STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943069	**08/12/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Atlantic Shore Retirement Residence	**1500 North Riverside Drive Pompano Beach, FL 33062**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

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

Specific Tag Findings:

0000-Initial Comments
An unannounced Relicensure survey was conducted on [redacted] at Atlantic Shore Retirement Residence. The facility had a deficiency found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on record review and interview, the facility failed to ensure as part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a health care provider within 30 days of admission or 60 days prior to admission and documented on a Resident Health Assessment form (AHCA 1823), for 1 out of 2 sampled residents' records reviewed (Resident #6).

The findings include:

Resident #6 was admitted to the facility on [redacted]. A review of Resident#6's AHCA form 1823 dated [redacted] revealed it was for the admission to another facility 5 months prior to the admission to the current facility. Further review of the AHCA form revealed it did not accurately reflect the residents current conditions.

During an interview with the Assistant Administrator on [redacted] at 11:30 AM, she acknowledged the findings.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Atlantic Shore Retirement Residence
1500 North Riverside Drive
Pompano Beach, FL 33062

RE: Relicensure survey

Dear Administrator:

This letter reports the findings of a state relicensure survey that was conducted on 2014 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 ***09/26/2014*** to verify that the necessary corrections are in place to correct the deficiency 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/dso
Enclosure: State form 5000-3547

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