STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966226	05/16/2016
NAME OF PROVIDER OR SUPPLIER SPRINGS WATER ALF	STREET ADDRESS, CITY, STATE, ZIP CODE 1411 EAST WATERS AVENUE TAMPA, FL 33604	

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

0000 Initial Comments

Assisted Living Facility

An unannounced Biennial licensure survey with Limited Mental Health services was conducted on .

The Springs Water ALF, Assisted Living Facility, had deficiencies at the time of this visit.

0084 Trainina - Assis Self-Admin Meds & Med Mamt

Based on observation, record review, and interview, the facility failed to ensure that 1 of 2 staff (staff A) who provides residents assistance with self-administration of medications has successfully completed annual 2-hour updates on providing assistance with self-administration of medications and safe medication practices in an assisted living facility.

Findings included:
Per Surveyor review of the facility ' s employee records conducted on , Staff A completed 4 hours of medication training on . As of / review, there was no evidence of Staff A completing an annual 2-hour training update on providing assistance with self-administration of medications and safe medication practices in an assisted living facility.
Per interview with Staff A on at 9:45am, observation of Staff A providing residents assistance with self-administration of medications on / at 12:00pm, and review of the facility ' s Medication Observation Records, Staff A has provided residents assistance with self-administration of medications throughout the month of , 2016.
Per interview on / at 3:30pm, the Administrator acknowledged Staff A ' s need for updated medication training. Staff A stated that he had updated medication training in , 2016; there was no documentation of the training available at the time of the survey.

Class III

0091 Trainina - Documentation & Monitorina

Based on record review and interview, the facility failed to ensure maintenance of training documentation as required in the facility's personnel files for 2 of 2 staff (staff A & B) who provide Caregiver services for 8 assisted living facility residents. The facility failed to ensure that employee training certificates document title, subject matter, & program agenda of the training program, trainee's name, dates of participation, number of hours, and location of the training program, and the training

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	AL11966226	05/16/2016
NAME OF PROVIDER OR SUPPLIER **SPRINGS WATER ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1411 EAST WATERS AVENUE** **TAMPA, FL 33604**	

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

provider's name, dated signature, and credentials, including professional license number as applicable, of the training program.

Findings included:
Per review of the facility ' s employee records conducted on , Staff A was hired as a Caregiver (Resident Care Aide/Medication Technician) on \/ and works with residents at the facility 7am-7pm; Staff B was hired as a Caregiver (Resident Care Aide/Medication Technician) on \/ and works with residents at the facility 7pm-7am & 10am-10pm.
Staff A ' s file included a list of trainings dated as accomplished / , including ADL & Behavioral Needs training and Emergency Preparedness & Evacuation training. There was no training certificate in Staff A ' s personnel file documenting training specifics as required. There was no training certificate in Staff B ' s personnel file documenting ADL & Behavioral Needs training.
Per interview on / at 3:30pm, the Administrator acknowledged the lack of training documentation.

Class III

L243 LMH - Training

Based on observation, record review, and interview, the facility failed to ensure that 1 of 2 staff (staff B) who has direct contact with 8 mental health residents in a licensed Limited Mental Health facility has received a minimum of 3 hours of continuing education biennially in subjects dealing with mental health diagnoses and treatment.

Findings included:
Per / observation of posted license and record review, the facility has a standard license (expires) as an Assisted Living Facility with Limited Mental Health services. Per interview with the Administrator on at 10:30am, the facility has 8 current mental health residents, including 5 Limited Mental Health residents receiving funding based on mental health diagnoses.
Per review of the facility's employee records conducted on / , Staff B was hired as a Caregiver (Resident Care Aide/Medication Technician) on / \/ and works with residents at the facility 4 days per week from 7pm to 7am & 2 days per week from 10am-10pm. Staff B completed 8 hours of specialized training in working with individuals with mental health diagnoses on . As of record review, Staff B has not completed the minimum of 3 hours of continuing education biennially as required.
Per interview on / at 3:30pm, the Administrator acknowledged that Staff B has not completed the required minimum of 3 hours continuing education biennially related to Limited Mental Health care.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Springs Water ALF
1411 East Waters Avenue
Tampa, FL 33604

Dear Administrator:

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

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

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