

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 11/21/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922348	(X3) DATE SURVEY COMPLETED 11/16/2016
NAME OF PROVIDER OR SUPPLIER HILLSIDE GARDENS II	STREET ADDRESS, CITY, STATE, ZIP CODE 3434 ZARA WAY CLEARWATER, FL 33761	

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

0000 Initial Comments

Assisted Living Facility

On / , a biennial relicensure survey was conducted at Hillside Gardens II (Lic. #8007). Deficient practice was identified during the survey.

0078 Staffing Standards - Staff

Based on record review and interview, one of two staff sampled who had been employed at least 30 days (A) had not had their freedom from () documented on an annual basis.

Findings include:

A personnel file review during the / / survey found that a /X-ray evaluation from for Staff A had been formally signed off by the physician to be valid for five (5) years with respect to this individual's freedom from related signs/symptoms. Thus, it officially expired , and further review of the record revealed no subsequent assessment. Interview with the administrator (Staff A) at 1pm on / / indicated that she had not obtained any new evaluation.

Class III

0085 Training - Nutrition & Food Service

Based on record review and interview, the administrator had not obtained the 2 hour continuing education in nutritional topics pertinent to an ALF on an annual basis.

Findings include:

A personnel record review during the / / survey indicated that the latest 2 hour nutritional seminar attended by the administrator (who stated she was in charge of the facility's food/nutritional service) was from . Interview with the administrator at 1:20pm on / / revealed that "she had taken the updated training, but the certificate was unavailable for inspection."

Class III



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

January 1, 2016

Administrator
Hillside Gardens II
3434 Zara Way
Clearwater, FL 33761

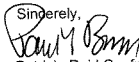
Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on January 1, 2016 by representative(s) 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 January 1, 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 **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

For Patricia Reid Cauffman
Field Office Manager

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

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