STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963806	07/31/2015
NAME OF PROVIDER OR SUPPLIER **ORMOND IN THE PINES**	STREET ADDRESS, CITY, STATE, ZIP CODE **101 CLYDE MORRIS BLVD** **ORMOND BEACH, FL 32174**	

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

0000 Initial Comments

An unannounced biennial licensure survey was conducted at Ormond in the Pines on , 2015. Deficiencies were identified.

0081 Training - Staff In-Service

Based on personnel record review and interview with the Administrator, the facility failed to provide the required training in incident reporting, resident rights and recognition and reporting of to 1 of 3 employees (Employee C) whose records were reviewed.

The findings included:

A personnel file review conducted for Employee C found she was hired as a Licensed Practical Nurse on . Further review of the record found no documentation the Employee C received the required training in reporting major and adverse incidents, resident rights in an assisted living facility, or recognizing and reporting resident , neglect and within 30 days of hire.

An interview was conducted with Administrator at 2:12 pm on / . She reviewed the record for Employee C and confirmed the missing trainings. She stated Employee C probably did not receive the required trainings.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Ormond In The Pines
101 Clyde Morris Blvd.
Ormond Beach, FL 32174

Dear Administrator:

This letter reports the findings of a state biennial licensure survey that was conducted on 31, 2015 by representatives 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 surveyors. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor

LL/JM/sm
Enclosure
XG90

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