

PRINTED: 12/20/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965317	(X3) DATE SURVEY COMPLETED 12/06/2016
NAME OF PROVIDER OR SUPPLIER BAYOU GARDENS	STREET ADDRESS, CITY, STATE, ZIP CODE 1585 CURLEW RD. DUNEDIN, FL 34698	

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

0000 - Initial Comments

Assisted Living Facility

A change of ownership (CHOW) state licensure survey with limited mental health (LMH) services done in conjunction with a complaint survey, (CCR# 2016012267), was conducted at Bayou Gardens Dunedin, Assisted Living Facility (lic# 9712) on . Bayou Gardens Dunedin, Assisted Living Facility, had one deficiency identified at the time of the survey.

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, interview, and record review, facility failed to maintain an accurate Medication Observation Record (MOR) for 2 out of 4 residents sampled. (#12 and #14).

Findings included:

[illegible]

In interview with Administrator at 1:17pm, she stated " they know better " . Also stated that she would call pharmacy to confirm correct order regarding resident #12. At 1:27pm Administrator confirmed that correct order is PRN. States " I guess they put times on the MOR because that's when we see her. I understand they can't do that."

Class III



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

January 1, 2016

Administrator
Bayou Gardens
1585 Curlew Rd.
Dunedin, FL 34698

RE: CCR# 2016012267 & CHOW

Dear Administrator:

This letter reports the findings of a complaint survey and a change of ownership (CHOW) state licensure survey with limited mental health services (LMH) that were conducted on January 1, 2016, by representative(s) of this office.

Attached are the provider's copies of the State (5000-3547) Forms, which indicate no deficiencies were identified relative to the complaint survey and the deficiency that was identified relative to the CHOW survey. 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 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 deficiency identified on your survey, which may include a desk review or onsite revisit.

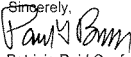
The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. 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
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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/kpr

Enclosures: State Forms 5000-3547

XG90