RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Eastside Care, Inc.
152 South East Defender Drive
Lake City, FL 32055

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) 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(s). Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Kriste J. Mennella
Field Office Manager

KJM/amw
Enclosure

XG90

Alachua Field Office
14101 N W Hwy 441, Suite 800
Alachua, FL 32615-5669
Phone:(386) 462-6201; Fax:(386) 418-5300
AHCA.MyFlorida.com

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942918	05/06/2016
NAME OF PROVIDER OR SUPPLIER **EASTSIDE CARE, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **152 S EAST DEFENDER DRIVE** **LAKE CITY, FL 32055**	

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

0000 Initial Comments

On , 2016 through , 2016, a biennial licensure survey with Limited Mental Health (LMH) was conducted at Eastside Care Assisted Living Facility (facility license number 5425). During the survey deficient practice was identified.. The facility was not in compliance at this time.

0025 Resident Care - Supervision

Based on observation, record review and interview, the facility failed to provide care and services specific to machines for 1 of 40 residents (#3).

Findings:

During a tour of the facility with the Home Manager on at 9:15 AM, a Continuous Positive Airway Pressure (CPAP) machine was noted in for Resident #3. The machine was half filled with water which had black debris floating in it. The water was so cloudy it could not be seen through. The outside of the machine had dark smudges on each side. The mask looked worn. There was duct tape on the tubing holding the connection together with the machine.

Review of Resident #3's record revealed a Physician's report for the visit. He noted the purpose of the visit was for the the resident must have through the night. It stated for her diagnosis: , Active Smoker and ". The report stated her 02 saturation level was 83 % while in the office on that date. It should be noted the Resident's Form 1823 notes she is "Legally |" and the Physician's report notes she is "Legally ". There was no information regarding her CPAP machine.

During an interview with the Manager on at approximately 9:50 AM she stated the doctor and hospital ordered the machine but did not provide her with any instructions for the care and servicing of the machine. She stated they had not provided any care or services for the machine or it's use. She stated the resident went to the emergency and she had the order for the machine when she came back to the facility. She stated she called the company asking them to come to the facility immediately to service the machine. They arrived in the early afternoon and replaced the tubing and water canister.

During an interview with Resident #3 on at approximately 2:15 PM, she stated she uses her CPAP and machine every night. She stated she uses medications like the inhaler, for her , daily. She stated she could not take care of the machine because "I cant see".

Class III

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