STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967005	R
NAME OF PROVIDER OR SUPPLIER **WESLEY HOUSE III**	STREET ADDRESS, CITY, STATE, ZIP CODE **28502 TALL GRASS DRIVE** **WESLEY CHAPEL, FL 33543**	

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

0000 Initial Comments

Assisted Living Facility

A revisit to the biennial state licensure survey of was conducted on &

The Wesley House III, Assisted Living Facility, had one uncorrected deficiency, A 0052, at the time of the visit.

0052 Medication - Assistance with Self-Admin

Based upon record review, interview & observation, the facility failed to ensure the medications for 1 resident (#6) was given as prescribed.

Findings include:

1. During the re-visit of 9 / , a review of the 2015 medication observation records (MOR) for resident #6 revealed that the MOR had not been annotated that the resident received his 20 mg, (give 1 tab at bedtime) on at 8pm. Per interview with the care giver on duty at 11:30pm the reason why it was not noted as given could not be explained. The staff responsible for the med pass at this time was not currently on duty.

The MOR also was not annotated that resident #6 received his 20mg.(to be given 1 tab in evening) at 5pm on .

Additionally, the MOR had not been annotated that the resident received his Megestrol 40ML, to be given 10ML 3 times daily, on for the doses of 8am, 12 noon & 8pm. and on at 8am & 12noon.

Per interview with the facility RN, the medication was finished & showed the surveyor the bottle was empty. During a telephone call to the Pharmacist at 12:40pm he confirmed this medication was to be given one time only for 16 days. According to the MOR reviewed the medication was given from through which was a total of 13 days, not 16 as indicated by the Pharmacist.

The bottle originally contained 480ML's upon fill date of ../.. It appears from this review that the medication dosages were not properly measured.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967005	R
NAME OF PROVIDER OR SUPPLIER **WESLEY HOUSE III**	STREET ADDRESS, CITY, STATE, ZIP CODE **28502 TALL GRASS DRIVE** **WESLEY CHAPEL, FL 33543**	

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

Uncorrected deficiency from the visit of

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11967005	A. Building B. Wing	9/17/2015

Name of Facility	Street Address, City, State, Zip Code
WESLEY HOUSE III	28502 TALL GRASS DRIVE WESLEY CHAPEL, FL 33543

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0055 Reg. # 58A-5.0185(6) FAC LSC	Correction Completed	ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	Correction Completed	ID Prefix A0090 Reg. # 58A-5.0191(11) FAC LSC	Correction Completed
ID Prefix A0093 Reg. # 58A-5.020(2) FAC LSC	Correction Completed	ID Prefix A0167 Reg. # 58A-5.025 FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TLK	9/18/15		
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Wesley House III
28502 Tall Grass Drive
Wesley Chapel, FL 33543

Dear Administrator:

This letter reports the findings of a state licensure revisit survey 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 corrected during the visit and the uncorrected deficiency that was identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2015.**

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 **Teresa Ryan**, RNC, at (727) 552-2000.

Sincerely,

Teresa Ryan RNC
for Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosures: State (5000-3547) Form & Revisit Report

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