STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968054	07/23/2015
NAME OF PROVIDER OR SUPPLIER **SOARING EAGLE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **1568 SW CALIFORNIA BLVD** **PORT SAINT LUCIE, FL 34953**	

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

0000 Initial Comments

An unannounced Relicensure survey was conducted on , 2015 at Soaring Eagle Assisted Living Facility. The facility had deficiencies found at the time of the visit.

0083 Training - First Aid and

Based on record review and an interview, the facility failed to ensure that 1 out of 2 sampled staff members (Staff A) who was left in sole charge of residents was trained in both First Aid and , as provided under Rule 58A-5.0191.

The findings include:

The personnel file for Staff A was reviewed on for documentation of First Aid training. Record review revealed no documentation of the required training was available for review at the time.

Staff A and the Administrator stated during interview at 11:00 AM on that they did not have documentation of additional training. The Administrator was interviewed at approximately 1:00 PM on and acknowledged that the documentation was not present and available for review.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on record review and an interview, the facility failed to ensure that 2 out of 2 sampled unlicensed staff members (Staff A and B) who provided assistance with self-administered medications had completed 2 hours of continuing education training conducted by a registered nurse or pharmacist annually on providing assistance with self-administered medications and safe medication practices in an ALF.

The findings include:

The personnel files for Staff A and B were reviewed on for documentation of a minimum of 2 hours of continuing education training annually on providing assistance with self-administered medications and safe medication practices in an ALF. The following training for these unlicensed staff who provided assistance with self-administration of medication to residents was reviewed.

a) Staff A Resident Aide-Date of Hire , no medication training certificate signed by an RN or

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968054	**07/23/2015**
NAME OF PROVIDER OR SUPPLIER **SOARING EAGLE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **1568 SW CALIFORNIA BLVD PORT SAINT LUCIE, FL 34953**	

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

pharmacist was available for review

b) Staff B Administrator-Date of Hire [redacted] (since open), no medication training certificate available for review.

c) Resident Aide D-Date of Hire [redacted] no medication training certificate signed by an RN or pharmacist was available for review.

The Administrator was interviewed at approximately 1:00 PM on [redacted] and acknowledged that the documentation was not present and available for review.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Soaring Eagle Assisted Living Facility
1568 SW California Blvd
Port Saint Lucie, FL 34953

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 this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dmb
Enclosure
XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida