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	AL11910377	09/19/2014
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List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D

Specific Tag Findings:

0000-Initial Comments
Unannounced licensure complaint surveys for CCR#s 2014006798, 2014007413, 2014007531, 2014007823, 2014008637 and 2014008836 were conducted on through at Grand Villa Delray East .

The facility was not in compliance and had deficiencies found at the time of the visit for 2014006798 at A53 and A56 (Class III), for 2014007413 at A25 (Class II) , for 2014007531 at A25 (Class II), for 2014007823 at A25 (Class II), for 2014008637 at A25 (Class III), A30 and A79 (Class III) and for 2014008836 at A79 (Class III).

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, interview and record review the facility failed to adequately provide care and services appropriate to meet the needs of the residents by not properly assessing, monitoring or supervising and did not promote safety and physical well-being to 5 out of 6 at-risk residents (residents # 1, 2, 14, 15 and 16).

The findings include:

a) Review of resident # 1 ' s record indicated that she was admitted to the facility on with medical diagnoses of , collapse, muscle and visual and hearing Review of her Admission Health Assessment dated indicated that the resident was alert and oriented, and required Physical and Home Health Nurse visits for monitoring. Further review of this assessment indicated that she needed to have precautions, required supervision for ambulation with a walker, dressing, and self-care, and required assistance with bathing, toileting and transfers with 1 person.

Review of resident #1 ' s Nursing Notes dated on indicated that the caregiver found the resident on the floor in her 4:30am, the resident was alert and oriented, complained of left hip pain and sustained several on her extremities. This nursing note indicated that the resident said that she " out of bed trying to roll over" and she was transferred via ambulance to the hospital

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for evaluation.

Review of resident #1 ' s Nurses Notes dated on ... indicated that the resident was readmitted to the facility from the rehabilitation unit, after she received hip surgery from the ... she sustained on ... This nursing note indicated that the resident was unable to ambulate, needed a wheel chair for mobility and required assistance with all of her activities of daily living (ADLs).

Review of resident #1 ' s Nurses Notes dated on ... indicated that the resident had complaints of left shoulder pain and left hip pain after she slipped off her bed at 10:00am. This nursing note indicated that upon assessment, the resident had no apparent injury and an investigation was conducted by the nursing manager, which concluded that the resident had been monitored during the previous night shift and no ... was reported. Further review of this nursing note indicated that at around 12:00pm, the Home Health Nurse assessed the resident and notified the physician that the resident had left shoulder and left hip pain, and the resident was subsequently sent to the hospital for evaluation. This nursing note indicated that the resident returned to the facility at 7:00pm and no additional documentation was provided to show that any monitoring or safety precautions were implemented after her readmission from the hospital.

Review of resident #1 ' s Nurses Note dated on ... indicated that the resident was found on the floor near her bed at 9:05am and she was assessed by the nurse to have no injury. Review of the Nurses Note dated on ... indicated that the resident was found on the floor in her ... 11:00am and she complained of head, shoulder, and hip pain. This note indicated that the resident stated that " she lost her balance while getting up from the commode " and she was sent to the hospital for evaluation. Review of this note indicated that there was no additional documentation of the resident ' s readmission to the facility, no discharge instructions given for her care or follow-up physician appointments, or nursing assessments/monitoring after the resident sustained a head injury.

Review of resident #1 ' s Nurses Note dated on ... indicated that the resident was readmitted from the rehabilitation unit and her Health Assessment dated on ... indicated that she required assistance with ambulation with a wheelchair, bathing and dressing. This assessment also indicated that the resident required physical and occupational ... for overall muscle ...

Review of resident #1 ' s Nurses Notes dated on ... indicated that the resident was found on the floor in her ... 12:15am and she was alert and refused to go to the hospital for evaluation. This note indicated that there was no additional documentation of any resident monitoring or notification to the physician regarding her recent ... Further review of this Nurses Note indicated that the nurse received a phone call from resident #1's ... at 11:05pm and informed her that the resident was on the ... and ... from her head. This note indicated that the 3pm-11pm shift nurse

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and the 11pm-7am shift nurse assessed the resident and transferred her to the hospital for evaluation.

Review of resident #1 ' s nurses notes dated on . . indicated that the resident was readmitted to the facility with head injury, unsteady gait and muscle , and she was treated in the hospital for a scalp laceration, right upper arm hematoma and left leg laceration. This note indicated that the resident was placed on Home Health nursing services for . . . . . care and physical . . . due to . . . . . and imbalance. Review of the resident ' s record indicated that there was no additional documentation to show any facility monitoring, accident-prevention interventions or safety precautions for the resident after her readmission from the hospital.

In an interview conducted on . at approximately 8:35 AM, with the Registered Nurse (RN) Manager, she stated that the resident had a history of , was very unsteady when standing and was using a wheelchair for mobility. In an observation at this time, another direct care staff member approached the RN nurse manager and told her that resident #1 had just in her . In an observation at this time inside resident #1's , with the RN nurse manager, the resident was found lying supine on the floor and the resident complained of head, neck, shoulder and back pain. In an interview with resident #1 at this time, she stated that she "was attempting to get up to arrange her clothing, her feet got tangled together and she and that she had been on the floor "all night" last night and no staff came into her about 8:00am.

In an interview, conducted on at 9 AM, with the 7am-3pm shift caregiver, she stated that she does not usually check up on resident #1 until after 8:00am because the resident preferred to "sleep in." She stated that on . . . at 8:15AM, she entered resident #1's . . . found her lying on the floor. She stated that the resident required assistance for ambulation and transfers, used a wheelchair for support when transferring since she was very unsteady and had history of numerous . . . .

In an interview conducted on . . . . . at approximately 10:30AM with the LPN Wellness Manager, she stated that resident #1 had numerous . . . due to overall . . . . . and she required assistance with mobility but could transfer herself independently. She stated that the resident had not been identified to require monitoring checks by the staff despite of the resident ' s . . history and assessed safety precaution.

In an observation on . . . . . at 12:30PM, resident #1 was wheeled into the Dining a staff member and she was positioned next to the table, and the staff member walked away. In an observation at this time, the resident stood up from her wheelchair, pulled the dining . . . . . from underneath the table and transferred herself into the dining . . . without any staff supervision or assistance. The resident presented to be swaying and unstable at this time.

Review of resident #1's Home Health Agency Plan of Care dated on . . . indicated that the Risk

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Assessment tool determined the resident was a very high health and ... risk, was extremely hard of hearing and having very poor eyesight. In an interview on ... at approximately 12:30 PM with the Home Health RN, she confirmed that the resident is alert, very assertive and determined to remain independent but had a history of poor safety awareness which resulted in numerous ..... She stated that the expectation was that the facility staff would provide assistance with all ADL care and monitoring for ... risk as per the resident ' s health assessment.

In an interview conducted on ..... at approximately 10:00AM, with the LPN Resident Care Supervisor, she stated the facility had no official policy or protocol for monitoring residents during the day or night, regardless of their assessed safety or ... vention status. She stated that she understood resident #1 to have been independent, used a wheelchair for mobility and was able to transfer herself, but that she had a history of repeated ... due to general ... visual ... and poor safety awareness. She stated that she did not have any documentation to prove that the resident had been reevaluated after her numerous ... or any safety interventions implemented to prevent or reduce the resident ' s ... risk. She also stated that the facility had not engaged in any discussions with the resident ' s physician regarding the resident's potential change in condition.

In an interview conducted on ..... at 3:30 PM with resident #1 ' s Physician Assistant, she stated that the resident had suffered numerous ..... while in the facility and that she examined the resident on ..., found that the resident was ... good, but the resident had a decline in her judgment and safety awareness. She also stated that she recommended that the resident must be transferred to a higher level of care to receive nursing/rehabilitation services and increased monitoring to prevent further injuries.

b) Review of Resident # 2's record indicated that he was admitted to the facility on ... with diagnoses including history of ... with hip ..., surgical site ..., bowel obstruction with ... incontinence, ... with ... and abnormality of gait. Review of the resident ' s health Assessment dated on ..... indicated that the resident was alert and oriented, required assistance with ambulation, bathing and dressing , and required supervision with toileting and transfers. The assessment also indicated that the resident was able to perform his own ... care and he used a walker and/or a wheelchair for his mobility.

In an observation on ... at approximately 9:40 AM the resident was in his ... in a wheel chair wearing only a pull-up diaper/brief and presented to be short of breath. In an interview with the resident at this time, he stated that he was increasingly fatigued during the past few days and that he had ..... several times since he has been living there because his legs were very weak and had difficulty walking. He stated that he was independently mobile in his ... his wheelchair and

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transferred to the toilet by himself "hanging on to the cabinet for support." He also stated that he changed his own bag when he needed, but was experiencing greater difficulty performing this task.

Review of resident #2's Nurses Notes dated on indicated that the resident was found on the floor of the activity : 10:00am and he was assessed to have no injury, except a to his right elbow. Review of the resident's Nurses Note dated on indicated that the facility nurse was contacted by telephone by the resident and informed her that he had in his . Review of this note indicated that the resident was found in a sitting position on the floor with a laceration on the back of his head and he was sent to the hospital for evaluation. Review of this note indicated that the resident returned to the facility the same day with a diagnosis of closed head injury and scalp laceration and he received closure staples for this laceration. Further review of the resident's record indicated that there was no documentation of further resident monitoring of status or implementation of any prevention/safety interventions.

Review of resident #2 ' s Nurses Note dated on indicated that the resident was found on the floor in his : 2:30am and he stated that he "slipped off sofa" and had no injury. Further review of the resident ' s record indicated that there was no documentation of physician notification or implementation of any prevention/safety interventions after the resident ' s 2nd consecutive in the last 24-hour period.

Review of resident #2 ' s Nurses Note dated on indicated that the resident slipped and in his : 4:00am and that he suffered no injury. Further review of the resident ' s record indicated that there was no documentation of further resident monitoring or implementation of any prevention/safety interventions after this .

Review of resident ' s #2 ' s Home Health Agency initial nursing evaluation dated on indicated that the resident had with minimal exertion, and had functional limitations with ambulation, incontinence, hearing and endurance. This evaluation indicated that the resident demonstrated proper knowledge and good technique with his daily care, but had and difficulty with ambulation and tranfers due to poor balance, which required supervision at all times.

In an interview conducted on at approximately 10:30 AM, with the LPN Wellness Manager, she stated that resident #2 had experienced numerous in the facility as a result of his overall . She stated that the resident required assistance with mobility and transfers, and he had not been identified to require frequent checks by the staff.

In an interview conducted on at 2:30 PM with the Home Health RN she stated that resident

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#2's overall condition had declined since his admission to the facility and that the resident was able to ambulate with the walker when admitted, but had become increasingly weak and fatigued with minimal exertion lately. She stated that the resident was having difficulty with transfers and was using his wheelchair for mobility, and that he was forgetful and could not recall the details of the recent ... She stated that the resident was able to perform his own ... care only when she would prepare the ... supplies for him, which facilitated the process for him. She stated that she was concerned with the current level of safety monitoring for the resident due to the repeated ... and she felt he needed to be transferred to a higher level of care.

In an observation on ... at 10:45am, with the nurse, in the main hallway outside the dining ... resident #14 was walking independently with a rolling walker without any assistance. In an interview with the nurse at 10:50am she stated that resident #14 usually walks without assistance and that since he does not call out for assistance, the facility does not extend assistance out to him and because he is able to walk independently with an unsteady gait. She stated that she was not aware of the resident's assessed functional status.

c) Review of resident #14's health assessment dated on ... indicated that he was diagnosed with Parkinson's ... (PD), ... and ... Further review of his assessment indicated that he needed assistance with all of his activities of daily living (ADLs) including ambulation, transferring, ... and toileting.

In an interview with resident #14's physical ... on ... at 11:45am, she stated that she was currently treating the resident for gait and general functional training and he had history Parkinson's ... (PD) and general mobility difficulties. She stated that even after the resident received his PD medications in the morning, he needed contact guard supervision with walking and needed assistance with walking when his PD medications wore off, like later during the day and at night. She also stated that the resident needed assistance with transfers and ambulation to go to and from the ... toileting, ... and bathing activities due to his decreased mobility and safety awareness. She stated that the resident told her that he constantly transferred and ambulated by himself to go to the ... she advised him against doing that without assistance. She also stated that she has had previous weekly meetings with the facility nurses and communicated the resident's current care needs to them.

d) In an observation on ... at 2:05pm, resident #15 was ambulating with a rolling walker independently and without assistance in the front lobby. In an interview with resident #15 on ... at 2:15pm, she stated that she was used to walking by herself since it took so long for the staff to respond to her. She stated that she felt unstable at times while walking.

Review of resident #15's health assessment dated on ... indicated that she was diagnosed with

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to her lower extremities, and previous to her ribs. Further review of her assessment indicated that she needed assistance with ambulation, transferring and toileting.

e) In an interview with resident #16 on at 9:45am, she stated that she walked to the her own because when she use to call for help, it would take too long for the caregivers to arrive. She stated that it hurts to stand up due to her pressure , but she stood up, transferred by herself to her motorized wheelchair and propel herself whenever she needed to go to the .

In an interview with resident #16's home health nurse on at 9:50am, she stated that she understood that the resident ambulated independently because the resident told her that the caregivers do not respond on time. She stated that the resident was not able to safely ambulate or transfer independently.

Review of resident #16's health assessment dated on indicated that she was diagnosed with abnormal gait, severe and leg . Further review of her assessment indicated that she needed assistance with ambulation and bathing.

Class II

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and interview, the facility failed to provide the residents freedom to participate in, interact and benefit from community events that were organized for persons not living in the facility.

The findings are:

In an interview with the receptionist on at 12:45pm, she stated that she was aware of monthly activities held in the facility that were held for non-residents and that residents were discouraged from attending these events.

Review of the facility flyer, as attached, titled "Tour to Win" indicated that the facility planned an event on from 2pm to 4pm offering food/refreshments and a prize to win a television set.

In an interview with the leasing coordinator on at 12:50pm, she stated that she was responsible to organize monthly events and activities for prospective residents and their families (non-residents) and that current residents were encouraged to attend other activities in the facility. She stated that on from 2pm to 4pm, she planned for a non-resident event which included food and prizes, including the opportunity to win a flat-screen television. She stated that this event was not geared for current residents, and the prize to be awarded was reserved for a non-resident.

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In an interview with the MCU activity coordinator on at 1:05pm, she stated that the activities held by the leasing/marketing office were primarily for non-residents and that current residents often saw these activities being held in plain view in the activity , but were not necessarily invited since there would be other resident activities being offered somewhere else in the facility.

In an interview with the activity director on at 2:00pm, she stated that she understood how a non-resident event may discourage current residents, especially if there were no other resident-specific activities scheduled at that time. She stated that on , there was no scheduled resident activity starting at 2pm, but there were bingo/cards activities scheduled at 1:30pm and refreshments/karaoke at 2:35pm, while the non-resident event was scheduled from 2pm to 4pm.

Review of the 2014 resident activity schedule, as attached, indicated that there was no scheduled resident activity starting at 2pm, but there were bingo/cards activities scheduled at 1:30pm and refreshments/karaoke at 2:35pm.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC
Based on observation, interview and record review, the facility failed to follow acceptable professional control standards of practice for glucose monitoring and administration of by the licensed practical nurse, for 9 of 10 sampled residents (Residents # 5,#6,#7,#8,#9,#10, #11, #12,and #17).

The findings include:

On between 5:00AM and 6:00AM, observations were conducted of 10 residents receiving glucose monitoring and injections for by the Licensed Practical Nurse (LPN).

a) Resident #5 is prescribed 25 units of daily. The LPN reviewed a copy of the Medication Observation Record (MOR) and donned gloves to perform the glucose testing. At 5:14 AM his glucose was 177 and the LPN administered the . The nurse did not sanitize her hands before or after donning gloves or sanitize the glucometer after or before resident use.

b) Resident #6 is prescribed 36 units of daily. The LPN reviewed the copy of the MOR and donned gloves to perform the glucose testing. At 5:17 AM her glucose was 144 and the LPN administered the . The nurse did not sanitize her hands before or after donning gloves or sanitize the glucometer after or before resident use.

c) Resident #7 is prescribed 30 units of Lantus daily. The LPN reviewed the copy of the MOR and donned gloves to perform the glucose testing. At 5:25 AM his glucose was 96 and the LPN administered the . The nurse did not sanitize her hands before or after donning gloves or sanitize the glucometer after or before resident use.

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d) Resident #8 is prescribed 5 units of Lantus and 4 units of . The LPN reviewed the copy of the MOR and donned gloves to perform the glucose testing. At 5:30 AM her glucose was 270 and the LPN administered the . The nurse did not sanitize her hands before or after donning gloves or sanitize the glucometer after or before resident use.

e) Resident #9 is prescribed on a sliding scale. The LPN reviewed the copy of the MOR and donned gloves to perform the glucose testing. At 5:35 AM her glucose was 184, the nurse administered 2 units of . The nurse did not sanitize her hands before or after donning gloves or sanitize the glucometer after or before resident use.

f) Resident #10 is prescribed 18 units of Lantus and 3 units of sliding scale. The LPN reviewed the copy of the MOR and donned gloves to perform the glucose testing. At 5:40 AM her glucose was 159 and the LPN administered the . The nurse did not sanitize her hands before or after donning gloves or sanitize the glucometer after or before resident use.

g) Resident #11 is prescribed 35 units of Lantus and 3 units . The LPN reviewed the copy of the MOR and donned gloves to perform the glucose testing. At 5:40 AM his glucose was 212 and the LPN administered the . The nurse did not sanitize her hands before or after donning gloves or sanitize the glucometer after or before resident use.

h) Resident #17 is prescribed daily glucose monitoring. The LPN reviewed the copy of the MOR and donned gloves to perform the glucose testing. At 6:00AM her glucose was 167. The nurse did not sanitize her hands before or after donning gloves or sanitize the glucometer after or before resident use.

i) Resident #12 is prescribed daily glucose monitoring. The LPN reviewed the copy of the MOR and donned gloves to perform the glucose testing. At 6:00AM her glucose was 167. The nurse did not sanitize her hands before or after donning gloves or sanitize the glucometer after or before resident use.

On at approximately 6:00AM during an interview with the LPN, she stated that she did not wash her hands between glove use because she had no available access to soap and paper towels since since was going from resident resident . She stated that she did not use hand sanitizer since it caused the gloves to stick when she applied them. She confirmed the glucometer had not been sanitized between resident use.

On at approximately 2:30 PM during an interview with the LPN Wellness Care Manager, she stated that she would expect the nurse to wash or sanitize her hands prior to donning and removing

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gloves. Also, the glucometer unit should always be sanitized between resident use.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation, interview and record review, the facility failed to properly administer prescription medications as evidenced by the failure to dispense medications as labeled, for 1 of 1 sampled residents (Resident #4).

The findings include:

Resident # 4 was admitted on with medical diagnosis of vision loss, and severe . The resident requires assistance with all ADL care and medication management.

On at 8:45 AM an observation was conducted of the unlicensed medication technician (med tech) administering drops to the resident. The med tech reviewed the Medication Observation Record (MOR), used hand sanitizer, donned gloves and administered solution, 1 drop in both eyes. The med tech closed the bottle, picked up the next bottle of solution, 0.3 % and placed 1 drop in the resident's both eyes. She closed the bottle and then opened a bottle of Tears solution and placed 1 drop in both eyes. The med tech did not wait 5 minutes between each medications. When the med tech was questioned, why she did not wait between eye medications, she stated she "was aware that she should wait 5 minutes between eye drops but the residents don' t like to wait".

Review of the MOR for 2014 reveals the resident was prescribed solutions and to "wait 5 minutes between administering eye drops".

On at approximately 2:30 PM during an interview with the Licensed Practical Nurse (LPN) Wellness Care Manager, the surveyor observations were reviewed with her. The LPN stated that the med tech should follow the physician order and always wait 5 minutes between administering eye drops even if the resident complains.

Class III

0079-Staffing Standards - Levels 58A-5.019(3) FAC
Based on observation, record review and interview, the facility failed to provide adequate staffing to provide resident services and meet their care needs.

The findings are:

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In an interview with the 11pm-7am shift nurse on at 6:20am, she stated that there is no shift overlap between the direct care staff on the 3pm-11pm, the 11pm-7am and the 7am-3pm shifts, since the staff members are expected to leave at exactly 11pm and 7am. She stated that there ' s hardly any reporting among nurses and caregivers between shifts, that this lack of communication poses a potential danger if residents ' conditions have changed and she mostly relies on reading the 24-hour book to find out about recent resident events. She stated that the facility stopped having a caregiver observing the MCU doors about a month ago and that the resident call bells are now only alerted on the computer screen in the MCU nursing station. She stated that the call bells use to be on beepers carried by direct care staff and now if she was not in the MCU nursing station next to the computer screen, there would be no way to know if a resident had activated a call bell or to answer any phone calls from residents needing assistance. She stated that on when she initially arrived for her 11pm-7am shift, she noticed on the computer screen that a call bell had been activated in at 9:37pm, but the 3pm-11pm shift nurse told her that she had been informed by the 2 caregivers working that night, that the call bell in was broken and there were no immediate concerns. She stated that a couple minutes later, a resident in called the nursing station to inform that her was on the floor in 1's

In an interview with a former caregiver on at 2:25pm, she stated that when she worked in the facility about 2 weeks ago during the 3pm-11pm shift, her workload included to care for about 50 residents during this shift, and the resident care usually required her to privately assist 5-7 residents to shower/bathe, to supervise/assist most of those residents to transfer/ambulate to the dining dinner and to assist them to return to their after dinner. She stated that she told the MCU nurse supervisor that her workload was too intense and that the residents required too much assistance, and that other supervising nurses were also aware of her workload.

In an interview with the 3pm-11pm shift nurse on at 6:35pm, she stated that on at around 9:45pm when she sat down in the MCU nursing station, the computer indicated that a resident in needed assistance. She immediately called out of the 2-way radio for the caregivers to respond to this call and she received a confirmation from a caregiver with a "copy" response. She at that time considered this called to have been handled by the caregiver, but after several minutes, she noticed that the alert was still on for and she then requested for a caregiver to physically check on the cord for any possible She stated that on around 11:00pm when she returned to the nursing station, she received a telephone call from resident #1's to report that the resident had on the floor. She stated that when she asked to meet with the caregivers shortly after 11:00pm on the 2 caregivers from the 3pm-11pm shift had already left the facility and she was not able to receive their assistance at that time.

In an interview with resident #19 on at 10:05am, she stated that she had been living in the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Grand Villa Of Delray East	**14555 Sims Road Delray Beach, FL 33484**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

facility for about 2 weeks and that the caregivers do not show up to her . . . she calls for them and it takes the staff over 15-20 minutes to show up whenever she calls for them.

In an interview with the nurse supervisor on . . . at 3:20pm, she stated that she was responsible for the direct care staff scheduling and she was currently adjusting the 7am-3pm shifts to include 3 staff members to be in the facility at 6am instead of the current 2 staff members. She stated that since the current 7am-3pm shift has 2 staff members supplementing the 11pm-7am shift staff, she realized that the facility needed an extra staff member at 6am, since that is a heavy workload time for all the direct care staff because most of the residents are awaking at that time. She stated that also since the census has increased during the last 3 weeks at 167 residents, which is almost to full capacity of the facility, she felt that this increase in direct care staff was needed.

Refer to A 0025 for additional findings.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Grand Villa Of Delray East
14555 Sims Road
Delray Beach, FL 33484

RE: CCR #2014007531, CCR #2014008836, CCR #2014006798, CCR #2014007823, CCR #2014008637, CCR #2014007413

Dear Administrator:

This letter reports the findings of complaint surveys that were conducted on 2014 through 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 Davis
Field Office Manager

AMD
Enclosure

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