| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11968344** | **09/16/2016** |
| NAME OF PROVIDER OR SUPPLIER **LIFESTYLE LIVING #1** | STREET ADDRESS, CITY, STATE, ZIP CODE **3513 POLK STREET HOLLYWOOD, FL 33021** | |

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

**0000 Initial Comments**

An unannounced re-licensure survey was conducted on 9/16/2016 at Life Style Living # 1 (license #12254). The facility had a deficiency identified at the time of the visit.

**0052 Medication - Assistance with Self-Admin**

Based on observation and interview, the facility failed to follow the proper procedures for providing assistance with self-administration of medication, for 1 out of 1 resident (Resident #5) observed during medication pass.

The findings include:

Observations on at 12:25 PM found Resident # 5 receiving the following medication: Carb/ Levo / mg.

At 12:25 PM, observations during assistance with self-administration of medication revealed Staff A, (unlicensed staff), assisted Resident # 5 with self-administration of medications. Staff A sanitized her hands, put Resident #5's medication in a cup, gave the medication along with a cup of water to the resident. Staff A did not state the name of the medication to Resident #5 at any time during the medication pass. Staff A observed Resident #5 take her medication and signed his/her Medication Observation Record (MOR).

During an interview on at 1 PM, Staff A and the Administrator acknowledged the error in not informing Resident #5 of the name of the medication given to him/her. The Administrator provided no further information for review.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Lifestyle Living #1
3513 Polk Street
Hollywood, FL 33021

**RE: Relicensure survey**

Dear Administrator:

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

Attached 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

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