AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910121	R 05/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY CREEK VILLAGE	8606 BOULDER COURT TAMPA, FL 33615

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

0000 Initial Comments

Assisted Living Facility

A revisit to a biennial survey with extended congregate care (ECC) and limited mental health (LMH) in conjunction with a revisit to complaints (CCR 2016002446 & 2016003215) was conducted at Rocky Creek Village on . Rocky Creek Village, Assisted Living Facility, had an uncorrected deficiency at the time of the visit.

0084 Trainina - Assis Self-Admin Meds & Med Mamt

Based on interview and record review, the facility failed to ensure that staff that provide assistance with self-administration of medications obtained a minimum of annual, 2 hours of continuing education for 1 (Staff A) of 3 employee records reviewed for training requirements.

Findings included:

An employee record review was conducted on . A review of Staff A ' s record showed a date of hire of / and that she assisted residents with self-administration of medications. Her record also showed that received her initial 4 hour medication assistance training (Med Tech) / . Staff A ' s record showed no annual, 2 hour continuing education Med Tech training.

An interview was conducted with the HR director at 9:41 AM on concerning the missing training certificate for Staff A. The HR director reviewed Staff A ' s record and acknowledged that it wasn ' t there and stated that Staff A is scheduled for the Med Tech training on / .

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11910121 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY CREEK VILLAGE	8606 BOULDER COURT TAMPA, FL 33615

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0078 Reg. # 58A-5.019(2) FAC LSC	Correction Completed	ID Prefix AL243 Reg. # 429.075(1) FS; 58A-5.0191(8) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) PB13	DATE 6/2/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/5/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: QEYM12

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Rocky Creek Village
8606 Boulder Court
Tampa, FL 33615

Dear Administrator:

This letter reports the findings of a two revisit surveys conducted on , 2016, by representative(s) of this office. Enclosed are the provider's copies of the Statement of Deficiencies (State Forms 5000-3547), which reference the uncorrected deficiencies and/or new deficiencies identified during the revisits.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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 **Paul Brown**, HFES, of this office at (727) 552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosures: State Forms 5000-3547 & Revisit Reports

BBT7

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