AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965596	08/31/2015
NAME OF PROVIDER OR SUPPLIER OF FLORIDA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH 10TH STREET HAINES CITY, FL 33844	

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

0000 Initial Comments

Assisted Living Facility

An unannounced Biennial licensure survey with Limited Mental Health and Extended Congregate Care services was conducted on /

The of Florida Assisted Living, Assisted Living Facility, had deficiencies at the time of this visit.

0055 Medication - Storage and Disposal

Based on observations and interview, the facility failed to ensure medications were secured for 1 of 4 medication carts.

Findings include:

During an observation on / at approximately 12:20 PM in the medication the assisted living side, the medication cart was noted unattended with the keys on the lock. Staff #B who was in charge of the medication cart was observed on the telephone in a was across the hall from the medication . Staff B was informed of the findings at that time and reported she has never done that before.
The administrator was informed of the findings on / at 1 PM.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observations and interview, the facility failed to maintain resident's good working order.

Findings include:

During an initial tour of the facility with staff #A on / at 10:15 AM, the following was observed:
An electric outlet on the right wall near the noted missing it's cover in #
The walk in shower in # was noted with cracked areas.
The wall in # was noted with a black color substance between the tiles covering approximately 10% of the surface, and the faucet was noted with a dark black substance

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around the base covering approximately 10 % of the surface.
had a broken towel rack hanging from the wall, and a toilet paper holder with rust - like substance covering 75% of the surface.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Of Florida Assisted Living
301 South 10th Street
Haines City, FL 33844

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with limited mental health (LMH) and extended congregate care (ECC) 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents 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 **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

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

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