

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

1190

D6TR12

If continuation sheet 1 of 2

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967289	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER AJR LOVING CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5900 DEAN ROAD OVIDO, FL 32765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
{A 164}	Continued From page 1 This Statute or Rule is not met as evidenced by: THE FOLLOWING DEFICIENCY REMAINED UNCORRECTED: Based on interview the facility failed to have 1 of 3 sampled resident (#2) record available for inspection at all times by the agency. Findings: Interview with the manager on _____ at approximately 10:30 AM who stated she was unable to find the resident's chart and the resident was not listed on the admission/discharge log. She stated the chart was not in with the discharged resident charts. There was no documentation provided by the facility to review the resident's record. Class III	{A 164}		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Ajr Loving Care Assisted Living
5900 Dean Road
Oviedo, FL 32765

Dear Administrator:

This letter reports the findings of a revisit survey conducted on _____ 2013, by representative(s) of this office.

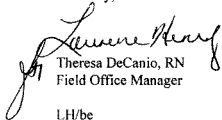
Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references the uncorrected deficiencies and/or new deficiencies, identified during the revisit.

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 _____, 2013.**

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

LH/be
Enclosure

