STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965218	09/23/2013
NAME OF PROVIDER OR SUPPLIER **Lakeview Retirement Residence, Inc**	STREET ADDRESS, CITY, STATE, ZIP CODE **2304 Nw 52nd Court Fort Lauderdale, FL 33309**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced Assisted Living Facility relicensure and Limited Nursing Services (LNS) survey was conducted on . . . . . Lakeview Retirement Residence, had deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on observation, interview and record review, the facility failed to properly complete the Resident Health Assessment Form (AHCA Form 1823), for 1 out of 3 sampled residents (Resident #1).

The findings include:

Resident #1 was admitted to the facility with medical conditions including . . . . . Multiple . . . . . Accident . . . with resulting speech aphasia and was placed on hospice services with a decline of function, as documented on the resident ' s health assessment dated . . . . . .

On . . . . at approximately 12:00 PM in the main dining . . . . . #1 was observed being fed cream of . . . . and juice by a family member. The resident consumed 75% of these items and then was taken to her . . . . her family. The posted menu items for the lunch meal included . . . . egg salad sandwich, tomato/lettuce salad and ice cream.

On . . . . . at approximately 12:20 PM, during an interview with the Licensed Practical Nurse (LPN), she stated that the resident is served soft foods at the request of the family for fear of . . . . . She stated that the resident had no documented swallowing difficulties. The LPN stated that the resident had consumed 2 portions of soup for lunch.

Review of the 1823 Resident Health Assessment form dated . . . . . revealed in the "Special Dietary Instructions" section a diet of "no salt added". The form did not reflect the current diet of soft foods being served to the resident by the facility staff. Review of the Facility Diet Roster revealed the resident was ordered a" no salt added" diet only. There was no documentation of a mechanical soft diet for the resident. Review of the Hospice Nurses Progress note dated . . . . . revealed the resident was nonverbal, unable to make her needs known. The note documents the resident requires a pureed diet and staff must feed the resident. The resident's meal intake is 75-100% over 25-30 minute timeframe.

On . . . . . at approximately 2:00 PM during an interview with the Administrator and LPN, they reviewed the record and confirmed that the resident ' s family had requested a soft diet but were unable to provide a written

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965218	**09/23/2013**
NAME OF PROVIDER OR SUPPLIER **Lakeview Retirement Residence, Inc**	STREET ADDRESS, CITY, STATE, ZIP CODE **2304 Nw 52nd Court** **Fort Lauderdale, FL 33309**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

order from the physician. The Administrator stated that the facility has been following the approved menu by cutting the food into very small pieces. She stated that she would immediately inform the physician about the family dietary requests for the resident and have the physician update the health assessment form to reflect current dietary practices for the resident.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Lakeview Retirement Residence, Inc
2304 NW 52nd Court
Fort Lauderdale, FL 33309

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2013 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. 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924