STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967884	10/22/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Orchids Home	2960 Meadows Oaks Dr S Clearwater, FL 33761	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Specific Tag Findings:

Assisted Living Facility

On a unannounced biennial state licensure survey was conducted.

Orchid Home had deficiencies at the time of the survey.

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on record review and interview the facility failed to ensure 1 (Employee C) of 3 direct care staff had evidence of a negative examination completed annually.

Findings Include:

During a review of staff records it was revealed employee C 's last examination was dated . There was not documentation of an annual negative available for review.

During an interview conducted with the Administrator on at approximately 4:30 p.m. it was stated employee C did have the test but did not return to pick up the documentation from the health care provider.

Class III

L243-LMH - Training 58A-5.0191(8) FAC

Based on record review and interview the facility failed to ensure that 2 (A, B,) of 2 who are direct care staff had completed the required 3 hours of continuing education annually..

Findings Include:

During a review of records it was revealed employee A, completed a 6 hour mental health training on / and B completed a 6 hour mental health training on . There was no other documentation of the required continuing 3 hours of education every two years.

On at approximately 4:40 p.m. the Administrator stated she did not know they were required to have additional training. The administrator believed it was only the one time 6 hour training that was needed.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Orchids Home
2960 Meadows Oaks Dr S
Clearwater, FL 33761

Dear Administrator:

This letter reports the findings of a biennial state licensure survey and a Limited Mental Health (LMH) 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 272-552-2000.

Sincerely,

Patricia Reid Caufman
for Field Office Manager

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

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