse incidents, facility emergency procedures, including emergency evacuation, resident rights in an assisted living facility, and recognizing and reporting resident neglect, and for 4 of 4 current facility employees. There was no evidence of in-service training in resident behavior and needs and providing assistance with the activities of daily living for 3 of 4 current facility employees. There was no evidence of in-service training regarding the facility's resident elopement response policies and procedures for 4 of 4 current facility employees. Employee start dates available for 3 of 4 employees include on or before , and on or before Widespread	A 081		
A 082	58A-5.0191(3) FAC Training - (3) (/). Pursuant to Section 381.0035, F.S., all facility employees, with the exception of employees subject to the	A 082		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 082	Continued From page 16 requirements of Section 456.033, F.S., must complete a one-time education course on _____ and _____, including the topics prescribed in Section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12) of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all staff have completed a one-time education course on _____ and _____ within 30 days of employment. Failure to ensure staff are trained on _____ / _____ places residents at risk of adverse medical consequences. Findings include: Per interview with the facility Administrator on _____ / _____ at approximately 11:15am, the facility has not been maintaining employee records -- 2 job applications and 1 CNA certificate were the only items available at the time of visit. There was no evidence of training on _____ / _____ for 3 of 4 current facility employees. Employee start dates available for 3 of 4 employees include _____, on or before _____, and on or before _____. Widespread	A 082		
A 083	58A-5.0191(4) FAC Training - First Aid and _____ (4) FIRST AID AND _____ (_____. A staff member who has completed courses in First Aid and _____ and holds a currently valid card documenting completion of such courses must be in the facility at all times.	A 083		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 083	Continued From page 17 (a) Documentation of attendance at First Aid or course offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American Association, or National Safety Council; or a provider approved by the Department of Health, shall satisfy this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under Part III of Chapter 401, F.S., shall be considered as having met the training requirements for both First Aid and This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses is in the facility at all times. Failure to ensure that a staff person trained in First Aid and is in the facility at all times places residents at risk of adverse medical consequences. Findings include: Per interview with the facility Administrator on at approximately 11:15am, the facility has not been maintaining employee records -- 2 job applications and 1 CNA certificate were the only items available at the time of visit. There was no evidence of First Aid and training for 4 of 4 current facility employees. Employee start dates available for 3 of 4 employees include , on or before , and on or before . Per review of staff planning schedules and interview with the facility Administrator on / /		A 083		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 083	Continued From page 18 (approximately 11:30am), staff work 24 hour shifts from 9am-9am and are frequently the only staff on duty throughout their shifts. Widespread	A 083			
A 084	58A-5.0191(5) FAC Training - Assis Self-Admin Meds & Med Mgmt (5) ASSISTANCE WITH SELF-ADMINISTERED MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with self-administered medications as described in Rule 58A-5.0185, F.A.C., must meet the training requirements pursuant to Section 429.52(5), F.S., prior to assuming this responsibility. Courses provided in fulfillment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates	A 084			

If continuation sheet 20 of 34

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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)	
A 084	Continued From page 20 provide assistance with self-administered medications have successfully completed the initial 4 hour training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. Failure to ensure staff are trained on providing assistance with self-administered medications and safe medication practices places residents at risk of adverse medical consequences. Findings include: There was no evidence of training in providing assistance with self-administration of medications for 4 of 4 current staff providing assistance with self-administration of medications. AHCA Surveyor conducted a review of the facility Record and Medication Observation Record on / / (beginning at approximately 10:30am). The Record review confirmed that Staff B was providing assistance with self-administration of medications on or before and Staff C was providing assistance with self-administration of medications on or before . The medication records review confirmed that Staff A, B, C, & D had all assisted residents with self-administration of medications during the month of , 2013. Per interview with the facility Administrator on at approximately 11:15am, the facility has no records of staff training and could not verify that staff providing residents with assistance with self-administration of medications completed the initial 4-hour training on providing assistance with self-administration of medications and safe medication practices in an assisted living facility. Widespread		A 084		
A 085	58A-5.0191(6) FAC Training - Nutrition & Food Service		A 085		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 085	Continued From page 21 (6) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. A certified food manager, licensed dietician, registered dietary technician or health department sanitarians are qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the administrator or person designated by the administrator as responsible for the facility's food service has obtained a minimum of 2 hours of continuing education annually in topics pertinent to nutrition and food service in an assisted living facility. Failure to obtain training in nutrition and food service places residents at risk of adverse medical consequences. Findings include: Per interview with the facility Administrator on _____ at approximately 11:15am, the facility has not been maintaining employee records -- 2 job applications and 1 CNA certificate were the only items available at the time of visit. There was no evidence of training in Nutrition & Food Service for 4 of 4 current facility employees. Employee start dates available for 3 of 4 employees include _____, on or before _____, and on or before _____. Per review of staff planning schedules and		A 085		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 085	Continued From page 22 interview with the facility Administrator on (approximately 11:30am), staff work 24 hour shifts from 9am-9am and are frequently the only staff on duty throughout their shifts. Widespread	A 085		
A 090	58A-5.0191(11) FAC Training - Do Not Orders (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility 's policies and procedures regarding within 60 days after the effective date of this rule. (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility 's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in Rule 58A-5.0186, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the administrator and direct care staff have received training in Failure to obtain training in places residents at risk of receiving unwanted medical treatment or services and violation of personal rights. Findings include: Per interview with the facility Administrator on	A 090		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669	
(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 090	Continued From page 23 I/ at approximately 11:15am, the facility has not been maintaining employee records -- 2 job applications and 1 CNA certificate were the only items available at the time of visit. There was no evidence of training in for 4 of 4 current facility employees. Employee start dates available for 3 of 4 employees include , on or before , and on or before . Per review of staff planning schedules and interview with the facility Administrator on (approximately 11:30am), staff work 24 hour shifts from 9am-9am and are frequently the only staff on duty throughout their shifts. Widespread	A 090		
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 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	A 161		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 24 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 interview, the facility failed to ensure the maintenance of personnel records for each staff member consisting of employment applications with references furnished and verification of freedom from communicable including documentation of compliance with all staff training required, and documentation of facility direct care staff and administrator participation in resident elopement drills. Failure to ensure staff are properly qualified and trained places residents at risk of adverse medical consequences. Findings include: Per interview with the facility Administrator on / / at approximately 11:15am, the facility has not been maintaining employee records -- 2 job applications and 1 CNA certificate were the only items available at the time of visit. AHCA Surveyor observed no employment	A 161			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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 25 applications for 2 of 4 facility employees, no verification of freedom from communicable including for 4 of 4 current facility employees, no record of required staff training for 4 of 4 current facility employees, and no documentation of facility direct care staff and administrator participation in resident elopement drills for 4 of 4 current facility employees . Widespread	A 161			
AZ815	408.809, 435.02(2), 435.06 Background Screening; Prohibited Offenses 408.809, F.S. (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest if the agency has reason to believe that such person has been convicted of any offense prohibited by s. 435.04. For each controlling interest who has been convicted of any such offense, the licensee shall submit to the agency a description and explanation of the conviction at the time of license application. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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
AZ815	Continued From page 26 personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, contracting with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients. Evidence of contractor screening may be retained by the contractor ' s employer or the licensee. (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person ' s fingerprints to the Federal Bureau of Investigation for a national criminal history record check. If the fingerprints of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g), the person must file a complete set of fingerprints with the agency and the agency shall forward the fingerprints to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The fingerprints may be retained by the Department of Law Enforcement under s. 943.05(2)(g). The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person fingerprinted. Proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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
AZ815	Continued From page 27 agency, the Department of Health, the Agency for Persons with _____, the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 satisfies the requirements of this section if the person subject to screening has not been unemployed for more than 90 days and such proof is accompanied, under penalty of perjury, by an affidavit of compliance with the provisions of chapter 435 and this section using forms provided by the agency. (3) All fingerprints must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony.	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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
AZ815	Continued From page 28 (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (g) Section 817.234, relating to false and fraudulent insurance claims. (h) Section 817.505, relating to patient brokering. (i) Section 817.568, relating to criminal use of personal identification information. (j) Section 817.60, relating to obtaining a credit card through fraudulent means. (k) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (l) Section 831.01, relating to forgery. (m) Section 831.02, relating to uttering forged instruments. (n) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (o) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (p) Section 831.30, relating to fraud in obtaining medicinal drugs. (q) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. A person who serves as a controlling interest of, is employed by, or contracts with a licensee on _____, 2010, who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by 31, 2015. The agency may adopt rules to	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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
AZ815	Continued From page 29 establish a schedule to stagger the implementation of the required rescreening over the 5-year period, beginning , 2010, through , 2015. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: - Does not have an active professional license or certification from the Department of Health; or - Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a	AZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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
AZ815	Continued From page 30 person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining fingerprints pursuant to s. 943.05(2). (8) There is no unemployment compensation or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06, F.S. (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity.	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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
AZ815	Continued From page 31 (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including fingerprints if required, must be disqualified for employment in such position or, if employed, must be dismissed.	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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
AZ815	Continued From page 32 (4) There is no unemployment compensation or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02(2), F.S. " Employee " means any person required by law to be screened pursuant to this chapter. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that Level 2 background screening pursuant to chapter 435 has deemed eligible for employment the Administrator and all employees providing personal care or services directly to residents or having access to client funds, personal property, or living areas. Failure to ensure residents receive care and services safely, securely, and from persons who have not committed offenses that preclude them from employment directly placed the residents at risk for exposure to persons whom the Florida Legislature has deemed inappropriate to provide care or services. Findings include: Per interview with the facility Administrator on 1/ at approximately 11:15am, the facility has not been maintaining employee records -- 2 job applications and 1 CNA certificate were the only items available at the time of visit. There was no evidence of Level 2 screenings conducted on 4 of 4 current employees of the facility (including the	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964933	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 15322 MATIS ROAD HUDSON, FL 34669		
(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	
AZ815	Continued From page 33 facility Administrator). Scope C	AZ815			



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

....., 2013

Administrator
Serenity House Assisted Living Facility
15322 Matis Road
Hudson, FL 34669

Dear Administrator:

Re: **CCR# 2013004707**

This letter reports the findings of a complaint 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 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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Paul Y Brown
Patricia Reid Kaufman
Field Office Manager

For

PRC/kpr

Enclosure: State Form 3020

