STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964731	R 06/14/2016
NAME OF PROVIDER OR SUPPLIER **HARBOR POINT ALF, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **1045 HARBOR LAKE DRIVE** **SAFETY HARBOR, FL 34695**	

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

0000 Initial Comments

Assisted Living Facility

A revisit to an abbreviated biennial state licensure survey was conducted at Harbor Point ALF, Inc. on . Harbor Point Assisted Living Facility had an uncorrected deficiency at the time of the visit.

(License # 9270)

0054 Medication - Records

Based on record review and interviews, the facility failed to maintain up to date medication observation records (MOR) for eight out of eight residents (resident's 1,2,3,4,5,6,7 & 8.

Findings Included:

During a review of medication records and a medication reconciliation for all eight residents conducted on at 9:15 AM it was revealed the Med/Tech, assisted with self-administered 8:00am medications to all eight residents, but had failed to initial any of the medications on the MOR. All eight residents had medications due and received at 8:00 am that morning.
During the interview the med-tech stated on / at 9:15AM that he had not initialed the MOR after assisting the residents with self-administered medication and asked to initial the 8:00AM medication before the surveyors started to review the MOR.
In interview with the administrator on / 11:00 AM, the administrator stated that the medication administrations should all have been recorded and that the Med Tech had recently had special training specifically to teach him to always do that.
Per the corrective action plan submitted to AHCA on , the administrator retrained all employees on the proper way to sign for medications in the med book.
A review of the MOR for resident #2 revealed that he had a prescription for shampoo three times per week for seborrheic . The shampoo was in his medication storage, however it had not been signed off as given to him in the month of 2016. In an interview with the Med/Tech, stated that he did not sign it off because he did not know what the times were that it should be given, but that he had, in fact, given the prescription shampoo to the resident to use three times a week.
A review of the MOR for resident #3 revealed that he also had a prescription for shampoo for a of the scalp, and it was to be given three times per week. On his MOR, instead of being given three times per week, it showed that it had been given every day.

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964731	R 06/14/2016
NAME OF PROVIDER OR SUPPLIER **HARBOR POINT ALF, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **1045 HARBOR LAKE DRIVE** **SAFETY HARBOR, FL 34695**	

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

In an interview with Med/Tech, on , at 10:30AM he stated that he really had given the prescription shampoo three times per week, however he signed it off every day as to not leave any holes in the MOR
On , at 11:00AM during an interview with the administrator, stated that the Med Tech had training that was required, as well as additional training.

Uncorrected

Class III

0058 Pharmacy & Dietary: Uncorrected Deficiencies

Based on an uncorrected class III deficiency regarding medication self-administration, (Aspen event 8MTO11 and 8MTO12), specifically not documenting immediately after assisting the resident with medication, the facility 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
AL11964731 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR POINT ALF, INC.	1045 HARBOR LAKE DRIVE SAFETY HARBOR, FL 34695

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 A0093 Reg. # 58A-5.020(2) FAC LSC	Correction Completed	ID Prefix AZ814 Reg. # 435.12(2)(b-d), 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
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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 4/28/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: 8MT012

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Harbor Point ALF, Inc.
1045 Harbor Lake Drive
Safety Harbor, FL 34695

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,

FOR Patricia Reid Caufman
Field Office Manager

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

BBT7

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