RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Good Samaritan Retirement Home
507 S.E. 1st Avenue
Williston, FL 32696

RE: CCRs #2016003609, 2016004885 & 2016006532

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by a representative of this office.

Enclosed 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. Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Kristie J. Mennella
Field Office Manager

KJM/amw
Enclosure

XG90

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910275	06/14/2016
NAME OF PROVIDER OR SUPPLIER **GOOD SAMARITAN RETIREMENT HM**	STREET ADDRESS, CITY, STATE, ZIP CODE **507 S.E. 1ST AVENUE** **WILLISTON, FL 32696**	

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

0000 Initial Comments

On , 2016 a complaint survey for CCR# 2016003609, 2016004885 & 2016006532 was conducted at the Good Samaritan Retirement Assisted Living Facility (facility license number 25). Deficient practice was identified. The facility was not in compliance at this time.

0030 Resident Care - Rights & Facility Procedures

Based on observation, interview, and record review, the facility failed to ensure that 1 of 8 residents (Resident #1) was free from use of a device, full bed rail.

Findings:

On at approximately 10:05 AM, an observation was conducted of Resident #1, who was in his . Resident #1 was observed in his bed eating breakfast. On his bed it was observed he had full bed rail in the down position.

On at approximately 10:20 AM, Staff B came into the assisted Resident #1 get comfortable in bed and it was observed that she pulled the full bed rail into the up position (photo taken).

On , a record review was conducted on Resident #1 for a bed rail order. No order for full bed rail was found; he had an order for hospital bed (long).

On at approximately 1:00 PM, an interview was conducted with the Administrator about Resident #1 having a full bed rail. He stated he thought Resident #1 had a half bed rail. He was asked to provide an order for the full bed rail which he was unable to provide.

Class III