STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966315	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMYRNA WEST ASSISTED LIVING FA	301 MILFORD PLACE NEW SMYRNA BEACH, FL 32168

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

0000 Initial Comments

An unannounced licensure complaint survey (CCR#2015013187) was conducted at Smyrna West Assisted Living Facility on . Smyrna West Assisted Living Facility had deficiencies at the time of survey.

0029 Resident Care - Nursing Services

Based on record review and interview, the facility failed to ensure that a licensed staff was measuring for 1 of 3 sampled residents (Resident #1)

The findings include:

A review was conducted of Resident #1's chart on . Resident #1's Resident Health Assessment (1823) dated // revealed he required assistance with self-administration with medication. Resident #1's physician orders dated // revealed an order to " ( ) check two times a day prior to (medication). Hold if lower 110 . A review of Resident #1's Medication Observation Record for 2016 revealed that staff were initialing that they were providing monitoring twice daily. On & , Employee C's initials were observed indicating that she assisted the resident with monitoring on those days.

A review was conducted of Employee C's personnel file revealed a hire date of // as a caregiver.

In an interview with the Administrator on at 11:51 AM, she confirmed that Employee C assists Resident #1 by taking his . She confirmed that Employee C is not a Certified Nursing Assistant or licensed nurse, and was hired as a caregiver.

Class III

0053 Medication - Administration

Based on record review and interview, the facility failed to have a licensed staff administer medications to 1 of 3 sampled residents (Resident #1).

The findings include:
A review of Resident #1's chart revealed a Resident Health Assessment (1823) dated // . The 1823 coded Resident #1 as requiring assistance with self-administration with medication. The resident's

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SUMMARY STATEMENT OF DEFICIENCIES
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diagnosis included

A review of the 2016 Medication Observation Report (MOR) for Resident #1 revealed the resident was receiving Lantus 20 units at bedtime. Employee C's initials were signed on , 3, 4, 5, 9, 10, 11, & 17, indicating that she assisted the resident with his
In an interview with Resident #1 on at 11:50 AM, he reported that he has taken "for years". He reported that he used to give himself his , but that now that he has been living at the facility, the staff give him his . He then stated that Employee C will inject him with his
In an interview with Employee B on / at 12:30 PM, he reported that "most of the time', ... Administrator assists Resident #1 with his . He confirmed that other staff at the facility assist Resident #1 with his as well. Employee B stated that he has observed Employee C inject Resident #1 with his .
A review was conducted of Employee C's personnel file revealed a hire date of / as a caregiver.
In an interview with the Administrator on at 1:00 PM, she confirmed that Employee C is not a Certified Nursing Assistant or licensed nurse, and was hired as a caregiver. She reported that she was unaware that Employee C was injecting Resident #1 ' s

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Smyrna West Assisted Living Facility
301 Milford Place
New Smyrna Beach, FL 32168

RE: CCR #2015013187

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on 2016 by a representative 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 19, 2016.** Staff from this office will conduct a review of the provided corrective action and suppo... 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 -4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JM/sm
Enclosure
XG90

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