STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963784	R
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 revisit to complaints (CCR# 2016004686 and CCR# 2016004446) was conducted in conjunction with CCR# 2016006057. The Wild Flower Inn, Assisted Living Facility, had an uncorrected deficiency and a new deficiency identified at the time of the visit.

(License # 8223)

0052 Medication - Assistance with Self-Admin

Based on observation and interview the Facility failed to provide proper assistance with self-administration of medication per the guidelines as noted in 429.256 of the Florida Statutes. Specifically, Staff F signed the Medication Observation Record (MOR) after providing medication to the resident.

Findings included:

At 9:35am, an observation was made of the Staff F flipping the pages, initialing the individual medications on each page of the MOR. He was asked what are you signing. He stated he was signing for the medications he gave this morning; he hadn ' t had a chance to sign for them. I requested the book from him he said no, he wasn ' t done and took the book into another him.

At 9:45am when Staff F brought the MOR back, during an interview, he revealed that yes, he knows that he ' s supposed to initial the MOR immediately after he assists with the medication but he didn ' t have time.

An 11:15am interview with the assistant administrator informed her of the actions of Staff F. She stated, " yeah, I don ' t know why he did that."

Class III

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963784	R
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)

0058 Pharmacy & Dietary: Uncorrected Deficiencies

Based on an uncorrected class III deficiency regarding medication self-administration, (Aspen event ID YVMQ11 and YVMQ12), specifically documenting immediately before and not documenting immediately after assisting the resident with medication, shall be required to employ the consultant services of a licensed pharmacist or a licensed registered nurse. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. This serves a written notification of such determination.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11963784 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILD FLOWER INN	639 MICHIGAN BLVD. #1500 DUNEDIN, FL 34698

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 AZ814 Reg. # 435.12(2)(b-d), FS LSC	Correction Completed	ID Prefix AZ816 Reg. # 408.809(2)(a-c) FS 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) PPB	DATE 6/22/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/28/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

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

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 this office at (727) 552-2000.

Sincerely,

FW Patricia Reid Caufman
Field Office Manager

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

BBT7

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