STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911279	**09/14/2015**
NAME OF PROVIDER OR SUPPLIER **ANN-WAY ASSISTED LIVING, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8207 FOREST CITY ROAD** **ORLANDO, FL 32810**	

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

0000 Initial Comments

A complaint investigation (CCR 2015008317) w/LNS/LMH, was conducted at Ann Way Assisted Living, Inc. on in conjunction with the biennial relicensure survey. Ann Way Assisted Living, Inc. had a deficiency at the time of the investigation.

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview the facility failed to ensure residents were treated with consideration and with due recognition of personal dignity and the need for privacy.

Findings:

Observation on / at approximately 12 PM revealed the resident's names were on labels, on the dining , where they seated themselves for meals.

The facility did not treat the residents with consideration, recognize personal dignity and honor their privacy, when labeling their places at the dining .

In an interview with Staff D, owner and Staff F, Registered Nurse on at approximately 5 PM who stated the resident's names were on the tables as they wanted to sit in their same seats and did not want other residents to sit in them.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Ann-Way Assisted Living, Inc
8207 Forest City Road
Orlando, FL 32810

RE: CCR #2015008317

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation survey that was conducted on , 2015 by representative(s) 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents 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 surveyor(s). Should you have any questions please call Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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