STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966361	01/03/2017
NAME OF PROVIDER OR SUPPLIER CAREGIVERS TOUCH, A.L.F.	STREET ADDRESS, CITY, STATE, ZIP CODE 4536 W IDLEWILD AVE TAMPA, FL 33614	

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

0000 - Initial Comments

Assisted Living Facility

On 3, 2017, an abbreviated biennial re-licensure survey with limited mental health (LMH) was conducted at Caregivers Touch ALF. Deficient practice was identified during the survey.

(License # 10588)

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

Based on interview and record review, the facility failed to ensure that medication observation records (MORs) were immediately updated each time a medication was offered or administered for 2 (Resident #4 and Resident #2) of 3 MORs reviewed.

Findings included:

A review of MORs for Resident #4 conducted at 10:45 AM on / showed the medication 100 MG Tab- take ½ tab by mouth in the morning and ½ tab at lunch. The MORs showed no documented updates for / / or / / for the noon (lunch) dosages.

A review of MORs for Resident #2 conducted on / at 10:50 AM showed the following medications and omissions on the record:
· Nystop 100,000 Units/GM Powd- apply under the twice a day until heals. Applications for 7:00 AM on / and 7:00 PM on / / and / were not documented.
· CRE 1%- apply to the feet twice a day until is cured. MORs lacked documentation for / / at 7:00 PM and / at 7:00 AM.
· - Cream- apply twice a day to the feet until healed. MORs lacked documentation for / / at 8:00 PM and / at 8:00 AM.

An interview was conducted with Administrator at 10:57 AM on / concerning the MORs and missing documentation for Resident #2 and Resident #4. Administrator reviewed the MORs and acknowledged that documentation was missing.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

Administrator
Caregivers Touch, A.L.F.
4536 W Idlewild Ave
Tampa, FL 33614

Dear Administrator:

This letter reports the findings of an abbreviated biennial state licensure survey that was conducted on , 2017, 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 , 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 ufman
Field Office Manager

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

XG90

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