STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968365	10/20/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
La Bella Vida Iii	14053 Briardale Ln Carrollwood, FL 33618	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D

Specific Tag Findings:

Assisted Facility Living

A Biennial Licensure survey was conducted on .

La Bella Vida III, assisted living facility, had a deficiency found at the time of the visit.

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC

Based on interview and record review the facility failed to ensure the live-in caregiver had obtained 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility.

Findings Include:

An employee record review was conducted with the facility's administrator on at 1:00 p.m. A review of the live-in caregiver's training records revealed that she had completed the required 4 hour initial training on providing assistance with self-administered medications and safe medication practices in an assisted living facility on . She did not complete the required 2 hours of continuing education training prior to the expiration of her prior training on . The administrator concurred with the finding and stated "I didn't realize that her 2 hour update was due. I will make sure she completes the training with our pharmacy as soon as possible."

CLASS III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

_____, 2014

Administrator
La Bella Vida Iii
14053 Briardale Ln
Carrollwood, FL 33618

RE: CCR #

Dear Administrator:

This letter reports the findings of a biennial state licensure survey 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 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 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 surveyor(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Paul M. Brown

for Patricia Reid Caufman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

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