

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 07/29/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965218	(X3) DATE SURVEY COMPLETED 07/20/2015
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

A relicensure standard survey was conducted on . 2015. Lakeview Retirement Residence, INC had a licensure deficiency found at the time of the visit.

0167 Resident Contracts

Based on record review and interview, the provider failed to ensure that 1 out of 2 (#3) sampled resident (SR) contract was executed by the resident or the resident's legal representative.

Findings include:

A review of the SR#3's contract revealed the contract date as and it was signed and dated on On at 1:01 PM, the administrator reviewed SR#3's contract and stated that it was signed by SR#3's son on Further record review revealed no documentation showing SR#3's son is SR#3's legal representative.

On at 3:55 PM, the Administrator acknowledged not having documentation showing that SR#3's contract was executed by SR#3's legal representative.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

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

RE: Relicensure Survey

Dear Administrator:

This letter reports the findings of a state Relicensure survey that was conducted on 2015 by a representative 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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

XG90

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