STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965709	03/05/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sam's Assisted Living Facility	1 Pebblewood Lane Palm Coast, FL 32164	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0077 - 429.176 Fs; 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0082 - 58a-5.0191(3) Fac - Training - S-S= D
St - A - 0085 - 58a-5.0191(6) Fac - Training - Nutrition & Food Service S-S= D
St - A - 0091 - 58a-5.0191(12) Fac - Training - Documentation & Monitoring S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - 0161 - 429.275(2) Fs; 58a-5.024(2) Fac - Records - Staff S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - 0167 - 58a-5.025 Fac - Resident Contracts S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

Specific Tag Findings:

0000-Initial Comments
An unannounced biennial licensure survey was conducted at Sam's Assisted Living Facility 2 on 2015. Deficiencies were identified.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, resident record reviews, and staff interview, the facility failed to protect the rights of 3 of 6 sampled residents observed during the survey (Residents #1, #2 and #6) by neglecting to ensure privacy, dignity, respect, and freedom from The facility failed to protect the confidentiality of personal health information for Residents #1 and #2 by posting personal information in the facility in full view of residents and visitors. The facility failed to ensure Resident #6 was free from and neglected to have her reviewed by the physician. Resident #6 was deprived of the right to dine with her housemates at the dining table, and was not provided any personal/incontinence care between the hours of 8:30 am and 1:20 pm.

The findings include:

1. A tour of the facility was conducted on at 8:45 am. On the walls adjacent to #1 and #2, was a yellow piece of paper. Each was taped to the wall near the door, and was observed to be a completed and signed Florida (DH form 1896). Resident #1's name was printed on the form outside her door, and Resident #2's was printed on the form outside of his.

An interview was conducted with Employee A on at 9:07 am. She stated the forms were posted to alert staff not to revive these residents in the event of an emergency.

2. An observation of Resident #6 was conducted on at 8:35 am. She was seated in a recliner-style rolling chair, and was talking to herself in Portuguese. A tray was fastened to the chair across Resident #6's lap. Resident #6 was observed to sit forward against the lap tray, then lie back against the seat back on numerous occasions. Resident #6 fiddled with the lap tray repeatedly, and appeared to be trying to push it away, or remove it. Each time

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she was unable to move the lap tray, Resident #6 would sit back in her chair. At 9:10 am, the Caregiver reclined Resident #6's chair. The resident continued to struggle against the lap tray, and move it from side to side.

During a tour of the facility on at 8:45 am, Resident #6's bed was observed with a full length bed rail on the of the bed. The rail was in the raised position at the time of the tour. The other side of the bed was pushed up against the wall.

An interview was attempted with Resident #6 on at 9:25 am by using a language translator cell phone application. Resident #6 paid little to no attention to this surveyor, and struggled against her lap tray while screaming words in her native language.

At approximately 11:40 am on , Resident #6 was observed in the same location of the living sitting in her tray-equipped chair. Two residents seated themselves and were served lunch at the dining Three residents ate their lunch in their . Without affording her the opportunity to change locations and join her housemates at the dining , Employee A fed Resident #6 her lunch in her chair in the living

At 1:20 pm on , five hours after survey entrance, Resident #6 was still sitting in her chair with the tray fastened about her waist. At no time during the survey was Resident #6 taken to her to a personal care or toileting needs.

An interview was conducted with Employee A on at 9:07 am. She explained that Resident #6 received hospice services. She stated Resident #6 was not able to get out of her chair because the resident was non ambulatory, and because the lap tray was locked into place.

3. A record review conducted for Resident #6 revealed she was , had a diagnosis of , and received hospice services. The Resident Health Assessment dated noted Resident #6 required assistance with all activities of daily living, including toileting and eating. Further review of the record found there were no physician's orders for the use of the bed rail, or for the locking lap tray on Resident #6's chair. In addition, there was no written consent from the resident's representative for either device.

An interview was conducted with the Administrator on at 1:20 pm. She blamed the hospice provider for the introduction of the full length bed rails for Resident #6. She confirmed there were no physician's orders for the side rails or for the locking lap tray, and confirmed there was no written approval from Resident #6's representative. The Administrator stated Resident #6 did not eat with the others because she ate in her chair. When asked if the chair might have been rolled adjacent to the dining table in order for Resident #6 to enjoy the company of her housemates, the Administrator confirmed that was a possibility. Finally, she confirmed Resident #6 had gone without personal care for too long, and instructed Employee A to tend to the resident. The Administrator acknowledged the of confidentiality of private health information for Residents #1 and #2 which resulted of the posting of the in full view of residents and visitors.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

Based on observation and staff interview, the facility failed to provide assistance with self-administration of medications in accordance with procedures described in Section 429.256, F.S. by failing to read the label in the

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presence of 1 of 1 sampled residents observed for medication self-administration (Resident #1).

The findings include:

An observation of Resident #1 was conducted on at 12:20 pm. Employee A retrieved a medication bottle, and took it to Resident #1, who was seated at the dining Without reading the label in the presence of the resident, the employee opened the bottle, dispensed one pill into her hand, and placed the pill in Resident #1's hand. Resident #1 put the pill into her mouth, and drank it down with a glass of water. Employee A remained with the resident until she took her medication, then left the table with the medication bottle and initialed the medication observation record (MOR).

An interview was conducted with the Administrator and Employee A at 12:26 pm on The Administrator confirmed the employee did not read the medication label in the presence of Resident #1. She instructed Employee A she was required to do so when providing assistance with the self-administration of medications.

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on observation, resident record review, and staff interview, the facility failed to maintain accurate medication records that included specific directions for use for 1 of 1 sampled residents (Resident #1) observed for assistance with self-administration of medication.

The findings include:

An observation of assistance with self-administration of medications was conducted for Resident #1 on at 12:20 pm. The Caregiver retrieved a bottle of pills, took them to the table, and assisted Resident #1 with her medication. The label was inspected and read 5 milligrams (mg), take one by mouth every day (qd).

A review of the Medication Observation Record (MOR) for Resident #1 revealed she was to receive 5 mg tablet daily at 7:30am.

A record review for Resident #1 found she had a physician's order for pril)5 mg daily at 9:30 am.

An interview was conducted with the Administrator on at 12:26 pm. She explained Resident #1's was given at noon, instead of 7:30 am per the MOR, because she felt Resident #1 received too many medications at breakfast time. The Administrator confirmed the discrepancy between the MOR, the physician's order, and the actual time Resident #1 took her medication.

Class III

0077-Staffing Standards - Administrators 429.176 FS; 58A-5.019(1) FAC
Based on observations, record reivews and interviews, the Administrator failed to provide responsible supervision of the operation and maintenance of the facility, including management of staff requirements, and the provision of care, to all residents residing in the facility. This had potential to impact the safety, health, and emotional well-being of all 6 residents (Residents #1, #2, #3, #4, #5 and #6) at the time of survey.

The findings include:

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Cross Reference St A-0030
Cross Reference St A-0052
Cross Reference St A-0054
Cross Reference St A-0078
Cross Reference St A-0081
Cross Reference St A-0082
Cross Reference St A-0085
Cross Reference St A-0091
Cross Reference St A-0093
Cross Reference St A-0152
Cross Reference St A-0160
Cross Reference St A-0161
Cross Reference St A-0162
Cross Reference St A-0167
Cross Reference St A-Z815

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on observations, a review of employee files, and staff interviews, the facility failed to obtain a written statement from a health care provider of freedom from communicable , including , for 1 of 3 sampled employees whose files were reviewed (Employee A).

The findings include:

Employee A, a Caregiver, was observed on duty and working with the residents on the day of survey. An interview was conducted with Employee A on at 9:17 am. She stated she had worked in the facility since 2014.

A personnel file review conducted for Employee A revealed she was hired as a Caregiver on . Further review found no documentation from a health care practitioner that Employee A was free from communicable , including .

An interview was conducted with the Administrator on at 1:00 pm. She confirmed the missing health care statements for Employee A.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on observation, employee record review, and staff interviews, the facility failed to provide the required 1 hour in-service training in control before giving personal care to the residents for 1 of 3 sampled employees, (Employee A) and failed to provide required in-service trainings within 30 days of hire to 2 of 3 sampled employees whose files were reviewed (Employees A and B).

The findings include:

Employee A, a Caregiver, was observed on duty and working with the residents on the day of survey. Employee A asssited with the lunch preparation and served the residents lunch during the survey. An interview

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was conducted with Employee A on at 9:17 am. She stated she had worked in the facility since 2014. A personnel file review conducted for Employee A revealed she was hired as a Caregiver on The employment application was incomplete, unsigned, and did not provide references. There was no documentation of the 1 hour training in control, including facility sanitation procedures and universal precautions, which was required prior to the provision of care to residents. A certificate indicated Employee A received training in activities of daily living (ADLs) and behavioral needs on however there were no contact hours noted. Therefore, it was not possible to determine if the 3 hour trianing requirement was met for this topic. Finally, Employee A's file contained no record of the required 1 hour training in nutrition and safe food handling within 30 days of hire.

An interview conducted with Employee B on at 10:25 am found he worked as a Caregiver and as a maintenance worker. He explained he performed a variety of duties for the facility. A personnel file review revealed Employee B was hired in 2006. There was no employment application in place for Employee B. A certificate was located that indicated Employee B received training in ADLs and behavioral needs on however there were no contact hours noted. Therefore, it was not possible to determine if the 3 hour trianing requirement was met for this topic. Finally,there was no record Employee B received the required 1 hour training in nutrition and safe food handling within 30 days of hire.

An interview was conducted with the Administrator on at 1:00 pm. She confirmed the missing trainings for Employees A and B.

Class III

0082-Training - 58A-5.0191(3) FAC
Based on employee record review, and staff interview, the facility failed to provide the required in-service training in Human within 30 days of hire to 2 of 3 sampled employees whose files were reviewed (Employees A and B).

The findings include:

A personnel file review conducted for Employee A revealed she was hired as a Caregiver on There was no documentation Employee A received the required training in within 30 days of employment.

A personnel file review revealed Employee B was hired in 2006. There was no documentation Employee B received the required training in within 30 days of employment.

An interview was conducted with the Administrator on at 1:00 pm. She confirmed the missing trainings for Employees A and B.

Class III

0085-Training - Nutrition & Food Service 58A-5.0191(6) FAC
Based on employee record review, and staff interview, the Administrator who was designated as the person responsible for the facility's food service, failed to obtain the required 2 hour annual continuing education in topics pertinent to nutrition and food service.

The findings include:

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A personnel file review conducted for the Administrator found missing documentation that she received the required 2 hour continuing education in topics related to nutrition and food service.

An interview was conducted with the Administrator on at 1:00 pm. She confirmed she was the food service designee, and admitted to the missing training.

Class III

0091-Training - Documentation & Monitoring 58A-5.0191(12) FAC
Based on employee record review, and staff interview, the facility failed to document the number of hours for required in-service trainings for 2 of 3 sampled employees whose files were reviewed (Employees A and B).

The findings include:

A personnel file review conducted for Employee A revealed she was hired as a Caregiver on A certificate of completion indicated Employee A received the required training in activities of daily living (ADLs) and behavioral needs on There were no contact hours noted on the certificate. Therefore, it was not possible to determine if the 3 hour trianing requirement was met for this topic.

A personnel file review revealed Employee B was hired in 2006. A certificate of completion for the required training in ADLs and behavioral needs on There were no contact hours noted on the certificate. Therefore, it was not possible to determine if the 3 hour trianing requirement was met for this topic.

An interview was conducted with the Administrator on at 1:00 pm. She confirmed the missing training hours for ADL training for Employees A and B.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation, facility record review, and staff interview, the facility failed to document menu substitutions before, or at the time the meal was served and failed to maintain documentation of food substitutions for 6 months. Additionally, the facility failed to maintain a sufficient supply of non-perishable food for a 3-day emergency supply for the current census of 6 residents.

The findings include:

An observation of the lunch meal on at 11:40 am found residents were served oven baked chicken, asparagus, corn, a biscuit, a slice of bread, and chocolate cake with strawberries.

A review of the facility menu, which was signed by the Registered Dietician in 2015, found the menu called for baked chicken, green beans, corn, a roll and sliced peaches.

A review of facility records found there was no substitution log in place for alternative items served to the residents at mealtimes.

An inspection of the non-perishable emergency food supply found insufficient stores of proteins for a 3-day supply in the event of an emergency for the current census of 6. The facility had one 1 4.7 ounce can of vienna sausage,

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two 5 ounce cans of tuna fish, and two 15 ounce cans of pork and beans. There was one small can of evaporated milk, and one opened box of powdered milk, which was 2/3 empty. The box label indicated there were a total of 20 servings per box. The box top was torn, and the milk's expiration date removed with the tear.

An interview was conducted with the Administrator on [redacted] at 12:13 pm. She confirmed there were insufficient supplies of emergency food for the current census of 6 residents. She also confirmed substitutions had not been noted or maintained by the facility.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observation and staff interview, the facility failed to provide a safe living environment by preventing safe egress from the facility in the event of an emergency, potentially affecting 6 of 6 residents in the facility at the time of the survey (Residents #1, #2, #3, #4, #5 and #6).

The findings include:

On arrival to the facility on [redacted] at 8:30 am, Employee A answered the door. She could be heard inside using a set of keys to unlock front door's deadbolt lock. Upon entry to the facility, the lock was observed to be a key-operated deadbolt. Employee A was observed to remove the key from the lock, and hide it under a tablecloth on a shelf inside the front door. A a hotel -style latch lock had been installed at the top of the door, approximately one foot below the door jamb. An illuminated sign mounted above the door clearly indicated it was an emergency EXIT.

An interview was conducted with Employee A on [redacted] at 8:50 am. She stated the keys to the front door were kept hidden (she showed me they were hidden under the table cloth) so the residents could not find them. She stated one resident knew how to use the key to exit the facility.

An interview was conducted with the Administrator on [redacted] at 1:20 pm. She acknowledged that in the event staff was [redacted] or unavailable during a situation requiring resident evacuation, the residents would be unable to safely leave through the front door. She did not realize the locks presented a safety hazard, and stated she would have them removed.

Class III

0161-Records - Staff 429.275(2) FS; 58A-5.024(2) FAC
Based on a review of employee records and interview with staff, the facility failed to maintain personnel records containing documentation of compliance with background screening for 1 of 3 sampled employees (Employee A), documentation of training requirements and completed applications for employment for 2 of 3 sampled employees (Employees A and B), and documentation of verification of freedom from communicable [redacted] including [redacted], for 1 of 3 sampled employees (Employee A).

The findings include:

A personnel file review conducted for Employee A revealed she was hired as a Caregiver on [redacted]. There was no documentation from a health care practitioner within 30 days of hire that Employee A was free from communicable [redacted], including [redacted]. The employment application was incomplete, unsigned, and did not provide references. There was no documentation of the 1 hour training in [redacted] control, including facility

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sanitation procedures and universal precautions, which was required prior to the provision of care to residents. A certificate indicated Employee A received training in activities of daily living (ADLs) and behavioral needs on , however there were no contact hours noted. Finally, Employee A's file contained no record of the required training in nutrition and safe food handling, or within 30 days of employment.

A personnel file review revealed Employee B was hired in 2006. There was no employment application in place for Employee B. There was no documentation of the 1 hour training in control, including facility sanitation procedures and universal precautions, which is required prior to the provision of personal care to residents. A certificate was located that indicated Employee B received training in ADLs and behavioral needs on however there were no contact hours noted. Finally, the record contained no documentation of the required training in nutrition and safe food handling, or within 30 days of employment.

An interview was conducted with the Administrator on at 1:00 pm. She confirmed the missing information for Employees A and B.

Class III

0162-Records - Resident 58A-5.024(3) FAC
Based on a review of resident records, and interview with staff, the facility failed to maintain complete resident records including documentation of the appointment of a health care surrogate, health care proxy, guardian, or power of attorney for 1 of 3 sampled residents whose records were reviewed (Resident #2). In addition, the facility failed to retain the AHCA form 1823 for 2 years for 1 of 3 sampled residents (Resident #6).

The findings include:

A record review conducted for Resident #2 found he was admitted to the facility on and was . All forms, including admission paperwork and the resident's contract, had been signed by Resident #2's representative. Further review found there was no documentation of the appointment of a health care surrogate, health care proxy, guardian, or power of attorney in Resident #2's record.

Record review for Resident #6 revealed she was admitted to the facility on and was . She had diagnoses of and . Resident #6 had an AHCA form 1823 (Resident Health Assessment) dated , three months after admission. Further review of the record found no original assessment for Resident #2.

An interview was conducted with the Administrator on at 11:00 am. She reviewed Resident #6's record, and confirmed there was no original health assessment. She stated the 1823 was taken by the hospice provider when they completed the current health assessment for Resident #6. The Administrator stated she did not realize she needed to keep the original assessment.

A second interview with the Administrator on at 1:20 pm confirmed the missing health care surrogate assignment for Resident #2.

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Class III

0167-Resident Contracts 58A-5.025 FAC
Based on resident record review, and staff interview, the facility failed to execute a resident contract with the responsible party before, or at the time of admission, for 1 of 3 sampled residents whose contracts were reviewed (Resident #2).

The findings include:

A record review conducted for Resident #2 found he was admitted on and was . He had diagnoses including prostatic hyperplasia, radiculopathy, chronic failure, chronic kidney and . The Resident Health Assessment noted Resident #2 had a visual and memory loss. A resident contract was signed by the resident's representative on seven days after the resident was admitted.

An interview was conducted with the Administrator on at 1:20 pm. She reviewed the contract and confirmed it was signed one week after admission. The Administrator explained Resident #2's representative came from out of state one week after admission, and signed the contract then. She acknowledged she was required to execute a contract with Resident #2's representative prior to, or at the time of, admission.

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06
Based on observation, employee record review, and interviews, the facility failed to obtain a Level 2 background screening prior to hire for 1 of 3 sampled employees whose records were reviewed (Employee A).

The findings include:

Employee A was observed on duty and working with the residents on , the day of survey. She provided personal care, prepared and served meals, and assisted residents with their needs.

An interview was conducted with Employee A on at 9:17 am. She stated she had worked in the facility since 2014.

A personnel file review conducted for Employee A revealed she was hired as a Caregiver on . Further review found no documentation of the required Level 2 criminal background screening prior to the provision of care and personal services to the residents.

A review of the Agency for Health Care Administration's Background Screening website on revealed that Employee A did not have a background screening completed.

An interview was conducted with the Administrator on at 1:00 pm. She reviewed the record, and confirmed Employee A had not ever completed the required Level 2 background screen. She stated she was not sure, on hire, how long or how often the employee would be working with the residents. She acknowledged the requirement for all employees.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Sam's Assisted Living Facility
1 Pebblewood Lane
Palm Coast, FL 32164

Dear Administrator:

This letter reports the findings of a state biennial licensure survey that was conducted on 5, 2015 by a representative 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. Should you have any questions please call this office at

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supernovas
Division of Health Quality Assurance

LL/JM/sm
Enclosure

Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone:(904) 798-4201; Fax:(904) 359-6054
AHCA.MyFlorida.com