State Form: Revisit Report

(Y1) **Provider / Supplier / CLIA / Identification Number**
AL11966840

(Y2) **Multiple Construction**
A. Building
B. Wing

(Y3) **Date of Revisit**

Name of Facility
ENGLISH ESTATES ALF

Street Address, City, State, Zip Code
1340 OXFORD RD
MAITLAND, FL 32751

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **A0079** Reg. # **58A-5.019(3) FAC** LSC	0079	ID Prefix **A0160** Reg. # **58A-5.024(1) FAC** LSC	0160	ID Prefix Reg. # LSC	ZZZZ
ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ
ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ
ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ
ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ

Reviewed By State Agency	**Reviewed By** [signature]	**Date:** 10/13/15	**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/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966840	R
NAME OF PROVIDER OR SUPPLIER **ENGLISH ESTATES ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1340 OXFORD RD** **MAITLAND, FL 32751**	

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

0000 Initial Comments

A follow up visit to complaint inspection (CCR 2015003749) was conducted at English Estates Assisted Living Facility on . English Estates had a deficiency at the time of the visit.

0025 Resident Care - Supervision

DEFICIENCY REMAINED UNCORRECTED.

Based on record review and interview the facility failed to ensure they documented significant changes and the healthcare provider and the responsible party were notified of a significant change for 1 for 3 sampled residents (#3).

Findings:

In an interview with Staff A on at approximately 9:15 AM who stated resident #3 was in the hospital. Prior to her sending the resident out to the hospital, another staff sent the resident to the hospital and the hospital did not keep her.
Review of facility note dated at 3:16 AM that revealed resident #3 was taken to the hospital with complaints of , body aches, and dry heaves. She said she felt very hot. Will call administrator and family. There was no documentation to review that indicated the healthcare provider and family member was notified.
Staff A further stated on at approximately 9:15 AM that she sent the resident out on at 9:30 PM. She stated she did not write a note in the communication book, wrote a note on a piece of paper and would then write her notes at the end of the week. She stated the family was with the resident at the hospital when she sent her out and was aware of the hospitalization. She stated that she did not notify the physician when the resident was sent out and did not document the family was notified and was not aware that was required.
Review of facility note revealed on at 9:30 AM the resident was sent to the hospital.
Resident record review for resident #3 revealed an Assisted Living Facility Health Assessment Form (1823) dated that indicated a diagnosis of chest pain.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
English Estates Alf
1340 Oxford Rd
Maitland, FL 32751

RE: Revisit to CCR#2015003749

Dear Administrator:

This letter reports the findings of a complaint investigation revisit survey conducted on 8, 2015by 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

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