STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911992	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULF WINDS	2745 VENICE AVENUE EAST VENICE, FL 34292

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

0000 Initial Comments

An unannounced monitoring visit was conducted on / at Gulf Winds, an assisted living facility in Venice, Florida.

The facility received the following citation as a result of this survey.

0079 Staffing Standards - Levels

Based on a review of the facility staff schedule and staff interview, the facility failed to staff the facility with the required 4 staff for each shift as directed by The Agency for Health Care Administration (AHCA).

The findings included:

A review of the facility staff schedule from / through / / showed there were three staff scheduled every day from 2:00 p.m. through 10:00 p.m. A review of the same staff schedule showed there were four staff scheduled from 6:00 a.m. through 2:00 p.m. and 10:00 p.m. through 6:00 a.m. daily.

An interview was conducted with the Administrator on / / at 11:45 a.m. She stated the residents usually start going to bed approximately 8:00 p.m. They get up in the morning approximately 7:00 a.m. The facility was instructed by AHCA to staff the facility with four staff when the residents are sleeping and three staff when residents are awake. Since the residents start going to bed at 8:00 p.m. the facility is to have four staff on the schedule starting at that time. The facility is short one staff from 8:00 p.m. through 10:00 p.m. daily.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Gulf Winds
2745 Venice Avenue East
Venice, FL 34292

Dear Administrator:

This letter reports the findings of a state licensure monitoring survey that was conducted on , 2015 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

sh
Enclosure: State Form

XG90

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
Phone:(239) 335-1315; Fax:(239) 338-2372
AHCA.MyFlorida.com