STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911771	09/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Inglenook	280 Pine Street Englewood, FL 34223	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D

Specific Tag Findings:
An unannounced Limited Nursing Services (LNS) survey was conducted on . . . . at Inglenook, an Assisted Living Facility (ALF) in Englewood, Florida.

The following is a description of non-compliance:

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation and staff interview, the facility failed to ensure a safe environment for the residents by utilizing unattached bed rails on 3 of the 16 beds in the facility.

The findings include:

Observation on . . . . revealed 3 resident beds with unattached bed rails. Bed #1 had a bed rail with bar fitting under the mattress and screwed to a plywood board, which was easily moved when gripped or pulled. Bed #2 had an unattached bedrail which fit under the mattress and was placed towards the foot (lower end) of the bed. Bed #3 had unattached bedrails with bar joining the two sides under the mattress.

During an interview at 3:30 p.m. on . . the Assistant Administrator stated, "Yes, we use the bed rails for some of our ladies (residents) so they won't . . out of bed."

During an interview at 4:45 p.m. on . . . . . the Administrator stated, "I am not going to remove or fix the bed rails. I am not going to lower the resident's to the floor. I will have to order 6 new beds and it will take a couple of weeks."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Inglenook
280 Pine Street
Englewood, FL 34223

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2014 by representatives 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 two weeks of the date of this letter. Staff from this office will conduct a review after 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 surveyors. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure: State Form

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