STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911992	R
NAME OF PROVIDER OR SUPPLIER **GULF WINDS**	STREET ADDRESS, CITY, STATE, ZIP CODE **2745 VENICE AVENUE EAST** **VENICE, FL 34292**	

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

0000 Initial Comments

An unannounced revisit survey was conducted from through / at Gulf Winds, an Assisted Living Facility, (license #7804), in Venice, Florida.

This is a follow-up to the monitoring visit survey completed on / /.

The following is a description of the deficiency found at the time of this visit.

0093 Food Service - Dietary Standards

Based on observation and staff interviews, the facility failed to ensure there was a supply of eating ware sufficient for all residents and failed to ensure there was the capacity to store enough water to meet the needs of the residents in case of an emergency.

The findings included:

1. Observation on / at 12:35 p.m., showed staff serving residents their desserts on styrofoam plates. An interview was conducted with Staff V on at 1:45 p.m. She stated the facility does not have enough saucers for the desserts and that is why she uses styrofoam plates.

Observation on / at 1:30 p.m., showed four saucers stored in a kitchen cabinet. An interview was conducted with Staff U on / at 1:30 p.m. She stated there are about four more saucers in the sink being cleaned. She stated they need more saucers for the desserts.

2. A review of the census showed there were 22 residents residing in the facility. On at 2:30 p.m., a review of the emergency water supply showed there were 10 that hold 5 gallons of water for each . These were empty. According to their census the facility needs 66 gallons of water for emergency purposes.

An interview was conducted with the Administrator on at 2:30 p.m. She stated she has the for 55 gallons of water and is not aware of any more containers to hold water.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11911992 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GULF WINDS	2745 VENICE AVENUE EAST VENICE, FL 34292

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 A0077 Reg. # 429.176 FS; 58A-5.019(1) FAC LSC	Correction Completed	ID Prefix A0079 Reg. # 58A-5.019(3) FAC 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)	DATE 8/22/2016	SIGNATURE OF SURVEYOR Paul Asdale, RNS	DATE 8-22-16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/13/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: HB7712

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Gulf Winds
2745 Venice Avenue East
Venice, FL 34292

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016 by representatives of this office. Attached are the provider copies of the State (5000-3547) Form and Revisit Report, which reference the corrected deficiencies and remaining deficiency identified during the revisit. All citations must be corrected by no later than , 2016.

You will not receive a copy of this report in the mail; you will only receive this faxed report.

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 surveyors. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form and Revisit Report

BBT7

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