State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11968108	A. Building B. Wing	

Name of Facility	Street Address, City, State, Zip Code
L & L ASSISTED LIVING COMMUNITY INC	4211 CHAIRES CROSS RD TALLAHASSEE, FL 32317

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0008 Reg. # 58A-5.0181(2) FAC LSC	Correction Completed	ID Prefix A0053 Reg. # 58A-5.0185(4) FAC LSC	Correction Completed	ID Prefix A0054 Reg. # 58A-5.0185(5) FAC LSC	Correction Completed
ID Prefix A0074 Reg. # 58A-5.019(3)(b) LSC	Correction Completed	ID Prefix A0079 Reg. # 58A-5.019(4) FAC LSC	Correction Completed	ID Prefix A0083 Reg. # 58A-5.0191(4) FAC LSC	Correction Completed
ID Prefix A0085 Reg. # 58A-5.0191(6) FAC LSC	Correction Completed	ID Prefix A0092 Reg. # 58A-5.020(1) FAC LSC	Correction Completed	ID Prefix A0093 Reg. # 58A-5.020(2) FAC LSC	Correction Completed
ID Prefix A0160 Reg. # 58A-5.024(1) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By **State Agency**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**	7/5/13
Reviewed By **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**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**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968108	07/03/2013
NAME OF PROVIDER OR SUPPLIER L & L Assisted Living Community Inc	STREET ADDRESS, CITY, STATE, ZIP CODE 4211 Chaires Cross Rd Tallahassee, FL 32317	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:
0008-Admissions - Health Assessment-07/03/2013
0053-Medication - Administration-07/03/2013
0054-Medication - Records-07/03/2013
0074-Staffing Standards - Personnel File (bgs)-07/03/2013
0079-Staffing Standards - Levels-
0083-Training - First Aid And
0085-Training - Nutrition & Food Service-
0092-Food Service - General Responsibilities-
0093-Food Service - Dietary Standards-
0160-Records - Facility-

Revisit Repeat Tags:
0161-Records - Staff-58a-5.024(2) Fac

Revisit New Tags:
0030-Resident Care - Rights & Facility Procedures-58a-5.0182(6) Fac; 429.28 Fs

Specific Tag Findings:

0000-Initial Comments

An unannounced follow up survey was conducted on 7/3/13 in conjunction with an ECC monitoring visit at Land L Assisted Living Facility. Deficiencies were cited.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observation and staff interview the facility failed to honor resident rights to be free of for 2 of 3 (#2,3) residents observed during the survey. The residents had beds with full side rails.

The findings are:

On at approximately 8:30 AM during the initial tour of the facility, residents #2 and #3 were observed resting in their beds. It was observed that full side rails were in the up position on both residents bed.

On at approximately 9:00 AM the administrator was observed letting the left side rail of resident #3 down and assisting her to sit on the side of the bed.

On an interview was conducted with the caregiver A. She stated resident #3 was able to ambulate with a walker. Resident #2 was not able to ambulate.

On at approximately 9:30 AM resident #3 was observed ambulating to the her walker with supervision from caregiver A.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968108	07/03/2013
NAME OF PROVIDER OR SUPPLIER **L & L Assisted Living Community Inc**	STREET ADDRESS, CITY, STATE, ZIP CODE **4211 Chaires Cross Rd Tallahassee, FL 32317**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

With the siderails in the up position the resident #3 is unable to get out of bed to be able to ambulate.

An interview was conducted with the administrator on at approximately 9:30 AM. She stated that she thought if the residents were Extended Congregate Care (ECC) or hospice they could have full side rails. Resident #3 is currently ECC receiving hospice and resident #2 was on hospice until a month ago. She stated she had physicians orders for the full side rails.

Class III

0161-Records - Staff 58A-5.024(2) FAC

Based on employee record review and staff interview the facility failed to provide documentation to verify freedom from communicable in 4 of 5 employee files (B,C, D, E).

The findings are:

On the facility received a citation for 2 of 2 employees with no documentation to verify freedom from communicable

On the employee B date of hire file was reviewed. There is no documentation that the employee is free of communicable

On the employee C date of hire file was reviewed. There is no documentation that the employee is free of communicable

On the employee D date of hire file was reviewed. There is no documentation that the employee is free of communicable

On the employee E date of hire file was reviewed. There is no documentation that the employee is free of communicable

An interview was conducted with the administrator at approximately 9:30 AM on She stated that all her staff had received the tests or had a chest x-ray but none of her employees and the documentation from their doctor that they were free of communicable

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
L & L Assisted Living Community Inc
4211 Chaires Cross Rd
Tallahassee, FL 32317

Dear Administrator:

Re: Revisit PLUS ECC Monitoring

This letter reports the findings of a state licensure survey that was conducted on 3, 2013 by representative(s) 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. Staff from this office will conduct a review after , 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 me at 850-412-4540.

Sincerely,

Donah Heiberg
Field Office Manager

DH/dh
Enclosure
XG90

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

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone 850-412-4540; Fax (850) 922-9162