STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967853	05/10/2016
NAME OF PROVIDER OR SUPPLIER **FLORRY HOUSE**	STREET ADDRESS, CITY, STATE, ZIP CODE **5111 SMITH RYALS RD** **PLANT CITY, FL 33567**	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

On , 2016, an abbreviated biennial re-licensure survey with limited nursing services (LNS) and limited mental health (LMH) services was conducted at Florry House assisted living facility. Deficient practice was identified during the surveys.

0078 Staffing Standards - Staff

Based on record review and interview, the facility did not obtain a written statement from a health care provider documenting the staff does not have any signs or symptoms of communicable within thirty (30) days of hire for one (#C) of four direct care staff who were sampled for communicable statements.

Findings included:

Record review on / / of direct care staff #C's personnel file revealed she was hired on and there was no communicable statement in her file. Staff #C had thirty (30) days to give the communicable statement to the facility.

During an interview administrator verified on / / at 1:15 pm that staff #C did not have a communicable statement in her file.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on record review and interview, the facility failed to provide two hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility annually for one (#A) of four direct care staff who were sampled for two hours of continuing education for medications.

Findings included:

A record review on / / of staff #A's personnel file revealed she had taken the initial four hour training for providing assistance with self-administered medications on and the last 2 hour

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967853	05/10/2016
NAME OF PROVIDER OR SUPPLIER **FLORRY HOUSE**	STREET ADDRESS, CITY, STATE, ZIP CODE **5111 SMITH RYALS RD** **PLANT CITY, FL 33567**	

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

medication update was . She needed the two hour continuing education training on medication done by / . There was no documentation in her personnel file which stated she had completed the training in 2015.

The staffing schedule for , 2016 was reviewed on / and Staff #A was scheduled to work ten times on either the 7:00 am to 7:00 pm shift (3 times) or the 7:00 pm to 7:00 am shift (7 times). Staff #A would be assisting the residents with their medications during those shifts.

The two hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility must be completed annually.

When interviewed on / at 1: 20 pm, the administrator verified the documentation which is to be completed annually for the two hours of continuing education regarding medication was not in her personnel file.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Florry House
5111 Smith Ryals Rd
Plant City, FL 33567

Dear Administrator:

This letter reports the findings of a abbreviated biennial state licensure survey with limited nursing services (LNS) and limited mental health (LMH) 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 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 , 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 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 **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

FOR Patricia Reid Caufman

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

Field Office Manager

PRC/clt
Enclosure
XG90