STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964869	**04/30/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
ZEPHYRHILLS HEALTH AND REHABILITATION CTR	**7350 DAIRY ROAD ZEPHYRHILLS, FL 33540**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2015001050, was conducted on .

The Zephyrhills Health and Rehabilitation Center, Assisted Living Facility, had deficiencies at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based upon record review & staff interview, the facility failed to ensure that one (#1) of three residents health assessments (AHCA form 1823) reviewed was completed in entirety.

Findings Include:

A review of the record for resident #1 revealed that the health assessment (1823) completed on contained all information required. The health assessment form did not include the method of management of the residents medications. This portion of the form was left blank.

During Interview with management at approximately 4:30 p.m. it was acknowledged that this missing information had not been obtained.

Class III

N275 - LNS - Licensing - 58A-5.031 FAC

Based upon record review & interview, the facility was providing nursing services (care &)exceeding the scope of their standard Assisted Living Facility license without first obtaining a Limited Nursing License for 2(# 1 & 2)of 3 residents reviewed.

Findings Include:

1. A review of the record for resident #1 admitted on revealed the facility was providing care for this resident as documented in the residents record.

The following orders were on file;

"obtain U/A,(urinalysis) C&S (culture & sensitivity) may st. cath.(straight) for sample".

noting to "cleanse to r. apply cuticom dressing then dry dressing cover".

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SUMMARY STATEMENT OF DEFICIENCIES
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N275 Continued From page 1

MD order stating " D/C Tx. (discontinue treatment) to R (right) -cleanse to . arm apply cuticorn dressing then dry dressing cover".

MD order stating "-cleanse to leg w/ NS apply dressing foam change q (every)3 days until healed & PRN (as needed)"
2. A review of the record for resident #2 admitted on revealed that the facility was providing care for the residents heal .
MD orders on file dated noted "cleanse left heel apply to bed, cover with dry dressing. Change daily..."
MD orders on file dated noted " D/C current treatment to heel /left, apply non-sting skin prep to left heel cover with adhesive , ', dry dressing change (twice daily) & PRN (as needed)".
During interviews with facility care staff who over sees & monitors wounds (at approximately 1 p.m.) it was acknowledged that the resident had a heal the size of a quarter which broke on residents left heel. The heel is currently in heeling process & is a scab approximately the size of a dime per this staff.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Zephyrhills Health And Rehabilitation Ctr.
7350 Dairy Road
Zephyrhills, FL 33540

RE: CCR #2015001050

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2015 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 727-552-2000.

Sincerely,

FOR Patricia Reid Caufman
Field Office Manager

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

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