STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964654	10/17/2016
NAME OF PROVIDER OR SUPPLIER ST... PLANTATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2507 OLD ST. ... ROAD TALLAHASSEE, FL 32301	

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

0000 Initial Comments

An unannounced complaint survey (CCR#2016010926) was conducted at St. Plantation Assisted Living Facility (license number 9149) on and completed on . At the time of survey the allegations were not substantiated; however, deficient practice was identified.

0052 Medication - Assistance with Self-Admin

Based on observation, and facility and resident record review, the facility failed to ensure the accuracy of medications for 1 of 9 residents observed during assistance with self administration of medication. (Resident #12).

The findings include:

On beginning at approximately 8:15 am, Staff E was observed during the process of assisting residents with medication self administration. At 08:50 am, Staff Member E carried all of Resident #12's medication cards and bottle medication to him, seated in the side the medication station. Staff E then proceeded to punch medications out of the medication cards into a medicine cup. Resident #12 took the medications and then handed Staff E back the medicine cup, in which Staff E then poured 10 ml (milliliters) of an ordered liquid medication. She stated out how much she had poured - "10 ml", and this was confirmed. The label on the bottle of medication indicated "Give 15ml (10grams) by mouth once daily".

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2016

Administrator
St Plantation
2507 Old St. Road
Tallahassee, FL 32301

RE: CCR #2016010926

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representatives 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 , 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 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 surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,

Kristi Combs RNC

FOR Donah Heiberg, M.S.W.
Field Office Manager

DH/kc
Enclosure

XG90

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