STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968191	11/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOPPA'S HOME LLC	440 CATALINA AVE NW MELBOURNE, FL 32907

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

0000 Initial Comments

On 2015 the biennial re-licensure survey with Limited Nursing Services was conducted at Boppa's Home LLC on / / . Deficient Practice was identified during the surveys.

0055 Medication - Storage and Disposal

Based on observation and interview the facility failed to ensure refrigerated medications was secured by being kept in a locked container within the refrigerator or by keeping the refrigerator locked.
Findings:
Observation of assistance of self-administration of medication / at 12 PM, the administrator retrieved from the refrigerator a plastic container with resident #4's bottle. The bottle was inside a plastic container that was not locked and not secured. After an observation of assistance with self-administration of medication the administrator checked the residents' sugar. The administrator checked the sugar and gave the appropriate amount required to resident #4 and put the bottle back into the unlocked and unsecured plastic container back in the refrigerator.
On / at 3:30 PM, the administrator confirmed the above finding.

Class III

0078 Staffing Standards - Staff

Based on personnel record review and interview the facility failed to have evidence of a negative ( ) test on an annual basis.
Findings:
Review of staff D's personnel file revealed the most recent documentation of a negative test was dated / (due / /).
On / / the administrator confirmed the above findings.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

_____, 2015

Administrator
Boppa's Home LLC
440 Catalina Ave NW
Melbourne, FL 32907

RE: Relicensure w/LNS

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 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 Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

XG90

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