STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966560	09/17/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Bayamo Assisted Living Facility, Inc	1199 Sw Bayamo Avenue 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 - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Relicensure survey was conducted on 2014 at Bayamo Assisted Living Facility, Inc. The facility had a deficiency found at the time of the visit.

0054-Medication - Records 58A-5.0185(5) FAC
Based on record review and an interview, the facility failed to ensure the medication observation record (MOR) was completed, for 3 of 3 sampled residents (Residents #1, #2 and #3).

The findings include:

On at 1:00 PM, the MOR's for Residents #1, #2 and #3 were reviewed with Staff A. The following omissions were identified:

1) Resident #1

a) 8:00 AM medications were not documented as given on
1.
2.
3.
b) 8:00 PM medications were documented as given on
1. Atorvasatin
2.

2) Resident #2

a) 5:00 PM medication was documented as given on
1.
b) 8:00 PM medication was not documented as given from through
1.

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3) Resident #3

a) 8:00 PM medication was not documented as given through
1. Traz

These findings were discussed with Staff A during interview at 1:15 PM on She stated the medications were given as ordered but the documentation was inaccurate.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Bayamo Assisted Living Facility, Inc
1199 SW Bayamo Avenue
Port Saint Lucie, FL 34953

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dmb

XG90

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