STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953618	02/17/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Absolute Care Assisted Living At Welleby	**3621 Nw 90th Terrace Sunrise, FL 33351**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Relicensure survey was conducted on [redacted] at Absolute Care Assisted Living at Welleby. The facility had deficiencies found at the time of the visit.

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and interview, the assisted living facility failed to ensure that a key for the facility's medication storage was secured at all times.

The findings include:

Observations during a tour of the facility on [redacted] at approximately 10 AM found the facility's medication cart locked and in the hallway. The key for the medication cart was found unsecured and placed on top of the medication cart. Observations revealed residents and staff members walk through this hallway. The key for the medication cart was observed accessible to residents walking by or using a wheelchair and any persons in the vicinity of the medication cart.

In an interview with the Administrator on [redacted] at approximately 10:15 AM, he stated the key for the medication cart is usually kept on top of the medication cart. He acknowledged the error and stated he will remove the key.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Absolute Care Assisted Living At Welleby
3621 NW 90th Terrace
Sunrise, FL 33351

RE: Relicensure Survey

Dear Administrator:

This letter reports the findings of a State Licensure Survey that was conducted on 2015 by representative from 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/jw
Enclosure

XG90

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