State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11966454	A. Building B. Wing	9/15/2015

Name of Facility

WILLIAMS LOVING CARE

Street Address, City, State, Zip Code

4213 CHANTELLE ROAD
ORLANDO, FL 32808

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 **A0010** Reg. # **429.26(1&9) FS; 58A-5.018** LSC	Correction Completed	ID Prefix **A0078** Reg. # **58A-5.019(2) FAC** LSC	Correction Completed	ID Prefix **A0083** Reg. # **58A-5.0191(4) FAC** LSC	Correction Completed
ID Prefix **A0084** Reg. # **58A-5.0191(5) FAC** LSC	Correction Completed	ID Prefix **A0093** Reg. # **58A-5.020(2) FAC** LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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:** 9/30/15 — **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/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966454	R
NAME OF PROVIDER OR SUPPLIER **WILLIAMS LOVING CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **4213 CHANTELLE ROAD** **ORLANDO, FL 32808**	

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

0000 Initial Comments

The revisit for the re-licensure survey was conducted on / . Williams Loving Care Assisted Living Facility had deficiencies that remained uncorrected.

0008 Admissions - Health Assessment

A 008 Remained Uncorrected
Based on record review and interview the facility did not obtain a complete and accurate medical examination after a significant change for 1 of 2 sampled residents (#2).

Findings:

Record review for Resident #2 revealed that she was admitted to hospice on / / . The Resident Health Assessment 1823 form used by the facility after the significant change was the 2013 form, not the required AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010. The , 2013 health assessment form did not have the date that the examination was completed, the printed name of the health care provider, address and telephone number.

During an interview with the Administrator on / / at approximately 12:15 PM, she stated she was not aware that information was left off the form and that is was not the correct form.

Class III

0162 Records - Resident

A162 remained uncorrected
Based on record review and interview, the facility failed to obtains weighs semi-annually for 1 of 2 sampled residents (#2) who required assistance with Activities of Daily Living.

Findings:

Record review for Resident #2 revealed a health assessment form that was completed after the hospice admission, by the hospice health care provider that was not dated revealed she required total assistance with all of her Activities of Daily Livings.
The last weight recorded was in / .
Review of a Hospice Interdisciplinary Plan of Care Revision/Physician Order dated that noted "Unable to be weighed due to poor Trunk Control."

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966454	R
NAME OF PROVIDER OR SUPPLIER **WILLIAMS LOVING CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **4213 CHANTELLE ROAD** **ORLANDO, FL 32808**	

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

During an interview with the Administrator on at approximately 12:15 PM, she stated the resident was not weighed, she was told by hospice that the resident did not have to be weighed if she was on hospice and had a health care providers order that she could not be weighed.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Williams Loving Care
4213 Chantelle Road
Orlando, FL 32808

RE: Revisit to Relicensure w/LNS

Dear Administrator:

This letter reports the findings of a revisit survey conducted on 15, 2015, by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

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. Should you have any questions please call this office at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

BBT7

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