STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963784	12/08/2016
NAME OF PROVIDER OR SUPPLIER **WILD FLOWER INN**	STREET ADDRESS, CITY, STATE, ZIP CODE **639 MICHIGAN BLVD. #1500** **DUNEDIN, FL 34698**	

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

0000 - Initial Comments

Assisted Living Facility

On 8, 2016 a change of ownership (CHOW) state licensure survey was conducted at Wild Flower Inn. A deficiency was identified at the time of the visit.

(license # 8223)

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to ensure 4 of 4 employee records reviewed (administrator, A, B and C) have a written statement from a healthcare provider documenting that the individual does not have any signs or symptoms of communicable .
Additionally the facility failed to ensure 1 of 4 employee records reviewed (B) have evidence of a negative examination.

Findings included:

On a record review was conducted for the administrator, with a hire date of . The record did not include a communicable statement from a healthcare provider documenting the individual does not have any signs or symptoms of communicable .

On a record review was conducted for staff A, with a hire date of . The record did not include a communicable statement from a healthcare provider documenting the individual does not have any signs or symptoms of communicable .

On a record review was conducted for staff B, with a hire date of / . The record did not include a communicable statement from a healthcare provider documenting the individual does not have any signs or symptoms of communicable .

On a record review was conducted for staff C, with a hire date of . The record did not include a communicable statement from a healthcare provider documenting the individual does not have any signs or symptoms of communicable .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963784	**12/08/2016**
NAME OF PROVIDER OR SUPPLIER **WILD FLOWER INN**	STREET ADDRESS, CITY, STATE, ZIP CODE **639 MICHIGAN BLVD. #1500** **DUNEDIN, FL 34698**	

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

On 12/8/16 a record review was conducted for staff B, with a hire date of 10/19/16. The record did not include evidence of a negative examination.

On an interview was conducted with the administrator. The administrator stated they were not aware they were required to obtain a communicable statement for the staff. They stated they believed staff B had in fact had a negative examination but did not have the statement in the file.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Wild Flower Inn
639 Michigan Blvd. #1500
Dunedin, FL 34698

Dear Administrator:

This letter reports the findings of a change of ownership (CHOW) state licensure survey that was conducted on , 2016, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 the identified deficiency. 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 deficiency 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.

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

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 Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

XG90