STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964862	**02/12/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Fountain Of Youth	**9001 Bana Villa Court Tampa, FL 33635**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:

0025-Resident Care - Supervision-02/12/2015
0026-Resident Care - Social & Leisure Activities-02/12/2015
0030-Resident Care - Rights & Facility Procedures-02/12/2015
0052-Medication - Assistance With Self-Admin-02/12/2015
0093-Food Service - Dietary Standards-

Revisit Repeat Tags:

0008-Admissions - Health Assessment-58a-5.0181(2) Fac

Specific Tag Findings:

Assisted Living Facility

The Fountain of Youth had an un-corrected deficiency found at the time of this visit.

A Revisit to the Biennial Licensure Survey was conducted on 2/12/15.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based upon record review, the facility failed to ensure that one (Resident #4) of one resident's health assessment was an accurate reflection of the resident's level of functioning.

Findings Include:

A review of the heath assessment on for Resident #4 revealed that it was dated The health assessment signed by the residents MD noted the resident required administration of medications. Per an interview with Resident #4, he stated at 11:15 a.m. that he doesn't need his medications administered by a licensed nurse & is able to take his medications himself, once handed to him by staff. The resident also said he does not take any , or any other medications injected sub-Q.

The Form #1823 was inaccurate per the Administrator at 11:20 a.m. because the MD had been on vacation and she was not able to reach him to get the health assessment corrected.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Fountain Of Youth
9001 Bana Villa Court
Tampa, FL 33635

Dear Administrator:

This letter reports the findings of a revisit, to a Biennial Licensure survey conducted on 2015 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

All deficiencies shall be corrected no later than thirty days from the date of this letter.

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. Should you have any questions please call **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,

FOR Patricia Reid Caufman
Field Office Manager

PRC/src
Enclosure: State Form 5000-3547

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