

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 07/23/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911336	(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER KIMBERLY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 26315 NORTHERN CROSS ROAD PUNTA GORDA, FL 33983	

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

0000 Initial Comments

An unannounced Change of Ownership (CHOW) survey was conducted on _____ at Kimberly Place, an Assisted Living Facility (ALF) in Punta Gorda, Florida.

The following is description of the deficiency.

0081 Training - Staff In-Service

Based on record review and interview, the facility failed to have required training for 1 (Staff B) out of 4 staff records reviewed.

The findings included:

Record Review of Staff B (hire date _____) revealed no documented training in recognizing neglect and _____ and nutrition and safe food handling.

The Administrator stated on _____ at 1:45 p.m., "I will make sure the staff has the training."

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Kimberly Place
26315 Northern Cross Road
Punta Gorda, FL 33983

Dear Administrator:

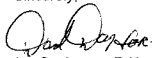
This letter reports the findings of a state licensure survey that was conducted on 2015 by a representative of this office.

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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies to the Field Office no later than 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 (239) 335-1315.

Sincerely,


Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

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