

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11943019	(X3) DATE SURVEY COMPLETED 10/08/2014
NAME OF PROVIDER OR SUPPLIER Gables Manor Independent Inc	STREET ADDRESS, CITY, STATE, ZIP CODE 1535 Venetia Avenue Coral Gables, FL 33134	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D

Specific Tag Findings:

0000-Initial Comments

A Standard Biennial Survey was conducted on . Gables Manor Independent Inc. Assisted Living Facility had the following deficiencies at time of the survey.

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

Based on record review and interview the facility failed to ensure that all hired staff had received an annual 2 hours of continuing education training on providing assistance with self-administered medication and safe medication practices for 2 out of 2 (A and B) sampled employees.

The findings include:

Personnel record review and interview on revealed documentation of an annual 2 hours of continuing education training on providing assistance with self-administered medication and safe medication practices for staff A. (hire date) had expired on and Staff B. (hire date) had expired on .

On at 12:10 PM administrator stated, " I will schedule the training as soon as possible. "

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Gables Manor Independent Inc
1535 Venetia Avenue
Coral Gables, FL 33134

Dear Administrator:

This letter reports the findings of a standard biennial 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 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 surveyor(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure

XG90

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