| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11953595 | 05/12/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**ALLEGRO AT COLLEGE HARBOR (THE)** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**4600 54TH AVENUE, SOUTH<br>SAINT PETERSBURG, FL 33711** | |

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

**0000 Initial Comments**

Assisted Living Facility

A complaint investigation (CCR# 2016001975) was conducted at Allegro at College Harbor (The) on / . Allegro at College Harbor (The) had deficiencies at the time of the visit.

**0025 Resident Care - Supervision**

Based on interview and record review, the facility failed to show proof of documentation concerning required, daily care and services provided to residents for 2 (Resident #1 and Resident #3) of 3 records reviewed.

Findings included:

The resident services director was interviewed at 12:42 PM on / . She stated that the direct care staff documented daily resident care on a form entitled 3 Month Care Log/ Signoff Sheet (Care Log).

Staff A was interviewed at 4:19 PM on / / concerning the Care Log and she stated that there should be initials for each shift and, at a minimum, residents should be observed during every shift.

A review of Resident #1 ' s record on showed an admission date of . Resident #1 ' s AHCA Form 1823 indicated that he needed assistance with ambulation, bathing, dressing, , toileting, and transferring. A review of Resident #1 ' s Care Log for through / showed numerous blanks without initials for morning, evening and night shifts.

A review of Resident #3 ' s record on showed an admission date of . Resident #3 ' s AHCA Form 1823 showed that she needed assistance with ambulation, bathing, dressing, eating, , toileting, and transferring. A review of Resident #3 ' s Care Log from through / showed numerous blanks without initials for evening and night shifts. A review of Resident #3 ' s Care Log for / - showed no initials for care provided by staff.

The administrator was interviewed at 4:50 PM on concerning the lack of documentation of daily care on the Care Log for Resident #1 and Resident #3. The administrator reviewed the Care Logs and acknowledged the gaps in documentation.

Class III

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11953595 | 05/12/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**ALLEGRO AT COLLEGE HARBOR (THE)** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**4600 54TH AVENUE, SOUTH SAINT PETERSBURG, FL 33711** | |

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

**0084 Trainina - Assis Self-Admin Meds & Med Mamt**

Based on interview and record review, the facility failed to show proof of annual, 2 hours of continuing education training on providing assistance with self-administered medications (Med Tech Update) for 1 (Med Tech A) of 3 employee records reviewed.

Findings included:

A review of employee records of staff that assist residents with self-administration of medication (Med Techs) was conducted on . A review of Med Tech A ' s record showed that her last Med Tech Update was dated / .

The HR Director was interviewed at 4:27 PM on concerning the lack of an up-to-date Med Tech Update in Med Tech A ' s file. The HR Director reviewed the file and stated that she did not see it.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Allegro At College Harbor (The)
4600 54th Avenue, South
Saint Petersburg, FL 33711

**RE: CCR #2016001975**

Dear Administrator:

This letter reports the findings of a state licensure survey 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
Field Office Manager

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

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

PRC/clt
Enclosure: State (5000-3547) Form
XG90