| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11966841 | 12/28/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**LINET TENDER LOVING CARE ALF INC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**4239 53RD AVE NORTH SAINT PETERSBURG, FL 33714** | |

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

**0000 - Initial Comments**

Assisted Living Facility

An unannounced, abbreviated biennial survey was conducted on at Linet Tender Loving Care. Linet Tender Loving Care had deficient practice identified at the time of visit.

(License # 10978)

**0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC**

Based on observation, interview, and record review, the facility failed to ensure that one of one medication storage cart was securely locked.

Findings included:

During facility tour, conducted on at 09:40 a.m., a medication cart was observed unlocked with the keys left in the lock. Further observation revealed that the medication cart contained medications belonging to the residents at the facility.
When brought to Staff A ' s attention, on at 09:45 a.m., she responded "yes it is open. " Staff was informed that the medication cart should be locked and the key should not be accessible to resident and visitors. Staff locked the medication cart and stated that she knows the cart should be locked, that she was simply nervous.
During interview with the Administrator, on at 01:03 p.m., She stated that the medication cart should not be unlocked.

Class III

**0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC**

Based on record review and interview, that facility did not ensure that meal substitutions were documented and maintained on file.

Findings included:

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11966841 | 12/28/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>LINET TENDER LOVING CARE ALF INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4239 53RD AVE NORTH<br>SAINT PETERSBURG, FL 33714 | |

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

Record review conducted during survey on revealed that there was no documented meal substitution.

During interview with the Administrator, on , at 01:03 p.m., she confirmed that that facility has made meal substitution in the past. She stated that meal substitutions are documented to inform the resident, but did not keep a log of meal substitutions.

Class III

**0181 - Emergency Plan Approval - 58A-5.026(2) FAC**

Based on record review and interview, the facility did not have an approved emergency plan by the local emergency management agency.

Findings included:

Record review revealed that the facility's Certification of Approval for Health Care Facility Plan was expired on , , 2016. Review of the Health Care Facility Receipt of Plan, provided by the Administrator, revealed that the County Emergency Management Planning Criteria was submitted on 11 / ; 53 days after expiration date.

During interview with the Administrator, conducted in , at 10:06 a.m., she confirmed that the emergency plan is currently being reviewed and it is not currently approved.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

Administrator
Linet Tender Loving Care ALF Inc
4239 53rd Ave North
Saint Petersburg, FL 33714

Dear Administrator:

This letter reports the findings of an abbreviated biennial 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 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 , 2017.** 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 Caufman
Field Office Manager

PRC/kpr
Enclosure: State Form 5000-3547

XG90

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