STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11968618 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PAMPERED PARENTS ALF, INC	6 SETON CT PALM COAST, FL 32164

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 A0026	Correction	ID Prefix A0032	Correction	ID Prefix A0078	Correction
Reg. # 58A-5.0182(2) FAC	Completed	Reg. # 58A-5.0182(8) FAC	Completed	Reg. # 58A-5.019(2) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0081	Correction	ID Prefix A0083	Correction	ID Prefix A0090	Correction
Reg. # 58A-5.0191(2) FAC	Completed	Reg. # 58A-5.0191(4) FAC	Completed	Reg. # 58A-5.0191(11) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0160	Correction	ID Prefix A0161	Correction	ID Prefix AZ813	Correction
Reg. # 58A-5.024(1) FAC	Completed	Reg. # 429.275(2) FS; 58A-5.024(2) FAC	Completed	Reg. # 59A-35.090(3)(c), FAC	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Robert D Webb for Tina Moye ing	10-16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 3/30/2016

☑ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☑ YES ☐ NO

EVENT ID: ZV7312

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968618	R
NAME OF PROVIDER OR SUPPLIER **PAMPERED PARENTS ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **6 SETON CT** **PALM COAST, FL 32164**	

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

0000 Initial Comments

A follow-up visit to a biennial survey was conducted at Pampered Parents ALF, Inc. on Pampered Parents ALF, Inc. (License #12487) had deficiencies at the time of the visit.

0055 Medication - Storage and Disposal

Based on observation, and interview with staff, the facility failed to keep medications for 1 of 4 sampled residents (Resident #1) in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times.

The findings include:

A tour of the facility was conducted at 9:18 am. Two residents were seated in the living , which was adjacent to the kitchen. A bottle of Methadone (an opiod medication used to treat pain or to help with in opiod dependent people) 5 milligram tablets was observed on the kitchen counter. The label indicated it was for Resident #1, with the instructions to take one tablet by mouth at bedtime for pain.

An interview was conducted with Emplolyee E, Certified Nursing Assistant, at 9:20 am on . She stated the medication for Resident #1 had been delivered by the pharmacy today. She apologized that they she had not locked them up immediately, acknowledging the requirement.

Observations conducted between 9:15 am and 11:15 am found that Resident #5 was ambulatory with the use of a wheeled walker. She was observed to pass by the kitchen on two occasions during the survey. Resident #1 was observed to be independently mobile in the home with the use of a manual wheelchair, and was also observed to wheel herself past the kitchen entry.

An interview was conducted with the Administrator at 11:10 am on . She confirmed the medications for Resident #1 should have been locked up immediately upon receipt from the pharmacy. The Administrator stated she did not know how many times she had instructed staff to keep medications

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SUMMARY STATEMENT OF DEFICIENCIES
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secured. She agreed she would need to retrain her staff in the requirements.

This was previously cited in a biennial licensure survey conducted on .

Class III

Z815 Background Screening: Prohibited Offenses

Based on observations, a review of personnel files, and interview with the Administrator, the facility failed to obtain Level 2 background screening for 1 of 3 sampled employees whose personnel files were reviewed (Employee E) prior to her working alone in the home, and providing care and services to the residents.

The findings included:

Upon arrival to the facility at 9:15 am on , Employee E was observed working alone in the facility. Four residents were confirmed to reside in the home at the time of survey. Observations conducted between 9:15 am and 11:15 am on revealed Employee E provided care and supports to residents in and out of their .

A personnel file review for Employee E revealed she was hired on as a Certified Nursing Assistant. Further review of the file found no documentation of Level 2 background screening results.

An interview with the Administrator was conducted at 10:35 am on . She confirmed she had not obtained a background screening for Employee E prior to permitting her to provide care to the residents. She stated she thought she had 30 days to obtain the screening. The employee confirmed at this same time she had not gone to get a Level 2 screening.

This was previously cited in a biennial licensure survey conducted on .

Unclassified

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PAMPERED PARENTS ALF, INC	**6 SETON CT** **PALM COAST, FL 32164**

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

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Pampered Parents ALF, Inc.
6 Seton Court
Palm Coast, FL 32164

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016 by a representative of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies identified during the revisit.

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 this office at (904) 798-4201.

Sincerely,

a Meyering,
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LL/JM/sm
Enclosure

BBT7

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