STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968054	10/01/2013
NAME OF PROVIDER OR SUPPLIER **Soaring Eagle Assisted Living Facility**	STREET ADDRESS, CITY, STATE, ZIP CODE **1568 Sw California Blvd Port Saint Lucie, FL 34953**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Assisted Living Facility standard biennial licensure survey was conducted _____. Soaring Eagle Assisted Living Facility, had licensure deficiencies found at the time of the visit.

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation and interview, the facility failed to ensure that a staff member (the Administrator) followed appropriate steps when assisting a resident with self-administration of medications, for 1 out of 1 sampled residents (Resident #1).

The findings include:

During medication pass observed on _____ beginning at 9:33 AM, the Administrator provided assistance with self-administration of medications to Resident #1. It was noted that the Administrator provided assistance with self-administered medications to Resident #1, without telling her what the medications were or observing the resident taking the pills.

Record review revealed the Administrator is not currently licensed to practice nursing or medicine. The Administrator has received training with respect to assisting with self-administration of medication.

A record review of Resident #1's current health assessment (AHCA Form 1823) dated documents that she requires assistance with self-administration of medications. In an interview conducted on at 1:21 PM, the Administrator stated that she usually reads the medication labels and watches the resident swallow them, but said she forgot this time.

Class III

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

0054-Medication - Records 58A-5.0185(5) FAC
Based on observation, interview and record review, the facility failed to ensure accurate Medication Observation Records (MORs) were maintained and accurate, for 1 out of 1 sampled residents (Resident #1).

The findings include:

a) An observation was made during a brief tour of the facility on at 8:49 AM, it was noted that Resident #1 had a portable tank in her During an interview with the Administrator on at 9:42 AM, it was revealed Resident #1 was prescribed at bedtime and as needed. Review of Resident #1's MORs for the month of 2013, failed to indicate an order for

b) During observation of the medication pass on at 9:33 AM, it was noted Resident #1 was assisted with an Ocuvite eye tablet. During an interview with the Administrator on at 9:42 AM, it was revealed Resident #1 was prescribed Ocuvite eye tablets once daily. Review of Resident #1's MORs for the month of 2013, failed to indicate an order for Ocuvite eye tablet.

c) Further review of the MORs with the Administrator revealed the MOR for the month of was initialed for but had a date of printed on it. A review of the MOR for the month of 2013, had one page with a date of and the second page with a date of

d) A record review of Resident #1's current health assessment (AHCA Form 1823) dated , documents that she requires assistance with self-administration of medications.

In an interview conducted on at 9:42 AM, the staff member stated the pharmacy did not send her the correct MORs with the current month printed on it. She stated that she normally transfers the medications written in from the previous month to the current month on the first of every month but had not done so yet. As a result, Resident #1's MOR did not reflect all of her current medications and treatments.

Class III

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	AL11968054	**10/01/2013**
NAME OF PROVIDER OR SUPPLIER **Soaring Eagle Assisted Living Facility**	STREET ADDRESS, CITY, STATE, ZIP CODE **1568 Sw California Blvd** **Port Saint Lucie, FL 34953**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on an interview, the facility failed to keep substitutions for meals on file for 6 months.

The findings include:

In an interview conducted on at 11:33 AM, the Administrator stated that menus are not always followed, since she has only one resident (Resident #1) residing in the facility. The Administrator further stated, she discusses with Resident #1 what she would like to eat and substitutions are made accordingly.

The Administrator stated she does not write down substitutions. Therefore, she does not have any documented substitutions to the noted menu on file.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Soaring Eagle Assisted Living Facility
1568 SW California Blvd
Port Saint Lucie, FL 34953

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2013 by a representative from 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 (30) 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

J. Wesley Mayo, Supervisor

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State form 5000-3547
XG90

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