State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number
AL11967289

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit

Name of Facility
AJR LOVING CARE ASSISTED LIVING

Street Address, City, State, Zip Code
5900 DEAN ROAD
OVIEDO, FL 32765

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 **A0081** Reg. # **58A-5.0191(2) FAC** LSC	Correction Completed	ID Prefix **A0084** Reg. # **58A-5.0191(5) FAC** LSC	Correction Completed	ID Prefix **A0090** Reg. # **58A-5.0191(11) 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	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** [signature]	**Date:** 8/15/13	**Signature of Surveyor:**	**Date:**
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
	AL11967289	R
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
AJR LOVING CARE ASSISTED LIVING	**5900 DEAN ROAD OVIEDO, FL 32765**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

The revisit survey to the Limited Nursing Services Monitoring was conducted on AJR Loving Care Assisted Living Facility had deficiencies found at the time of the visit.

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Deficiency remains uncorrected....

Based on record review and interview the facility failed to ensure 1 of 5 sampled staff (B) had documentation from a health care provider that they were free from communicable including , and failed to ensure 2 of 5 sampled staff (B and C) had a freedom from communicable statement in their file from a health care provider on an annual basis.

Findings:

Review of personnel files for Staff B, reveals date of hire on There was no statement in the file saying she was free from communicable including There is no statement in her file to say she is free from communicable on an annual basis (needed

Review of personnel file for Staff C, reveals date of hire on The Freedom from Communicable statement in her file was dated (needed again on

In an interview with the administrator on at approximately 9:45 am she requested an opportunity to provide the statements. An opportunity was provided to the administrator. At approximately 11:15 am the administrato stated she did not have the information.

Class III

Z815 - Background Screening; Prohibited Offenses - 408.809, 435.02(2), 435.06

Deficiency remains uncorrected....

Based on record review and interview the facility failed to ensure 1 of 5 sampled staff (E) received a Level II Background rescreening when there was more than a 90 lapse in service prior to scheduling the staff to provide care for the residents in the facility.
Findings:
Personnel record review for staff E revealed she was hired on Further review revealed the level II background screening eligibility date was (9 months prior to being hired). Further review revealed she quit an Agency for Health Care Administration (AHCA) approved facility on (5 months prior to being hired). Continued review reveals no employment in the file from through date of hire at facility on

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967289	R
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
AJR LOVING CARE ASSISTED LIVING	**5900 DEAN ROAD OVIEDO, FL 32765**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Z815 Continued From page 1

On [redacted] at approximately 9:00 am in an interview with Staff E, she stated she worked at a church driving the bus from [redacted] until she was hired at the facility on [redacted]. She stated she did not get rescreened.
On [redacted] at approximately 9:10 am a phone call was placed to the AHCA background screening unit and spoke to a representative who stated that staff E level II background screening shows an eligibility date of [redacted].
Review of the staffing schedule reveals that staff B worked alone with residents from 7:30am to 7:30 pm on: 10, 11, 14, 15, 16, 17, 21, 22, 23, and 24; and [redacted]5, 6, 7, 8, and 12. Additionally during the entrance conference at the facility on [redacted] at approximately 8:30am Staff B was working alone with the residents.
On [redacted] at approximately 9:30 am in an interview with the administrator. She stated she did not know Staff E needed to be rescreened. She stated she will send staff E home and not let her work until she is rescreened.
Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

RE: 2nd revisit to LNS monitoring

Dear Administrator:

This letter reports the findings of a **second** State Licensure Revisit Survey conducted on May 14, 2015 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

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 , 2015.**

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 (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
YOSF

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