STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968254	02/08/2016
NAME OF PROVIDER OR SUPPLIER **INN ON THE POND**	STREET ADDRESS, CITY, STATE, ZIP CODE **2010 GREENBRIAR BLVD** **CLEARWATER, FL 33763**	

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

0000 Initial Comments

Assisted Living Facility

A biennial relicensure survey with extended congregate care (ECC) services was conducted at Inn on the Pond on . Inn on the Pond, Assisted Living Facility, had a deficiency at the time of the visit.

0008 Admissions - Health Assessment

Based on record review and interview, the facility failed to ensure the completion and accuracy of the Initial health assessment (AHCA Form1823) for two residents (# 11 and #12) out of two resident records reviewed.

Findings included:

During a record review, for resident # 11, The Heath Assessment (Form 1823) has a double copy of the list of medications, with a different first name and different levels of medication assistance. An interview with the Director of Resident Services at 2:10 pm on confirmed the discrepancies.
During a record review, for resident #12, The Heath Assessment (Form 1823) had no diagnosis listed. In the space provided, it stated " See attached ". After searching the medical record, the Director of Resident Services in an interview at 2:10 pm on , confirmed the absence of any attached documents and is unable to provide a list of resident diagnoses.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Inn on the Pond
2010 Greenbriar Blvd
Clearwater, FL 33763

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with extended congregate care (ECC) that was conducted on , 2016, by representative(s) 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 deficiency. Submit summary and documents to the Field Office no later than , 2016.** 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 deficiency 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.

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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,

Paul M Brown

For Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547