STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968310	08/18/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Ivy Ridge Living Center	7179 4oth Ave N Saint Petersburg, FL 33709	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A limited nursing services (LNS) monitoring visit was conducted on .

Ivy Ridge Living Center, assisted living facility, had a deficiency at the time of the visit.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on record review and interview, the facility failed to discharge a resident from the facility after the pressure ... failed to improve within 30 days for one (#1) of 2 residents with pressure sores.

Findings include:

Review of resident #1 revealed a Physicians communication form with order dated documenting right heel breakdown and redness to left heel.

Further review of the resident record revealed a physician communication form dated documenting the right with tissue.

Review of the home health agency plan of care orders for the certification period from ... revealed the diagnosis included .

The resident care coordinator reviewed the record for resident #1 and stated he agreed with the findings.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Ivy Ridge Living Center
7179 40th Ave N
Saint Petersburg, FL 33709

Dear Administrator:

This letter reports the findings of a limited nursing services (LNS) monitoring visit that was conducted on , 2014, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 deficiency 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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid ufman
for Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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