STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911678	07/03/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Northpointe Retirement Community	**5100 Northpointe Parkway Pensacola, FL 32514**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0092 - 58a-5.020(1) Fac - Food Service - General Responsibilities S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced biennial licensure, complaint survey, and follow-up survey was conducted - .
The survey included allegations contained in CCR#s 2013004462, 2013005362, 2013005430, and a revisit for a previously substantiated complaint allegation. Northpointe Retirement Community had deficiencies found at the time of the visit.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on record reviews and interview the facility failed to ensure 3 of 15 sampled residents (#4, #9 and #16) had the required face to face medical examination by a physician at least every three years to ensure continued residency.

The findings are:

Record review for sampled resident #4 revealed the contained an AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities signed and dated by the physician .

Record review for sampled resident #9 revealed the contained an AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities signed and dated by the physician .

Record review for sampled resident #16 revealed the contained an AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities signed and dated by the physician .

Interview with the Assistant Administrator on at approximately 11:00AM confirmed these are the residents' latest physician completed AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities and revealed her statement she thought these evaluations had be completed on residents every 5 years not every 3 years.

Class III

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0054-Medication - Records 58A-5.0185(5) FAC
Based on observation, record review, and interview, the facility failed to maintain accurate physician orders on the Medication Observation Record (MOR) for 1 of 8 residents observed in the medication pass observation (sample resident #12); and failed to ensure 2 of 8 residents in the sample had annual physician reviews of the continued need for the use of chemical (sample residents # 2 and #9).

The findings are:

1. A medication administration observation was conducted during the noon meal on . The facility Licensed Practical Nurse (LPN) conducted the medication administration. The LPN was observed to give to resident #12 ex-strength 125 mg (milligrams), one tab, chewable. The resident was observed to take the medication by mouth and chew it.

The MOR was reviewed for resident #12. The MOR instructions read " 80 mg (1) by mouth three times daily".

On at approximately 2:45 p.m. an interview was conducted with the LPN. The LPN stated the pharmacy does not have the 80 mg dose on their formulary. The pharmacy got a clarification order from the physician, changing the dose to 125 mg chewable tab, extra strength. The LPN provided a copy of the pharmacy communication effective . The LPN explained that another staff member responsible for maintaining the monthly MOR document failed to make the change in dose on the MOR.

2. Record review of the 2013 medication administration record for sampled resident #2 revealed the resident is currently taken 0.5mg one by mouth at bedtime. Review revealed the most recent physician annual review of the , as a chemical , on . The record review failed to reveal an annual review of the medication since . Interview with the Assistant Administrator on at approximately 1:35PM confirmed the resident has not received an annual review of the chemical medication.

3. Record review for sampled resident #9 revealed the resident currently taking 3 mg one daily due to . Review of the record revealed the most recent annual chemical review was done on . Interview with the Assistant Administrator on at approximately 4:00PM confirmed these findings.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observations and interview the facility staff failed to ensure residents' medications were stored appropriately, properly closed and sealed, in one of two medication storage areas.

The findings are:

Observation on at approximately 3:51PM revealed sampled staff A unlocking the door to . Interview and observation revealed this for the staff. Observation in the a small a

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refrigerator sitting on a desk. Interview with the staff revealed the refrigerator is only used for medication storage and remains off; the door is locked with a lock. There is a large chain attached with a key on the end of the chain. The staff unlocked the refrigerator with this key. Inspection at approximately 4:12PM of the refrigerator revealed mulitiple appropriately labeled medications in the refrigerator. Inspection revealed two small medication cups in the back left corner of the refrigerator, behind a basket containing medication bottles. One cup is marked with the hand written words sampled resident #13 's name and " " and contains one white round pill; the second medication cup was marked with the handwritten words sampled resident #14 and " prn " which contains one white oblong pill. The medication was not appropriately closed an sealed. Interview with sampled staff A confirmed these findings and revealed her statement she does "not know why they are in the refrigerator."

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation of medication administration, interviews with residents and staff, and record reviews of sampled residents, the facility failed to ensure the availability of medication refills for 2 of 8 residents (sample resident #s 4 and 12) in a timely manner; failed to ensure "as needed" medication orders (PRN orders) were written with specific instructions for use for 6 of 6 residents sampled (#s 7, 8, 13, 14, 15, and 16); and failed to protect the integrity of resident medications by transferring medications to secondary containers for 2 of 6 sampled residents (#s 7 and 12).

The findings are:

1. During the noon medication pass on / resident #4 was observed to requested a PRN dose of 7. for pain. The Licensed Practical Nurse (LPN) conducting the medication pass informed the resident there was only one dose left. The LPN gave him an option of taking the dose now, or saving it for later in the day. The resident opted to save it for the end of the day. The nurse told the resident the VA (Verterans' Administration) had been contacted for a refill.

On at approximately 11:45 a.m. the LPN provided the empty container for the , stating the resident took the last dose of it on / at 5:00 p.m., and he did not get a dose this morning, nor will he get a dose a noon today, as is his usual request, because there are no more left to give to him. The nurse stated the refill is on order through the VA, and it has not arrived at the facility as of this time. There is no documentation on the reverse side of the MOR to explain the missed doses or the actions taken to get the medication refilled.

On at approximately 2:40 p.m. the interview with the LPN was continued. The LPN was asked what is the facility policy for obtaining refills for medications. She stated she had not read any policies since she has been employed here (about one month). She stated she tries to call in to the specific pharmacy for refills when the resident has 7 days of medications remaining in the drug cart. She states that it takes 2-3 days usually to get a refill, unless there is no prescription refills remaining, and then the pharmacy will have to call the physician to get a new order for refills, and that usually takes a bit longer. She acknowledged that this resident has missed one

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dose yesterday, and one dose today, so far, and the medication refill has not yet arrived.

The administrator/owner of the facility was asked to provide a copy of the facility policy for medications administration. The administrator/owner of the facility provided an undated policy entitled "Supervision of Self Administration of Medication". Paragraph #9 of the policy states "When the medication is down to a five (5) day supply, bring the card to the office and put it in a designated drawer. Return card to medication basket before noon".

2. A review of Medication Observation Record (MOR) for sample resident #12 reveals the resident is scheduled to have 0.5 mg (milligrams) one (1) by mouth in a.m. and at bedtime. The MOR reveals that doses for were not given at 8:00 a.m. on both and , and the 8:00 p.m. dose was not given on . A review of the back of the MOR for this resident has the following handwritten notes: unavailable. Refill on order (nurses initials)". unavailable. Doctor contacted to renew prescription (nurses initials)". I contacted (physician office group name) and spoke to (staff name) about getting and refilled. She said they didn't receive any fax from Pharmacy. I then called (drug store name) and asked them to re-fax the request again (nurses initials)".

On at approximately 2:15 p.m. the pharmacy representative was observed delivering medications to the facility. The nurse was observed to receive the medications. The nurse verified through interview that one of the medications was 0.5 mg tab, quantity 60 tabs, for resident #12. The nurse was then asked what is the facility policy for obtaining refills for medications. She stated she had not read any policies since she has been employed here (about one month). She stated she tries to call in to the specific pharmacy for refills when the resident has 7 days of medications remaining in the drug cart. She states that it takes 2-3 days usually to get a refill, unless there is no prescription refills remaining, and then the pharmacy will have to call the physician to get a new order for refills, and that usually takes a bit longer. She acknowledged that this resident has missed her last 3 scheduled doses of the medication (an medication, 2 doses yesterday, and one dose today).

The administrator/owner of the facility was asked to provide a copy of the facility policy for medications administration. The administrator/owner of the facility provided an undated policy entitled "Supervision of Self Administration of Medication". Paragraph #9 of the policy states "When the medication is down to a five (5) day supply, bring the card to the office and put it in a designated drawer. Return card to medication basket before noon".

3. Observation on at approximately 3:51PM revealed sampled staff A unlocking the door to . Interview and observation revealed this for the staff. Observation in the a small a refrigerator sitting on a desk. Interview with the staff revealed the refrigerator is only used for medication storage and remains off; the door is locked with a lock. There is a large chain attached with a key on the end of the chain. The staff unlocked the refrigerator with this key. Inspection at approximately 4:12PM of the refrigerator revealed mulitiple appropriately labeled medications in the refrigerator. Inspection revealed two small clear medication cups in the back left corner of the refrigerator, behind a basket containing medication bottles. One

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cup is marked with the hand written words of sampled resident #3 name and " " and contains one white round pill; the second medication cup was marked with the handwritten words sampled resident #14 name and " prn " which contains one white oblong pill. Interview with sampled staff A confirmed these findings and revealed her statement she does "not know why they are in the refrigerator."

4. Interview with the facility's Licensed Practical Nurse, sampled staff C, on at 9:54AM revealed this is her first job. She graduated from nursing school in and passed her nursing exams in 2013 and started working here about a month ago. Stated she only works 7a-5p Monday through Friday. When asked how she administers her medications she revealed that Assistant Administrator "trained her". She has been instructed by the Assistant Administrator not to leave a full 30 day supply of in the locked refrigerator in her office. So she stated for example sampled resident #7 gets pain medications including Methadone which comes in a bottle of 180 pills from the pharmacy. She transfers the methadone from the original bottle from the pharmacy and places them in different bottles and these second bottles are then locked in the little refrigerator (which is used only for storage not refrigeration) on the second floor for the night staff to assist with self-administration. She has been instructed by Assistant Administrator not to keep a count log. The nurse took the surveyor to the medication refrigerator in her office where she unlocked it. She then showed the surveyor a little blue basket of medications which contained some bottles of medications she stated she had transferred the some medications from the original pharmacy bottle to another pharmacy labeled bottle. They included a medication bottle for sampled resident #7 labeled Methadone 10mg, take 4 tablets by mouth at 7AM, 2 PM and 8PM and the bottle contained 12 tablets, on top of the medication bottle lid there is a hand written note "night". She stated she transferred these methodone pills from the originial pharmacy bottle of 180 tablets. She stated she transfers enough methodone tables from the original bottle for the night shift for a week supply of pills for Monday -Friday someone else fills it for the weekend. She stated the night staff will place the empty bottle on her desk when they need to be refilled.

The surveyor asked the nurse for further clarification of what she has been doing. The nurse revealed again that she takes the orginal pharmacy filled medications bottles which contain large numbers of and then transfers a few of the pills from that container into another pharmacy labeled medication bottle for the night shift to use. She showed the surveyor which bottles she had transferred medications and they included the following:

a)The nurse pulled the original pharmacy medication bottle from her medication cart for sampled resident #7 Methodone 10mg take 4 tables by mouth at 7AM, 2PM and 8PM bottle dated as filled . She then showed the surveyor the second bottle in which was labled Methodone 10mg take 4 tablets by mouth at 7AM, 2PM, and 8PM with a filled date of which at one time contained 270 pills, in which she had transferred medication into; this second bottle contains 12 tablets at this time. And she had handwritten the word "night" on the bottle lid.
b) She then showed the surveyor another orignial bottle dated as filled on / / for sampled resident #7 for 8mg tablets one tablet by mouth four times daily and showed the surveyor a second bottle which she stated she had transferred medications into. This bottle is labeled 8mg tablets one tablet by mouth four times a day with a date filled of with the lid marked in hand written black magic marker "night" which contained 5 tablets.
c) She then showed the surveyor another original pharmacy bottle for sampled resident #7 dated labeled for Methadone 5 mg take 2 tablets at 7AM, 2 PM and 8PM and to be taken with methadone 10mg (8 tabs)and she showed the surveyor the second bottle she had transferred some of these pills in for the night shift .

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d) Then she showed the surveyor an original pharmacy medication bottle for sampled resident #12 dated from the pharmacy - 5-500 mg one every 12 hours routinely. This bottle contained one tablet in it. She then showed the surveyor the second bottle which contained one tablet dated from the pharmacy in which she had transferred for the night shift. She stated that the procedure is when these second bottles of medications are empty, the night shift staff place the empty bottles on her desk and she refills them, from the original medication bottles from the pharmacy. She showed the surveyor the orginal bottle of -APAP5-500mg one container with one tablet and a new bottle of 60 tablets. She stated these are the only two residents in which she transfers medications from the original medication bottle to another bottle for the night shift.

She was asked if she ever transferred resident's medications into the small clear medication cups and wrote the resident's name on these medication cups for other staff members to administer. She stated yes. That in the past when sampled resident #13 was on ( ) as needed; she would draw one up for the night shift and then would place the cup into the plastic bin that is kept in the refrigerator in her office and lock it in there for the night shift to use; but stated she no longer does this as the resident is now on the medication routinely. She stated she has pre drawn medication for sampled resident #14, , she pre drew her for the night shift but hasn't done it in a long time. Surveyor asked her if she was the one who pre drew the and for sample residents #13 and #14 two residents, in reference to the ones the surveyor found in the second floor refrigerator and she stated she did not. The surveyor and this staff member returned to the second floor refrigerator and observation revealed these medication cups were no longer in the refrigerator. She stated yesterday afternoon sometime after 4:00PM the Assistant Administrator instructed her to go upstairs to this refrigerator and get her these medication cups. She stated she gave these two medication cups and pills to the Assistant Administrator and she does not know what she did with this medications.

An interview on at approximately 4:15PM with the Assistant Administrator reveiwed these findings and revealed her statement that they have had problems in the past with a large bottle of missing and this was the only way she knew how to prevent the problem from reoccuring. She also stated she would not allow the prefilled marked medications cups for the night staff.

5. Record review for sampled resident #14 revealed a physician order dated which stated discontinue , start one tablet by mouth every six hours prn. (as needed). The order does not contain the circumstances under which it would be appropriate for the resident to request the medication and any limitations. Review of the medication administration record (MAR) revealed the medication being taken on 15 and 16, 2013. Interview with the facility LPN, sampled staff C, on at 2:41PM revealed that sampled staff A, an unlicensed staff , assisted with these medications. Record review of the sampled resident's AHCA form 1823, Resident Health Assessment for Assisted Living Facilities, dated revealed the physician stating the resident needs assistance with self administration of medications.

6. Record review of the AHCA form 1823, Resident Health Assessment for Assisted Living Facilities for sampled resident #7, dated revealed the physician statement the resident needs assistance with self administration of medications. Record review revealed a physician order for 5mg one by mouth twice daily as needed. The order does not contain the circumstances under which it would be appropriate for the resident to request the medication.

7. Record review for sampled resident #13 revealed AHCA Form 1823 Resident Health Assessment for

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Assisted Living Facilities dated revealed the physician stated the resident needs assistance with self administration of medications. Review of the physician orders revealed an order for 325 mg take 1-2 tablets every 6 hours as needed orally. The order does not contain the circumstances under which it would be appropriate for the resident to request the medication and any limitations. Record review of the 2013 revealed the resident required the medication on and by the nurse and on and by the med tech, an unlicensed staff.

8. Record review for sampled resident #15 revealed an AHCA 1823 form Resident Health Assessement for Assisted Living Facilities completed by the physician on which states the resident needs assistance with self administration of medications. Review of the physician orders for parnoate 50 mg one every 6 hours prn and 2 mg one every 6 hours prn. Record review of the resident's 2013 MOR revealed he received the medication 24- , 2013. The order does not contain the circumstances under which it would be appropriate for the resident to request the medication.

9. Record review for sampled resident #16 revealed an AHCA 1823 form Resident Health Assessement for Assisted Living Facilities completed by the physician on which states the resident needs assistance with self administration of medications. Review of the physician orders revealed an order dated for one by mouth every day as needed, a physician order dated for ( ) 0.5mg one by mouth every 8 hours as needed and a physician order dated 50mg one po qhs prn dated . The orders do not contain the circumstances under which it would be appropriate for the resident to request the medication.

10. Record review for sampled resident #8 revealed a AHCA 1823 dated which the physician stated resident needs assistance with self-asministration of medications. Review of the physician orders dated revealed orders for Extra Strength 1000mg one every 8 hours as needed. The orders do not contain the circumstances under which it would be appropriate for the resident to request the medication or any limitations.

11. An interview with the Assistant Administrator was on at approximately 11:00AM, to reveiwed these concerns. During this interview, it was revealed that unlicensed staff do and may need to assist with these medications and revealed these residents are not always cognizant.

Class III

0092-Food Service - General Responsibilities 58A-5.020(1) FAC
Based on observations, interview and review of the facility's policy and employee training manual the facility administrator failed to ensure facility food service staff performed their duties in a safe and sanitary manner by failing to ensure they wear hair protectors and failed to ensure they did not handle food with bare hands, to reduce food contamination for two of two observed meals.

The findings are:

On / at approximately 11:40AM observation of the kitchen staff from the kitchen door leading into the dining the surveyor complete visualization of the kitchen area and the staff serving the lunch meal. The observation revealed one staff serving the meal from the steam table, the surveyor observed steam rising from the food as it was being served from the steam table. This staff served up two plates. Continued

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observation revealed sampled staff # D, placing a roll on each plate using his bare hands, he then goes into the dining serves these two plates to two residents. He returns to the kitchen repeats this process by placing a roll, using his bare hand, on four more resident meal plates that had been prepared and then serves these to residents. This staff person was not observed to wash his hands at any time. At approximately 11:50AM sampled staff #E enters the kitchen and also uses her bare hands to place rolls on the prepared resident plates.

Observation at 12:04PM revealed sampled staff #F sitting beside a resident assisting her with her meal. At approximately 12:09PM the staff is observed to butter the resident's roll with butter holding the roll with her bare hands.

On at approximately 7:20AM observations of the staff preparation/serving of the breakfast meal began. Observation revealed two staff, sampled staff #G preparing the breakfast meal, preparing the residents plates and also cooking pancakes. Sampled staff #D is observed placing bread in the toaster with his bare hands. Sampled staff #D and #G are also observed without use of hair nets or caps and sampled staff #G also has a beard and does not have a covering over his beard. Continued observation at approximately 8:01AM revealed sampled staff #G continues to prepare food and prepare residents breakfast plates and continues to have no hair or beard covering. During this observation sampled staff #G was also observed placing a link sausage on two different residents' plates using his bare hands. Observation of sampled staff #D is now observed to be wearing a hair net and continues to be observed to place toast on the plates using his bare hands. Staff sampled #G was observed to be cooking pancakes, a staff member came in to the kitchen and requested a piece of sausage for a resident and sampled staff #G again placed the sausage on the plate using his bare right hand.

Interview on at approximately 4:53PM with the owner/administrator revealed his statement that the latest food safety information and training revealed it is more sanitary to use bare hands and not gloves due to less chances of cross contamination. His interview also revealed it his expectation that his staff wear hair nets during the preparation and servicing of food. On at approximately 9:00AM the owner/administrator was asked for and provided the facility policy and procedures. Review of the facility's food service department policy and procedure manuals revealed under section Food Service Personnel Personal Hygiene page XI-4 revealed section 5c "A hairnet will be worn at all times while working in the kitchen." and section 6f "Use plastic (one use) gloves for handling food". The owner/administrator also provided the surveyors with a manual titled "Employee Training Manual" which he stated all employees review and are expected to follow. The manual included a booklet entitled "Preventing Food Contamination A Guide for Many of Florida's Food Service Industries". The booklet was published by the Florida Department of Health Division of Environmental Health DH150-111, . The owner/administrator stated this booklet is part of the employee's training. Review of this booklet revealed on page 8 the following: "In addition to being personally clean and well , the food service worker should follow these rules for safe food handling practices:..Use spoons, forks and other utensils when handling food. This reduces hand contact and contamination of the foods being prepared". The owner/administrator also presented the surveyor with a Food Safety and Sanitation manual which he stated he had prepared himself to teach a course. Review of this manual revealed under the section tilted "The Flow of Food (part two) under Learning Objective 4 revealed the statement Service Hazards 1. Employees may contaminate ready-to-eat foods with their hands. Under Consideration 1.1 Employee should avoid bare hand contact with ready-to-eat food. They may use single use gloves, deli paper, utensils, etc." Review of these findings was done with the owner/administrator on at approximately 10:45AM.

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0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on record review and interview the facility failed to ensure the facility menus used by the facility are reviewed annually by a registered dietician.

The finding are:

Review of the current menus posted on the wall outside of the dining at approximately 8:30AM revealed they are signed by the registered dietician and dated . Interview with the owner/administrator on at approximately 8:45AM confirmed the menus are to be reviewed annually and these menus are past due. The surveyor requested the name and phone number of the registered dietician who reviews the facility's menus and this information was provided. A telephone interview was conducted with this registered dietician on at approximately 3:30PM. The dietician stated she called the facility's Assistant Administrator about a month ago to remind her the facility needed their menus reviewed. She further stated this Assistant Administrator, called her this morning ( ) and told her that they were reviewing their menus and making some changes and did not have them ready for her review.

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06
Based on employee record review, and interview with the assistant administrator, the facility failed to ensure there was evidence of the "Affidavit of Compliance for Background Screen" in the personnel records for 2 of 5 employees in the sample (employees designated at "A" and "D").

The findings are:

A sample of employee records was inspected during the course of the survey. There was no evidence of the required Affidavit of Compliance for Background Screen found in the employee records for employees identified as "A" and "D".

An interview was conducted with the assistant administrator at the exit conference on at approximately 4:30 p.m. During the exit conference, the assistant administrator stated she could not explain why employees "A" and "D" did not have the Affidavit of Compliance for Background Screen, as she was certain they were there the last time she reviewed their records.

class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Northpointe Retirement Community
5100 Northpointe Parkway
Pensacola, FL 32514

RE: BIENNIAL LICENSURE SURVEY PLUS COMPLAINT REVISIT

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 1-3, 2013 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) 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.

As a result of the uncorrected citation at A0052 for the complaint revisit done in conjunction with the biennial survey, we are providing you a Directed Plan of Correction relating to medication administration. Only licensed nursing personnel may have any involvement with provision of care relating to tube feedings, medication administration through a tube or flushing of feeding tubes. You must ensure this corrective action is taken immediately.

Due to your uncorrected citations related to medication management for the complaint revisit done in conjunction with the biennial survey, you must employ (on staff or by contract) the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse. The initial on-site consultant visit shall take place within 7 working days of the date of this letter. The facility shall have available for review by the agency a copy of the pharmacist's or registered nurse's license and a signed and dated recommended corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. The facility shall provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required.

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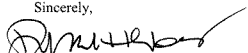
Tallahassee, FL 32308
Phone 850-412-4540; Fax (850) 922-9162

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