RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Generations On The Beach
427 Oriole Lane
Indialantic, FL 32903

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2017 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2017.**

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. Should you have any questions please call this office at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

TDC:clr
Enclosure

BBT7

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967977	R / /2017
NAME OF PROVIDER OR SUPPLIER: GENERATIONS ON THE BEACH	STREET ADDRESS, CITY, STATE, ZIP CODE: 427 ORIOLE LANE INDIALANTIC, FL 32903	

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

0000 - Initial Comments

A revisit to the biennial re-licensure survey was conducted at Generations on the Beach (license #11930). The facility had deficiencies found at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

REMAINS UNCORRECTED

Based on review of the Health Assessment (1823) and interview, the facility failed to ensure the health assessments were completed and signed by a licensed health care provider for 3 of 5 sampled residents (#2, #5 & #6).

Findings:
1. Review of the 1823 for resident #2 revealed a notation that the resident required assistance with self-administration of medications. The notation was dated and initialed by KBT.
2. Review of the 1823 for resident #5 revealed a notation that the resident required assistance with self-administration of medications. The notation was dated and initialed / by KBT.
3. Review of the 1823 for resident #6 revealed a notation that the resident required assistance with self-administration of medications. The notation was dated and initialed / / by KBT.
In an interview with the facility manager on / / at 10:09 AM, she stated that KBT was the social worker with Vitas. She confirmed that KBT was not a licensed health care provider.
Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

REMAINS UNCORRECTED

Based on personnel record review and interview, the facility failed to maintain certificates for required in-service training that included the number of hours in the training program for Elopement and ( ) for 1 of 3 employees (C).
Findings:
1. Review of the personnel record for Staff C revealed a training certificate dated / / that included several in-service topics. The training session for Elopement did not include the number of hours of the class.
2. Review of the personnel record for Staff C revealed a training certificate dated / that included several in-service topics. The training session for did not include the hours of the class.
In an interview with the facility manager on / at 10:45 AM, she stated she just added the elopement

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967977	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS ON THE BEACH	427 ORIOLE LANE INDIALANTIC, FL 32903

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

and [redacted] to the class. She did not realize that the hours were to be specified on the certificate.
Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11967977 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS ON THE BEACH	427 ORIOLE LANE INDIALANTIC, FL 32903

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0010	Correction	ID Prefix A0078	Correction	ID Prefix A0081	Correction
Reg. # 429.26(1&9) FS; 58A-5.0181(4) FAC	Completed	Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.0191(2) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0082	Correction	ID Prefix A0083	Correction	ID Prefix A0090	Correction
Reg. # 58A-5.0191(3) FAC	Completed	Reg. # 58A-5.0191(4) FAC	Completed	Reg. # 58A-5.0191(11) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0162	Correction	ID Prefix A0167	Correction	ID Prefix	Correction
Reg. # 58A-5.024(3) FAC	Completed	Reg. # 58A-5.025 FAC	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
11/14/2016	