STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963974	10/09/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Belleair Country House	2298 Belleair Road Clearwater, FL 33764	

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

List of Tags Cited:

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0028 - 58a-5.0182(4) Fac - Resident Care - Activities Of Daily Living S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= G
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - 0161 - 58a-5.024(2) Fac - Records - Staff S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2013010068, was conducted on .

The Belleair Country House, assisted living facility, had deficiencies at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure that 1 (#2) of 3 sampled residents had documentation from a physician that the resident's needs could be met at an Assisted Living Facility (ALF) as evidenced by a blank present on the Health Assessment that would substantiate appropriate placement in an ALF.

Findings include:

A review of Resident #2's clinical file, the face sheet documented that the resident was admitted to the facility in . The clinical file had an 1823, dated , that documented that the male needed assistance with all of the categories of Activities of Daily Living, with the exception of eating, which was documented to need supervision and for transferring " at times, 2 people ". Further review of the Health Assessment, documented that Resident #2 had a history of a fx neck, Chronic kidney and .

A review of the area on the 1823 that would document whether the placement in the ALF was appropriate was blank.

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An interview conducted on [redacted] at approximately 12:00 p.m. with the facility manager confirmed that no other 1823 was available for review for Resident #2.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on record review and interview, the facility failed to provide resident care supervision for 1 (#1) of 3 sampled residents as evidenced by the discovery of the resident beside her bed after an "extended" period of time with large amounts of dried [redacted] on the resident and the carpet and the noticeable "old" [redacted] smell surrounding the resident. Failing to ensure appropriate supervision for a resident places them at risk for non-receipt of health care services and can potentiate neglect.

Findings include:

Review of Resident #1 's clinical file revealed an 1823, dated [redacted]. The form documented a Medical history and diagnoses: [redacted] with [redacted] or behavioral status of [redacted]. The Special precaution box documented "[redacted]". The Activities of Daily living categories documented: Assistance in all categories except: eating and toileting, which she was documented to need supervision.

A record review of Resident Aid notes for [redacted] for Resident #1 revealed at approx. 7:30 a.m., staff found Resident #1 on the floor in her [redacted], head by window sill, [redacted] hand, face head, covered in dry [redacted] no clothes on except a soaking wet diaper. No night gown in sight, only a flat sheet, half on half off bed. 911 called to transport resident to a local hospital. Emt's (Emergency medical technicians) said, she apparently [redacted] quite a while before 7:30 a.m. due to the dryness of [redacted] on her and the carpet and window sill.

A record review of facility incident / Illness report, dated [redacted] documented that the exact time of the incident was [redacted] at 7:00 a.m.; type of incident [redacted] Resident #1. Brief Description of incident= 1st shift staff found her on floor in [redacted] on hands and head; 911 called. Type of injury=Laceration.

In an interview with Staff member B, on [redacted] at 9:20 a.m., discussing the event of [redacted] with Resident #1 being found, she stated : I usually go in to get her , she was almost in a [redacted] position at the top of the [redacted] (on the floor), where the window sill was; I did not want to move her; a lot of [redacted] the [redacted] around her head was still I dripping; the spot on the carpet was dry; areas on her hair had dry [redacted] She did not have any clothes; the gown was on the bed that should have been on her body; she was soaking wet; she had a diaper on; no BM; just soiled it had that odor that when you have had it on there for a while, it is strong. The person working the working the shift before us was Staff member A, she had left when we found her.

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A review of the Emergency Transport services report, dated , documented the following: (Resident) is curled up in the position, laying on her right side on the floor next to her bed at the ALF (Assisted Living Facility). Her head is resting on the marble window sill that is just a few inches above the floor. It appears she rolled out of bed and hit her head on the sill. The is dried; (resident) has redness and the imprint of the carpet on her right side, suggesting she has been lying on the floor for an extended period of time. (Resident) has a laceration on the right side of head, has subsided, is clotted.

In an interview conducted on at 6:45 a.m. with Staff member A, she confirmed that she was working during the night, 10 p.m. to approximately 7 a.m. on and she also confirmed she usually works alone. In regards to a that Resident #1 had on Staff member A stated: "I do not know what happened. I did my rounds about 6 a.m., and then at 7:30 a.m., they found her on the floor (after I left the facility), by the window sill on the floor, she had bumped her head. The window sill that is right by her bed. "

In an interview conducted on at 10:08 a.m. with a Hospice, Certified Nursing Assistant, she stated that she has been coming to the facility for 5-6 years. Familiar with Resident #1.; come in M-W- F; services are I provide her showers and change her linen. Usually come in at 8 a.m.; I used to come in at 7:00 a.m., but, they (Hospice) told me to come in at 8:00 a.m. ; I spend about an 1.25 hours with her. (The change took place about 2-3 weeks ago, as far as the change in schedule). Before, when I would come in at 7 a.m., I would find her soiled sometimes; I would tell Staff member B and she would report it to the Manager. (Approximately over a 2 week period, I would find her soiled every other time. This was occurring prior to her

Record review of an employee counseling for Staff member A, dated , documented the following: " In your charting 10 p.m.-7 a.m., you charted you changed Resident #1 at 6:00 a.m.; She would not have been that wet had you checked and changed her. I don ' t know what happened on your shift for you not to check Resident #1 more frequently, but this cannot happen ever. This incident is considered a form of neglect that has never happened in the 6 years you have worked at the facility. I am placing you on a 3 month probation and at the end we will sit and re-evaluate Thursday, . Please take your time when charting and be very accurate with the times.

A review of a job description for 3rd shift, that Staff member A signed, date unknown, documented the following: Rounds should be done every hour, unless there is someone that requires more frequent checks.

CLASS II

0028-Resident Care - Activities of Daily Living 58A-5.0182(4) FAC

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Based on record review, observation and interview, the facility failed to ensure that it offered assistance with Activities of Daily Living to promote the health and dignity of the residents; For 1 (#2) of 3 sampled residents in regards to toileting assistance; for 1 (#1) of 3 sampled residents in regards to assistance with eating.

Findings include:

A.) Review of Resident #2 ' s clinical file revealed the face sheet documented the resident was admitted to the facility in . The clinical file had an 1823, dated , that documented the male needed assistance with all of the categories of Activities of Daily Living, with the exception of eating, which he was documented to need supervision and for transferring " at times, 2 people " . Further review of the Health Assessment, documented that Resident #2 had a history of a fx neck, Chronic kidney and . Review for weights for this client was conducted and the documentation was not available. The weight of the client was estimated to be approximately 150 lbs.

During observations conducted the date of survey on , it was observed that staff members brought Resident #2 from his the dining table at 7:42 a.m. Resident #2 was observed to sit at the dining table, in a slouched position, with no offering by staff to toilet him or assist him to reposition him until at 11:16 a.m. when a visiting HHC ST (Home Health Care Speech asked for staff assistance to reposition the resident, at which time Staff member B and C., moved the client minimally while repositioning him. The resident was observed to be awake during the observations.

An observation conducted at approximately 11:45 a.m. revealed, while leaving the facility, it was observed that Resident #2 had not been moved from the dining , he had not been offered to toilet, nor had staff changed him during the almost 4 hours of observation.

B.) Review of Resident #1's clinical file revealed the most recent 1823 was dated , that documented a medical history and diagnose of and . It was noted that Resident #1 had documentation on file that she had been admitted to Hospice Care as of . During an interview conducted on at approximately 12:00 p.m. with the facility manager, she confirmed that the resident had a diagnosis of and Severe .
Further review of the 1823 revealed that she was documented to need assistance in all ADL categories with the exception of eating and toileting. Per an interview conducted on at approximately 6:45 a.m. with Staff member A, she stated that she changes the resident in bed, that they do everything for the resident because she cannot do for herself.

Observations conducted on :

Observation conducted on at 7:43 a.m. of Resident #1, staff member B was bringing the resident out of her , had transferred the resident to the w/c, backed the resident out of her pulled her into the dining , through the dining , approximately 50 feet, backwards.

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Staff member B positioned resident #1 at the dining table in her w/c. Resident #1 had a hospital gown on. Staff member C bought a plate of oatmeal out, at 7:45 a.m., place it in front of Resident #1, within reach, chopped up a couple slices of bananas with the spoon; handed the spoon to Resident #1 and then pushed the plated oatmeal out of reach of the resident.

At 7:57 a.m., the oat meal was still out of reach, while the resident was taking spoon and running it along the table as if eating in a repetitive manner.
At 7:58 a.m., Staff member A positioned the oatmeal in front of the resident with the spoon.
Resident #1 reached her right hand into the oatmeal and started to feed herself.
At 7:59 a.m., Staff member A got a new spoon for Resident #1, scooped the oatmeal out her hand; gave the spoon to the resident; left the resident; came back stood by the resident; gave the resident one spoon full of oat meal and moved on across the another resident.
At 8:01 a.m., Staff member C, walked up to Resident #1, stood by her, picked up the spoon and gave the resident spoonfuls of oatmeal while she stood next to the resident..
At 8:03 a.m., Staff member C, still assisting Resident #1, standing, moved the plate out of reach of the resident.
At 8:04 a.m., Staff member C left the side of Resident #1.
At 8:05 a.m., Staff member C, returned to push the ½ eaten oatmeal out of reach of Resident #1, She brought back a ½ of a glazed donut which she cut up for the resident.

An interview conducted at this time with Staff member C, asked her if the resident was prescribed a diet, she stated that she was not sure. Asked if the resident could eat by herself; she stated that sometimes; she is better at lunch and dinner; she will try to hold the spoon, but mostly she eats with her hands.
She then walked away from the resident.
At 8:15 a.m., Staff member A assisted the resident by giving her one scoop of oatmeal from the out of reach plate. Placed the donut in front of the resident and walked away.

Resident #1 was not receiving the assistance she needed in regards to being fed by one staff member in a dignified manner. Staff were assisting her as they were passing by and placing the food out of her reach.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

Based on observation, record review and interview the facility failed to ensure that 1 (Staff member A) of 1 staff members reviewed for Medication Assistance, provided Medication with Self-Administration within the scope of an unlicensed staff member as evidenced by the staff member crushing medications, spoon feeding the resident

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the mixture with no verbalization of what medication was being provided to the resident (#1).

Findings include:

An observation was conducted on [redacted] at 8:17 a.m. of Staff member A, a Resident Aid, crushing medications in a cup with a mushy material, who proceeded to the side of Resident #1 with the cup and spoon feed the resident the mixture without verbalizing to the resident any information about what she was feeding her. Resident #1 consumed approximately 80% of the mixture. When asked what was it that she just gave to the resident, Staff member A stated that she did not know the Resident ' s medication, pulled 3 bubble packs and a liquid bottle of medication from the cart and stated that this is what she had just given the resident.

A review of the labels on the medication revealed the following:
Pot [redacted] Cap [redacted], 10MEQ ER, take one capsule orally, " Do not crush or chew ", dispense date of [redacted]
[redacted] Tab 5 mg [redacted] take one tablet orally every day, dispense date of [redacted]
Levothyroxin tab 112 MCG, take one tablet orally every day.
[redacted] 250 mg/5 ml soln [redacted] take 10 ml po every morning and take 5 ml every evening.
Dispense date of [redacted]

Class III

0053-Medication - Administration 58A-5.0185(4) FAC

Based on observation, record review and interview, the facility failed to ensure that it provided a licensed staff member to administer a medication, Pot [redacted] Cap [redacted] 10MEQ ER, in accordance with the prescription label for 1 (#1) of 3 sampled residents. Failing to ensure that directions for drug administration are followed can place a resident at risk for health complications.

Findings include:

Review of Staff member A's personnel file revealed that she was hired to assist with resident care at the facility and she was not a licensed nurse. Further review of Staff member A's personnel file revealed that she had not had a 2 hour training update for Assistance with Self-Administration of Medication in the last 365 days.

A Record review Resident #1's clinical file, revealed an 1823, dated [redacted]. The form documented a Medical history and diagnoses: [redacted] with [redacted] or behavioral status of [redacted]. The Nursing treatment box, documented " Meds " (Medications).

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An observation was conducted on at 8:17 a.m. of Staff member A, a Resident Aid, crushing medications in a cup with a mushy material, proceed to the side of Resident #1 with the cup and spoon feed the resident the mixture without verbalizing to the resident any information about what she was feeding her. Resident #1 consumed approximately 80% of the mixture. When asked what she just gave to the resident, Staff member A stated that she did not know the Resident ' s medication, pulled 3 bubble packs and a liquid bottle of medication from the cart and stated that this is what she had just given the resident.

A review of the labels on the medication revealed the following:
Pot Cap 10MEQ ER, take one capsule orally, " Do not crush or chew " , dispense date of

Tab 5 mg take one tablet orally every day, dispense date of
Levothyroxin tab 112 MCG, take one tablet orally every day.
250 mg/5 ml soln , take 10 ml po every morning and take 5 ml every evening.
Dispense date of

A review of Daily Med, Current Medication information, dated revealed the following warning for the Pot Chlorid Cap 10 MEQ ER:

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC

Based on record review and interview the facility failed to ensure that 1 (A) of 1 staff members reviewed for Medication training had completed a 2 hour continuing education on providing assistance with self-administered medications and safe medication practices within the last 365 days.

Findings include:

A record review of Staff member A ' s personnel file revealed that she was hired to assist with resident care at the facility and she was not a licensed nurse. Further review of Staff member A ' s personnel file revealed that she had not had a 2 hour training update for Assistance with Self-Administration of Medication in the last 365 days. Review of Staff member A ' s personnel file revealed that she had signed her application in 2007.

Staff member A was observed to assist residents with medications on during the survey.

During an interview conducted on at approximately 12:00 p.m., via phone, the facility manager confirmed that Staff member A "probably needed an update" in regards to the medication training.

Class III

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0093-Food Service - Dietary Standards 58A-5.020(2) FAC

Based on observation, record review and interview, A.)The facility failed to ensure the provision of therapeutic diets for 2 (#2 and #3) of 3 sampled residents and B.)The facility failed to ensure the resident food menu was reviewed on an annual basis by a dietician.

Findings include:

A record review of Resident #2 ' s clinical file revealed a Health Assessment, 1823, signed by a physician, . The 1823 documented the resident was to be served a pureed diet and honey thick liquids.
During the breakfast meal at approximately 8:00 a.m., resident #2 was observed to be served a whole donut with regular liquids.

A record review of Resident #3's clinical chart revealed a Health Assessment, 1823, signed by a physician, , which documented the resident was to be served a diet.

A review of the facility menu prepared by the licensed dietician revealed no information in regards to preparation of a pureed diet or diet. Further review of the menu revealed that the cycle menu's effective date was thru which meant that more than a year had passed since it had been updated or reviewed.

During an interview conducted on at 10:55 a.m. with the Administrator, he confirmed no further information was available in regards to a pureed diet or diet. He appeared to be unaware that Residents #2 and 3 had therapeutic diets prescribed.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC

Based on observation and interview, the facility failed to maintain residential equipment in a safe and sanitary manner for 1 (#2) of 3 sampled residents as evidenced by a buildup of dried food product and dust on the undercarriage of the resident's wheel chair.
Findings include:

During the survey conducted on between 6:45 a.m. and 11:45 a.m., Resident #2 was observed to sit at the dining in the same position for approximately 3.5 hours. Resident #2 ' s wheel chair was observed to have heavy buildup of dried food product thru out the undercarriage of the wheelchair, on the sides and in the wheels.

An interview conducted on at 11:17 a.m. with the Administrator, confirmed that Resident #2's wheelchair needed cleaning.

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CLASS III

0161-Records - Staff 58A-5.024(2) FAC

Based on record review and interview, the facility failed to ensure that it maintained the minimum personnel records for 1 (C) of 2 sampled staff members.

Findings include:

A review of Staff member C's personnel file revealed that she began employment at the facility on . . . . . Further review of her file revealed that the only documents in the file were an application, ... screening and background screening. No training in regards to resident care, i.e. ADL training, Food service training, ... prevention, elopement training, or . . in-service.

During the survey conducted on . . . between 6:45 a.m. and 11:45 a.m., Staff member C was observed to work in the kitchen as the cook, bring food out to the dining area to serve residents, assist residents with eating (Resident #1 and #2) assist a resident with a reposition in a chair (Resident #2).

During an interview conducted on . . at approximately 11:00 a.m. with Staff member C, she confirmed that to her knowledge, she had not received safe food handling training. She confirmed that she was the cook and that sometimes she will assist residents with eating or other ADL's.

Class III

0162-Records - Resident 58A-5.024(3) FAC

Based on record review and interview, the facility failed to ensure that 3 (#1, 2, 3) of 3 residents had semi-annual weights documented.

Findings include:

A record review of Resident #1's clinical file revealed that she was admitted to the facility in . . . .

A record review of Resident #2's clinical files revealed that he was admitted to the facility . . . . .

A review of Resident #3's clinical file revealed she was admitted . . . . .

A review of Resident #1, 2 and 3's health assessments revealed that each one of them needed supervision or assistance with all or most of their activities of daily living.

During an interview conducted on . . . . . at 11:17 a.m. with the Administrator, he was asked if the facility

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maintained weights for the residents and he provided the following:

Resident #1 was last weighed at 180 lbs.
Resident #2 had no weights recorded.
Resident #3 ' s health assessment documented a weight of 203 on

During an interview conducted on at approximately 11:30 a.m. with the facility manager, she confirmed that the residents that were in wheel chairs were not weighed; the facility did not have a weight machine that would hold a resident in a wheel chair. The facility only had a small, step on scale. The step on scale was observed near a wall in the dining The manager stated that another problem with getting weights is that a lot of the residents are seen by the house doctor who comes to the facility (the residents do not get weighed in the doctor's office).

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC

Based on record review and interviews, the facility failed to ensure that it submitted an initial 1 day adverse incident report or a 15 day follow up report for 1 (#1) of 3 sampled residents that had an event that met the definition of an Adverse Incident as evidenced by the resident being found in a pool of dried with a laceration on her head and subsequently transferred to the hospital for a higher level of care.

Findings include:

Review of Resident #1's clinical file, revealed an 1823, dated The form documented a Medical history and diagnoses: with or behavioral status of The Special precaution box documented " ". The Activities of Daily living categories: Assistance in all categories except: eating and toileting, which she was documented to need supervision.

A review of the Emergency Transport services report, dated documented the following: (Resident) is curled up in the position, laying on her right side on the floor next to her bed at the ALF (Assisted Living Facility). Her head is resting on the marble window sill that is just a few inches above the floor. It appears she rolled out of bed and hit her head on the sill. The is dried; (resident) has redness and the imprint of the carpet on her right side, suggesting she has been lying on the floor for an extended period of time. (Resident) has a laceration on the right side of head, has subsided, is clotted.

In an interview with Staff member B, on at 9:20 a.m., discussing the event of with Resident #1 being found, she stated : I usually go in to get her , she was almost in a position at the top of the (on the floor), where the window sill was; I did not want to move her; a lot of the around her head was

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still dripping; the spot on the carpet was dry; areas on her hair had dry . . . . . She did not have any clothes; the gown was on the bed that should have been on her body; she was soaking wet; she had a diaper on; no BM; just soiled it had that odor that when you have had it on there for a while, it is strong. The person working the shift before us was Staff member A, she had left when we found her.

Record review of an employee counseling for Staff member A, dated , documented the following: " In your charting , 10 p.m.-7 a.m., you charted you changed Resident #1 at 6:00 a.m.; She would not have been that wet had you checked and changed her. I don ' t know what happened on your shift for you not to check Resident #1 more frequently, but this cannot happen ever. This incident is considered a form of neglect that has never happened in the 6 years you have worked at the facility. I am placing you on a 3 month probation and at the end we will sit and re-evaluate Thursday, . Please take your time when charting and be very accurate with the times.

During an interview conducted on . . . . . at approximately 11:30 a.m. with the Facility Manager, she confirmed that an Adverse incident had not been submitted to the Agency for the . event involving Resident #1.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Belleair Country House
2298 Belleair Road
Clearwater, FL 33764

Dear Administrator:

Re: **CCR# 2013010068**

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 (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 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,

Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Belleair Country House
2298 Belleair Road
Clearwater, FL 33764

Dear Administrator:

This letter reports the findings of a complaint survey, CCR# 2013010668, conducted on , by a representative of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0028 - 58a-5.0182(4) Fac - Resident Care - Activities Of Daily Living S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= G
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - 0161 - 58a-5.024(2) Fac - Records - Staff S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Directed Corrective Actions:

1. The Assisted Living Facilty is required to employ, on staff or by contract, the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse, as determined by the agency. The initial on-site consultant visit shall take place withn 7 working day of receipt of this letter. See 429.42(4)(a) of the Florida Statutes.
2. The Assisted Living Facilty is required to maintain two employees on every 11 p.m. - 7 a.m. shift to ensure there is adequate supervision.

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Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call **Catherine Anne Avery**, Survey and Certification Support Branch, at (850) 412-4505.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/brn

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