RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Key Training Center
5391 West Safari Lane
Lecanto, FL 34461

RE: CCR #

Dear Administrator:

This letter reports the findings of a state licensure 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send 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(s). Should you have any questions please call Jasmine Hayes at (386) 462-6201.

Sincerely,

for

Kristel J. Mennella
Field Office Manager

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911735	07/09/2015
NAME OF PROVIDER OR SUPPLIER **KEY TRAINING CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **5391 WEST SAFARI LANE** **LECANTO, FL 34461**	

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

0000 Initial Comments

on a biennial survey was conducted at Key Training Center, an Assisted Living Facility. deficient practice was identified at the time of the survey.

0008 Admissions - Health Assessment

Based on record review and interview, the facility failed to obtain and document information which was omitted from the health assessment for 1 of 2 residents sampled for a record review (Resident #1).

The findings include:

A review of Resident #1 ' s record revealed a health assessment form (AHCA Form 1823) dated . There was no information regarding Resident #1 receiving hospice services in the " nursing service requirements " section. The form did not state if Resident #1 ' s needs could be met in an Assisted Living Facility. There was no information to state the level of assistance (assistance with the self-administration or administration) Resident #1 required with medication.
On at 4:26 p.m. the Residential Supervisor was interviewed. She confirmed the information was omitted from the health assessment and stated the nurse is responsible for updating the AHCA 1823 health assessments.

Class III

0010 Admissions - Continued Residency

Based on record review and interview, the facility failed to ensure an Interdisciplinary Care Plan which specifies the services to being provided by hospice and those being provided by the facility was implemented by a licensed hospice for 1 of 2 residents sampled for a record review (Resident #1).

The findings include:

A review of Resident #1 ' s record revealed Resident #1 was admitted to hospice on . Further review revealed there was no ' which specified the services to being provided by hospice and those being provided by the facility in Resident #1 ' s record. A continued review revealed there was a care plan developed by hospice for the certification period starting on file for Resident #1. This plan only described the services to be offered by hospice and did not reflect services to be provided by the facility.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

On at 4:26 p.m. the Residential Supervisor was interviewed. She confirmed the facility did not have an which included services to be provided by hospice and the facility for Resident #1. She stated it was assumed that the facility would provide care that was not provided by hospice.

Class III