AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963784	06/10/2016
NAME OF PROVIDER OR SUPPLIER **WILD FLOWER INN**	STREET ADDRESS, CITY, STATE, ZIP CODE **639 MICHIGAN BLVD. #1500** **DUNEDIN, FL 34698**	

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

0000 Initial Comments

Assisted Living Facility

On , a complaint survey (CCR# 2016006057), was conducted at Wild Flower Inn, Assisted Living Facility, in conjunction with a revisit to (CCR# 2016004686) of . Wild Flower Inn had a deficiency at the time of the investigation.

0025 Resident Care - Supervision

Based on interview and record review, the facility failed to maintain written records for 3 of (#1, #2, #3) 3 reviewed resident records. The facility did not have documentation of observations for residents and changes in resident behaviors.

Findings included:

During a review of resident records on at 10:00 am it was revealed that the facility did not maintain a written record, updating as needed of any significant changes and there was no documentation of any incident that occurred between the two residents on .
During the intervies the assistant administrator stated that sometime around mid to late , two residents got into an altercation: Resident #3 and Resident #2. She was not on the premises when it happened. The staff told her that he heard the yelling and responded to the . Staff went into the separate the residents and got Resident #2 to leave the Resident #1. The assistant administrator stated the staff called her to notify her of the incident and the assistant administrator told them to keep resident #2 away from the other two residents.
The assistant administrator states she notified resident #2's case worker and phoned resident #3's family. The assistant administrator confirmed the facility failed to have documentation available. The Assistant administrator stated she has not been updating the residents charts. She could not remember the time or date of the incident.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Wild Flower Inn
639 Michigan Blvd. #1500
Dunedin, FL 34698

RE: CCR #2016006057

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

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Enclosure: State (5000-3547) Form
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