

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 07/02/2013
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11967024	(X3) DATE SURVEY COMPLETED 07/02/2013
NAME OF PROVIDER OR SUPPLIER La Grande Belle	STREET ADDRESS, CITY, STATE, ZIP CODE 5898 Orchard Pond Road Tallahassee, FL 32303	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:

0054-Medication - Records-07/02/2013
0055-Medication - Storage And Disposal-07/02/2013
0057-Medication - Over The Counter (otc) Products-07/02/2013
0161-Records - Staff-07/02/2013
0162-Records - Resident-07/02/2013
Z815-Background Screening; Prohibited Offenses-

Revisit Repeat Tags:

0081-Training - Staff In-Service-58a-5.0191(2) Fac

Based on employee record review and staff interview the facility failed to provide proof of required training for 1 of 4 (#1) employee files reviewed.

The findings are:

A review of the employee #1 record date of hire reveals proof of training is still not provided from the survey conducted. Employee #1 has not provided a communicable statement, proof of completing first aide training, elopement training, and training for recognizing and reporting neglect and

A phone interview was conducted with the administrator at approximately 10:00 AM. He stated he thought all the training had been completed, and would be sure the screening tests would include the communicable statement in the future.

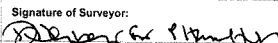
class III

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967024	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/2/2013
Name of Facility LA GRANDE BELLE		Street Address, City, State, Zip Code 5898 ORCHARD POND ROAD TALLAHASSEE, FL 32303

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0054</u> Reg. # <u>58A-5.0185(5) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0055</u> Reg. # <u>58A-5.0185(6) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0057</u> Reg. # <u>58A-5.0185(8) FAC</u> LSC _____	Correction Completed
ID Prefix <u>A0161</u> Reg. # <u>58A-5.024(2) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0162</u> Reg. # <u>58A-5.024(3) FAC</u> LSC _____	Correction Completed	ID Prefix <u>AZ815</u> Reg. # <u>408.809, 435.02(2), 435.06</u> LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency _____ Reviewed By _____ CMS RO _____	Reviewed By _____ Reviewed By _____	Date: _____ Signature of Surveyor:  Date: _____ Signature of Surveyor: _____	Date: <u>7/2/13</u> Date: _____
Followup to Survey Completed on: _____		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO	



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
La Grande Belle
5898 Orchard Pond Road
Tallahassee, FL 32303

Dear Administrator:

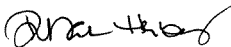
Re: Limited Nursing Services Monitoring Plus Revisit

This letter reports the findings of a state licensure survey that was conducted on 2, 2013 by representative(s) of this office. Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. 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(s). Should you have any questions please call me at 850-412-4540.

Sincerely,


Donah Heiberg
Field Office Manager

DH/dh
Enclosure
XG90

