Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint inspection CCR#2013005267 was conducted on ... . were deficiencies found at the time of the visit.	A 000		
A 008	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or therapy ... required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable disease ..... is likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual ' s needs can be met in an assisted living facility; and 8. The date of the examination, and the name, signature, address, phone number, and license	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 008	Continued From page 1 number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state. (b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, [illegible] 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows: 1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment. a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion. b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider. c. Omitted information received verbally must be documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided. 2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 008	Continued From page 2 elements in Section 3. This requirement does not apply for residents receiving: a. Extended congregate care (ECC) services in facilities holding an ECC license; b. Services under community living support plans in facilities holding limited mental health licenses; c. Medicaid assistive care services; and d. Medicaid waiver services. (c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823. (d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule. (f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a order for residents who do not wish to be administered in the case of or (g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	06/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 008	Continued From page 3 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility ' s admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to obtain a completed medical examination report (1823) for 2 of 5 sampled residents that addressed all criteria necessary to determine admission to the Assisted Living Facility (#2 and #5). Findings: Record review for resident #5 revealed that there were two resident health assessment forms 1823 one was dated . . . and noted she needed assistance with her medications. Further review of the 1823 revealed that the type of assistance was left blank (assistance with self-administration of medication or Administration). An 1823 dated . . . did not note whether or not the resident required assistance with the self-administration of medication. Record review for resident #2 revealed an 1823 that was dated . . . The type of assistance required with his medications was left blank. The administrator confirmed the above findings.	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 008	Continued From page 4 Class . '	A 008		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on resident record review and interview the facility failed to provide care and services to	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 025	Continued From page 5 ensure 3 of 5 sampled residents (#1,#4 & #5) received medications as ordered by the healthcare provider and did not notify the health care provider for 1 of 5 (#2) sampled residents who was in pain and remained in bed all day. Findings: 1. Review of the Medication Observations Record (MOR) for ... for resident #1 revealed that it noted ... 0.125 mg 1 tablet every 2 days at 6 PM. Further review of the MOR revealed on ... the resident received the medication and also the next day ... The resident was not to receive the next dose until ... 2. Record review of resident #5 revealed an health care providers order that was dated ..., revealed it noted that the resident was to received ... 40 mg one daily. The MOR for ... noted ... 40 mg twice daily the medication was given 6/1-6/4 in the morning; at bedtime the resident refused on 6/1 and 6/2 and it was marked as given on 6/3. 3. Staff A (resident assistant) stated on ... at approximately 12:45 PM that she worked with resident #2 and he was in a lot of pain on ... She further stated that he had not gotten out bed all day. She told the Wellness Director the resident was in pain sometime that morning before lunch time and that he was not getting out of bed. That was not normal for him. She explained that she and Staff B were going to help him get out of bed together and he did not want to get out of bed. He could not stand for you to touch him. She stated because he could not get	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 025	Continued From page 6 out of bed to use the [redacted] would urinate on himself. After he [redacted] she would just change the Chux (incontinence [redacted] that was under him. She stated she did not think about getting a urinal. She stated that around 2-2:30 PM, the Wellness Director told her to call the resident's family member. She talked to the family member and told him that resident #2 was in a lot of pain and would not get out of bed. The family member spoke with him and told him he needed to go to the hospital. The paramedics arrived and took him to the hospital. She stated that she stayed after her shift was over because of this. Staff B (Med Tech/Resident Assistant) stated on [redacted] at approximately 1:10 PM that on [redacted] she went in resident #2's [redacted] check on him, because he did not come to the second floor loft to get his medications and he did not come to breakfast. The resident said he was in pain and wanted a pain pill and he needed to go to the [redacted] He further stated that he did not want her to help him because she was too small. Staff B called a male staff to assist her. When the male staff came to the [redacted], they tried to lift him and the resident stated he did not want him to help either because it hurt too much. According to staff B she told the Wellness Director after breakfast at around 9 AM. The wellness director told her to give the resident a pain pill to see if that would help. She was going back and forth to check on him. He refused all of his medications except his pain medication. The resident was spoon fed soup for lunch. He could not sit up to be fed, because he was in too much pain, he continued to urinate on himself. Staff B stated she continued to change his Chux, he was soaked and he continued to urinate on himself.	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 025	Continued From page 7 She stated she tried to get him to use the urinal and he could not use the urinal. She changed about 4 Chux during the day . She changed the Chux in between his med pass. The resident did not want to go to the hospital. She did not tell the Wellness Director again that the resident was not getting better. A facility note on PM- noted "resident complained of pain in lower back. was called and family called to be (hospital Name noted)". There was no documentation that the resident was in pain all day and was declining. Further record review revealed there was no documentation to confirm that the health care provider was contacted to inform him/her that the resident could not get out of bed due to his severe pain in order to obtain direction. The staff interviewed stated that they did not call the health care provider to notify him/her of the change in the resident's condition. Interview with staff E the Wellness Director on at approximately 5:30 PM who stated that no one reported to her the resident remained in pain all day. She stated that a staff told her that he was in pain and she told them to give him a pain pill; however they did not tell her that he remained in bed all day. 4. record for resident #4, review revealed and ALF Health Assessment (1823) dated that stated diagnoses of pain, with possible to spine, and The resident needed assistance with medications. Review of the 2013 Medication Observation Record (MOR) revealed:	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 025	Continued From page 8 (for : 0.4 milligrams (mg) at bedtime. The medication was not charted as given on 2/3, 2/4 and , the initials were circled on the MOR and there was no documentation to indicate, on the back of the MOR, the reason the medication was not given. The Wellness Director on : at approximately 5:45 PM stated she thought the medication was given and she was not aware of the circles that were on the MOR. Class II	A 025		
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	06/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 030	Continued From page 9 Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida Hotline " 1(800)9€ or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents. (e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements. (f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law. (g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 030	Continued From page 10 (h) Pursuant to Section 429.41, F.S., the use of physical ..... shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical ..... 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from ..... and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to achieve	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 030	Continued From page 11 the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room . or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Access to adequate and appropriate health care consistent with established and recognized standards within the community. (k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, ... guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 030	Continued From page 12 of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. This Statute or Rule is not met as evidenced by: Based on Record review and interviews the facility failed to ensure that 1 of 5 sampled residents (#2) lived in a safe and decent living environment, free from neglect and did not ensure he was treated with personal dignity and allowed the resident to lay in his soaked from morning to the afternoon and did not seek medical attention when the resident informed the staff that he was in so much pain that he could not move. Findings: Through a confidential interview, it was revealed that resident #2 was allowed to remain in his bed all day and urinate on himself. The interviewee stated that the staff would only change the Chux (incontinence in the bed when the resident would urinate. The interviewee further stated that the resident had his clothes on and all of the contents in his wallet were soaked with and the resident was embarrassed. The resident was in so much pain that he could not get out of bed and no medical attention was obtained until around 3:30 PM.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 030	Continued From page 13 Record review for resident #2 revealed a Resident Health Assessment form 1823 that was dated . . . . . The resident was independent with all of his Activities of Daily Living (ADL's). He had diagnosis of , , essential , and Nurses note dated no time) Resident . . in apartment about 2 PM, assisted resident ambulating to bed, says he had some pain in tail bone but not wanting to go to hospital. . . . . 4 PM, resident was complaining of pain and asked to be transport to hospital 911 was called and resident was transported to CFR Dr. and family. . . . . . 1 every 6 hours s needed for pain. . . . . No time. Resident spent day in his . . . . . Ambulating around of pain in lower back pain meds were given resident refused meals from dining . . . . . he had food in his he wanted to eat instead. . . . . . PM- "resident complained of pain in lower back. . . . was called and family called to be transported to Hospital (name noted) ". A level of care evaluation form that was dated . . . . noted that the resident was independent with all of his ADLS, needed supervision with self-administration of medication, the form noted that he was continent A review of the staff schedule for . . . . revealed that staff A and Staff B worked the 7 AM- 3 PM shift. Staff A (Resident Assistant) stated on . . . . at approximately 12:45 PM she was assigned to work the floor that resident #2 resided on and she would take care of his needs when assigned to	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 030	Continued From page 14 the floor. She stated that resident #2 was in a lot of pain on [redacted]. He had not gotten out of bed all day. She told the Wellness Director that morning that he was in pain sometime before lunch time and that he was not getting out of bed. That was not normal for him. She explained that she and Staff B were going to help him get out of bed together and he did not want to get out of bed. He could not stand for you to touch him. She stated because he could not get out of bed to use the [redacted] would urinate on himself, after he [redacted] she would just change the Chux (incontinence [redacted] that was under him. She stated did not think about getting a urinal. She stated that around 2-2:30 PM, the Wellness Director told her to call the resident's family member. Staff A talked to the family and told him that resident #2 was in a lot of pain and would not get out of bed. The family member spoke with him and told him he needed to go to the hospital. The paramedics arrived and took him to the hospital. She stated that she stayed after her shift was over because of this. Staff B (Med Tech/Resident Assistant) stated on [redacted] at approximately 1:10 PM on [redacted] when she went in the [redacted] check on the resident, because he did not come to the second floor loft to get his medications and he did not come to breakfast. She went to his [redacted] the resident said he was in pain and wanted a pain pill. He needed to go to the [redacted] but he did not want her to help him because she was too small. Staff B called a male staff to assist her and when the male staff came to the [redacted], they tried to lift him. The resident stated he did not want him to help either, because it hurt too much. She told the Wellness Director after breakfast at around 9 AM. She was told to give the resident a pain pill to see	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 030	Continued From page 15	A 030		

if that would help. She was going back and forth to check on him. He refused all of his medications except his pain medication. The resident was spoon fed him soup for lunch; he could not sit up to be fed, because he was in too much pain. The resident continued to urinate on himself; she stated she continued to change his Chux. The resident was soaked he continued to urinate on himself. She stated she tried to get him to use the urinal and he could not use the urinal. She changed about 4 Chuxs during the day. She changed the Chux in between his med pass. The resident did not want to go to the hospital. She did not tell the Wellness Director again that the resident was not getting better.

There was no documentation found in the resident's chart that noted that the resident was in pain all day and was declining.

Interview with Staff E the Wellness Director on [redacted] at approximately 5:30 PM who stated that no one reported to her that the resident remained in pain all day. She stated that a staff told her that he was in pain and she told them to give him a pain pill; however they did not tell her that he remained in bed all day.

The facility staff allowed resident #2 to remain in bed all day, He was in so much pain that he could not tolerate the staff moving him. The facility staff allowed resident #2 to remain in bed in his [redacted] and would only change the Chux from underneath him. The facility staff did not contact the family until the afternoon; no one from the facility contacted the health care provider to inform him/her of the resident's condition. Allowing the Resident to remain in bed all day in pain and in [redacted] directly threatened the health safety and well-being of the resident.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	ST	ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC		300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 030	Continued From page 16 Class II	A 030		
A 054	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider ' s name, the resident ' s name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known the resident may have; the name of the resident ' s health care provider; the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility did not maintain an accurate and up-to-date daily medication observation records (MORs) for 5 of 5	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 054	Continued From page 17 sampled residents (#1,#2,#3,#4,#5) who received assistance with self-administration of medications. Findings: Review of the Medication Observations Records (MORs) for Residents #1, #2, #3, #4 and #5 revealed that they received assistance with the self-administration of their Medications: Review of their MORs revealed there were spaces on that were left blank, there was no explanation on the back as to why the spaces were left blank. There was no way to determine whether the residents received their medications as ordered: Resident #1 The MOR for ... noted that Certa-Vite one daily was left blank on . Bocustate SOD Cap 100 mg one daily was left blank on , and 1/20; Ferrex 150 cap one daily was left blank on and . Furosemdie 40 mg 1 daily was left blank on .... The MOR for noted on ... the AM medications were left blank as follows: Lantus 100 U/ inject 6 units once daily in the morning, ... 25 mg one twice daily, Fish Oil, Omega 3; 0.005% solution instill 1 drop into each eye once daily at bed time was left blank on DR 20 mg one twice daily was left blank on ... and ..... 40 mg one tablet at bed time was left blank on ... and 3/3; Beano tablets one in the morning and noon was left blank at noon on ..... through .... Resident #2 The MOR for . Noted the resident was to	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 054	Continued From page 18	A 054		

have 125 mcg 1 tablet at 6 AM the MOR was left blank on .

Resident #5
The MOR for noted the resident was to have 600 mg 1 twice daily was left blank at 8 AM on .
Review of the health care providers order that was dated revealed it noted that the resident was to received
40 mg one daily. The MOR from through noted 40 mg twice daily. The MOR for also noted that there was an order change on to take one tablet daily.
Review of the MOR revealed that the MOR noted 40 mg twice a day in the morning and bedtime. The staff wrote resident refused for the entire month of for the Bedtime dosage. The MOR for noted 40 mg twice daily the medication was given 6/1-6/4 in the morning, at bedtime the resident refused on 6/1 and 6/2 and it was marked as given on 6/3.
There was an order change on and The and MOR was not updated to reflect the order change.

Interview with the Wellness Director on at approximately 6 PM that the residents received their medications and the staff did not mark the MOR as require

Resident #3

Review of 2013 Medication Observation Record revealed:
250 milligrams (mg) twice a day for 10 days was not charted as given

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 054	Continued From page 19 on [redacted] and [redacted] in the PM, there were no initials in the box [redacted] 0.5 mg twice daily in AM and PM was not charted as given on the MOR, the month was not written on the MOR, on the 16th in the AM and on the 29th, 30th and 31st in the PM. Resident #4 [redacted] 250 mg 5 milliliters once every other day. The medication was not charted on [redacted] and [redacted] in the AM, there were no initials in the boxes. There was no documentation on the back of the MOR to indicate the reason the medication was not given. Interview with the Wellness Director and administrator on [redacted] at approximately 5:45 PM who stated the medications for #1, #2, #3, #4 and #5 were given and were not charted. Class III	A 054		
A 077	58A-5.019(1) FAC Staffing Standards - Administrators Staffing Standards. (1) ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429, F.S., and this rule chapter. (a) The administrators shall: 1. Be at least [redacted]; 2. If employed on or after [redacted], 1990, have a high school diploma or general equivalency diploma (G.E.D.), or have been an operator or administrator of a licensed assisted living facility in the State of Florida for at least one of the past	A 077		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 077	Continued From page 20 3 years in which the facility has met minimum standards. Administrators employed on or after 1995, must have a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening standards pursuant to Section 429.174, F.S.; and 4. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C. (b) Administrators may supervise a maximum of either three assisted living facilities or a combination of housing and health care facilities or agencies on a single campus. However, administrators who supervise more than one facility shall appoint in writing a separate " manager " for each facility who must: 1. Be at least and 2. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C. (c) Pursuant to Section 429.176, F.S., facility owners shall notify both the Agency Field Office and Agency Central Office within ten (10) days of a change in a facility administrator on the Notification of Change of Administrator, AHCA Form 3180-1006, 2006, which is incorporated by reference and may be obtained from the Agency Central Office. The Agency Central Office shall conduct a background screening on the new administrator in accordance with Section 429.174, F.S., and Rule 58A-5.014, F.A.C. This Statute or Rule is not met as evidenced by: Based on facility record review and interview, the administrator who was responsible for the operation and maintenance of the facility	A 077		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 077	Continued From page 21	A 077		

including the management of all staff and the provision of adequate care to all residents, did not thoroughly conduct an investigation regarding medical neglect for 1 of 5 sampled resident (#2)

Findings:

Through a confidential interview, it was revealed that on resident #2 was allowed to remain in his bed all day and urinate on himself. The interviewee stated that the staff would only change the Chux (incontinence bed in the bed when the resident would urinate. The interviewee further stated that the resident had his clothes on and all of the contents in his wallet were soaked with , the resident was embarrassed. The resident was in so much pain that he could not get out of bed and no medical attention was obtained until around 3:30 PM.

Through interviews with staff on who worked the 7 AM- 3 PM shift, it was revealed that resident #2 complained of pain, could not get out of bed to use the could feed himself. The staff allowed the resident to lie in bed and urinate and would change the Chux (incontinence bed that was underneath him. The facility staff did not contact the health care provider to notify him of the resident's pain and change in condition. The facility staff did not contact the family member to inform him until around 2-2:30 PM, and he persuaded the resident to go to the hospital. The resident left the facility at around 3:30 PM for the hospital.

The only note that was in the file regarding the incident was on PM- "resident complained of pain in lower back. was called and family called to be transported to Hospital (name noted) ".

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 077	Continued From page 22 The administrator was asked on [redacted] at approximately 2:30 PM what type of investigation had she conducted regarding the alleged medical neglect. The administrator stated she was not aware of the allegations until the family member informed her on [redacted] The administrator stated that she had spoken with the Staff E, the Wellness director who conducted the investigation and the Wellness Director informed her that staff did not admit to leaving the resident in bed in Pain. She did no further investigation. Interview with the Staff E on [redacted] at approximately 6 PM who stated that she interviewed the 2nd Shift staff (3 PM-11 PM) regarding the allegations and they all denied placing Chux under the resident to allow him to urinate on them. She stated she questioned the 3 PM-11 PM staff because the resident went to the hospital. She stated she did not question any other staff that worked on [redacted] from the other shifts regarding the allegation. A telephone interview was conducted with the administrator on [redacted] at approximately 12 PM who stated she had conducted an investigation on [redacted], spoke with all of the staff involved and obtained written statements. She stated after her investigation she notified Adult Protective Services and was going to provide staff training. Class III	A 077		
A 162	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records shall be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name;	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 162	Continued From page 23	A 162		

2.
3. Race;
4. Date of birth;
5. Place of birth, if known;
6. Social security number;
7. Medicaid and/or Medicare number, or name of other health insurance
8. Name, address, and telephone number of next of kin, responsible party, or other person the resident would like to have notified in case of an emergency, and relationship to resident; and
9. Name, address, and phone number of health care provider, and case manager if applicable.

(b) A copy of the medical examination described in Rule 58A-5.0181, F.A.C.

(c) Any health care provider ' s orders for medications, nursing services, therapeutic diets, , or other services to be provided. supervised, or implemented by the facility that require a health care provider ' s order.

(d) A signed statement from a resident refusing a therapeutic diet pursuant to Rule 58A-5.020, F.A.C.

(e) The resident record described in paragraph 58A-5.0182(1)(e), F.A.C.

(f) A weight record which is initiated on admission. Information may be taken from the resident ' s health assessment. Residents receiving assistance with the activities of daily living shall have their weight recorded semi-annually.

(g) For facilities which will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident ' s contract.

(h) For facilities which manage a pill organizer, assist with self-administration of medications or

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 162	Continued From page 24 administer medications for a resident, the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident ' s contract with the facility, including any addendums to the contract, as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, or staff, or representative thereof serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required under Section 429.27, F.S. (k) For any facility which maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required under Section 429.27, F.S. (l) A copy of Alternate Care Certification for [illegible] Form, CF-ES 1006, [illegible] 1998, if the resident is an [illegible] recipient. The absence of this form shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Family Services. (m) Documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required under Rule 58A-5.0181, F.A.C. (o) For apartments, duplexes, quadruplexes, or single family homes that are designated for independent living but which are licensed as assisted living facilities solely for the purpose of delivering personal services to residents in their homes, when and if such services are needed, record keeping on residents who may receive	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 162	Continued From page 25 meals but who do not receive any personal, limited nursing, or extended congregate care service shall be limited to the following: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required under this subsection; 3. The medical examination described in Rule 58A-5.0181, F.A.C.; 4. The resident ' s contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider ' s order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (p) Except for resident contracts which must be retained for 5 years, all resident records shall be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents shall be provided a copy of their resident records upon departure from the facility. (q) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to have evidence that a Medication Observation Record (MOR) was maintained for 2 Of 5 sampled residents (#1 and #2) of received assistance with the self-administration of medications. Findings:	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922141	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE RETIREMENT CENTER, LLC	300 WEST AIRPORT BLVD. SANFORD, FL 32771

(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)	(X5) COMPLETE DATE
A 162	Continued From page 26 1. Record review for Resident #1 revealed that there was no MOR available for review for 2. Record review for Resident #2 revealed that there was no MOR available for review for The administrator stated on . . . at approximately 5 PM that she had search for both of the above MORs and could not locate them. Class III	A 162		

AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Renaissance Retirement Center, LLC
300 West Airport Blvd.
Sanford, FL 32771

Dear Administrator:

Re: CCR #2013005267

This letter reports the findings of a state licensure survey that was conducted on , 2013 by representative(s) of this office.

Attached is the provider's copy of the State (3020) 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. Staff from this office will conduct a review after **, 2013,** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 Lorraine Henry at

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

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