STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910568	**07/24/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Garden View Alf	**526 N. Mary Ave. Panama City, FL 32404**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0000-Initial Comments
An unannounced complaint survey in conjunction with a revisit survey was conducted at Garden View Assisted Living Facility located in Calloway, FL on [redacted] to review CCR 2014006102. Deficient practice related to the complaint was identified during the survey.

0092-Food Service - General Responsibilities 58A-5.020(1) FAC
Based on resident interviews and staff interviews the Administrator failed to maintain appropriate supervision of food services and food services staff. Resident #1 was allowed to cook the breakfast meal for the residents.

The findings include:

Resident interviews were conducted with resident # 1, 3, 5 and 6 on [redacted] beginning at approximately 9:30 AM. Resident #1, 3, 5 and 6 all confirmed resident #1 was allowed to cook breakfast for the residents in the facility on several occasions.

An interview was conducted with employee A on [redacted] at approximately 12:05 PM. She confirmed resident #1 cooks breakfast for the residents in the facility from time to time.

An interview was conducted with the Administrator on [redacted] at approximately 12:08 PM. She confirmed resident #1 should not be allowed to cook breakfast for the residents and was not appropriately trained to provide food services. She stated she was not previously aware the staff were allowing resident #1 to cook breakfast for the other residents.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Garden View Alf
526 N. Mary Ave.
Panama City, FL 32404

RE: CCR #2014006102

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2014 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 after 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 surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,

for Jonah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure
XG90

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