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0000 Initial Comments

Unannounced Complaint Investigation #2015012858 with limited mental health services (LMH) was conducted on , and / / . Homestead Retirement Living had deficiencies at the time of the visit.

0025 Resident Care - Supervision

Based on observations, record review and interviews the facility failed to maintain an awareness of residents' whereabouts by not following the facility's own policy of utilizing sign in and sign out sheets. The facility failed to notify the health care provider or case manager of significant behavioral changes for 3 of 6 residents (#1, 2, 11). The facility failed to maintain progress notes for 3 of 6 residents with significant behavioral changes (#2, 7 & 9). These failures placed residents at risk for their safety.

Findings:

1. In an interview on / at 5:15 PM with the brother of Resident #1, he stated Resident #1 was sitting on his front yard when he returned from work on at 8:15 PM. The brother of Resident #1 stated he lives in New Jersey. He stated Resident #1 indicated he had taken a bus from Florida to New Jersey.

On / / at 7:20 PM, a local bus transportation representative stated the transportation time by bus between Kissimmee, Florida to New York City is between 26 and 28 hours. The representative indicated New York City is the nearest bus station to the brother of Resident #1's home in New Jersey.

On / at 11:28 AM, the acting administrator stated the facility became aware Resident #1 was missing when New Jersey law enforcement contacted the facility on at 8:30 PM.

On / at 3:49 PM, staff H stated she had taken a call from New Jersey law enforcement which indicated that Resident #1 was in their custody as a . Staff H stated she called and told the administrator of the telephone call and the administrator stated, "It is okay, as long as he can figure out how to get back." Staff H stated prior to the call, the facility was not aware that Resident #1 was missing.

On / at 11:54 AM, staff E stated she attempted contact with Resident #1 on at 7 AM and on at 7 AM. Staff E indicated she knocked on Resident #1's door on both days but did not get an answer from the resident.

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Resident #1's progress notes revealed the last contact with Resident #1 had been made by the facility on at 5 PM during a medication pass by the acting administrator.

Review of the sign-in and sign-out sheets for the week of to revealed Resident #1 had not signed out of the facility during that time frame.

Resident #1's record revealed he is a limited mental health resident with a diagnosis of .

On , Resident #1's medication observation records (MORs) revealed he had refused to take his medication since .

Review of the facility's internal incident log did not include any documentation of the elopement of Resident #1 on . The incident log revealed the facility documented 4 incidents of elopement in 2015 for Resident #1.

2. Review of an internal incident report filed on revealed Resident #13 was last seen at 10 AM. The report revealed local law enforcement was contacted to investigate at 8 PM. The report did not reveal the final outcome.

3. Review of an internal incident report filed on revealed Resident #14 had not been seen since . The report revealed local law enforcement was contacted to investigate at 9 PM on .

4. Review of an internal incident report filed on revealed Resident #15 left the facility at an unknown time that day. The report revealed the facility was notified by the Oakland Police Department, Florida at 9 PM that they had custody of Resident #15.

5. Review of an internal incident report filed on revealed Resident #16 was noticed missing at 9 PM. The report revealed at 10:30 PM, local law enforcement was contacted to investigate. The report revealed local law enforcement found Resident #16 unharmed.

On at 12:24 PM, the acting administrator stated all of the facility elopements for are documented in the incident log book. She was asked about the other elopements and responded, "What other elopements?"

6. Review of local law enforcement calls to service revealed three additional elopements the facility failed to document. The calls to service report revealed local law enforcement was contacted to investigate a missing person at 12:01 AM on . The report revealed that Resident #17 left the facility without signing out. The report revealed the facility could not provide a time frame in which the

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resident was last seen. The report revealed Resident #17 was found at the home of his father.

7. Review of local law enforcement calls to service report revealed local law enforcement was contacted to investigate a missing person at 10:36 PM on . The report revealed Resident #11 was considered at risk due to his diagnosis of . The report revealed local law enforcement found Resident #11 and returned him to the facility. The calls to service report revealed local law enforcement was contacted to investigate a missing person at 2:25 PM on .

8. Review of local law enforcement calls to service report revealed Resident #2 left the facility on . The report revealed Resident #2 was located in Smyrna, Georgia. The report revealed Resident #2 was considered at risk due to a diagnosis of .

In an interview on at 12:24 PM, the acting administrator stated the incidents documented by local law enforcement were resident elopements. The acting administrator stated Resident #2 was at risk for her health and safety while missing from the facility because she did not have her medication. The acting administrator stated Resident #2 had a diagnosis of . When asked about reassessment and a safety plan for Resident #2, the acting administrator stated she talked with Resident #2 and a family member and they promised it would not happen again.

On at 10:35 AM, the acting administrator was asked to provide a copy of the facility operating procedure for residents signing in and out of the facility and elopement procedures. The acting administrator stated all of the facility policies have been given to the local emergency management office and are not available for review.

On at 11:28 AM, the acting administrator stated all residents are required to sign out of the facility and list where they are going and the expected time of return. The acting administrator stated, "At the end of the day, we look for residents who have not returned."

Review of the sign in and out sheets for the week of to revealed only 5 to 6 residents had signed out during the entire week. Review of the sign in and out sheets for the week of to revealed only 3 residents had signed out for the day.

On an observation was made at 10:15 AM. Four individuals were observed walking toward a city park. It was later observed all 4 individuals were residents at the facility.

On at 11:54 PM, staff E stated residents are required to sign in and out when coming and going from the facility. Staff E stated she is not sure why we require them to sign in and out when she was told the residents can come and go as they please. Staff E stated, "We don't use the sheets to do a head

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count at night."

On at 2:51 PM, staff J stated she is aware of the sign-in and sign-out policy for residents. Staff J stated she is not sure why they have to sign in and out because most of the residents come and go as they please.

On at 3:02 PM, Resident #4 stated he doesn't know anything about the sign-in and sign-out sheet. Resident #4 stated he tells a staff where he is going. Resident #4 stated he likes the facility because they let you come and go as you please.

On at 3:24 PM, Resident #7 stated, "if you don't return when you say on the sign-in and sign-out sheet, you get a stern lecture from the staff."

On at 3:28 PM, Resident #8 stated she understands the policy about signing in and out and uses the sign in and out sheets sometimes when she is going out.

On at 3:49 PM, staff H stated residents are supposed to sign in and out but the residents don't actually use it because the administrator doesn't do anything.

On / at 2:26 PM, the acting administrator stated residents are expected to use the sign in and out sheets. When asked what happens if a resident doesn ' t use the sign in and out sheet, the acting administrator stated, "We talk to them and encourage them to use the sheets." When asked if they use the forms at the end of the day to determine if a resident is back, the acting administrator stated "No."

On at 11:54 PM, staff E stated all behavioral changes are documented in the notes kept in the residents' medication observation records (MORs). Staff E stated she documented Resident #1 not taking his medication in the notes. Staff E stated she contacted the case manager for Resident #1 and told her he was not taking his medication but she, staff E did not document that in the resident's notes.

On / at 2:26 PM, the acting administrator stated that behavioral concerns and significant changes are documented in the notes which are placed into the MORs folder.

Review of Resident #1's progress notes with the acting administrator present revealed the facility documented Resident #1 had stopped taking his medication on /. The record revealed the facility failed to document attempts to notify the case manager, family member or health care provider for Resident #1. The record did not reveal any documentation of Resident #1's current elopement.

Review of Resident #9's progress notes with the acting administrator present revealed the facility failed

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to maintain any progress notes for Resident #9.

Review of Resident #2's progress notes with the acting administrator present revealed the facility failed to maintain any progress notes for Resident #2. The record review revealed the facility had not documented Resident #2's recent I/. . . . elopement. The record did not contain documentation of notification to Resident #2's health care provider, case manager or family member of the significant behavioral changes as the result of Resident #2's elopement.

Review of Resident #11's progress notes with the acting administrator present revealed the facility documented Resident #11's refusal to take his medication but did not contain documentation of notification to Resident #11's case manager, family member or health care provider of the medication refusal.

Review of Resident #11's progress notes with the acting administrator present revealed the facility failed to maintain any progress notes for Resident #7.

Class I

0026 Resident Care - Social & Leisure Activities

Based on observations, record review and interviews, the facility failed to provide residents with 12 hours of ongoing social and leisure activities per week.

Findings:

Review of the activities calendar posted on the resident bulletin board on revealed that for the week of / to , the facility only had activities for 5 days and did not provide the starting or ending times for those activities.

On at 11:28 AM, the acting administrator was asked how many hours of social and leisure activities the facility has each week and she stated 6 hours per week of social and leisure activity. She stated the starting time for today's music activity was 1:30 PM.

On at 1:30 PM, it was observed that the facility failed to provide the listed music activity program.

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0077 Staffing Standards - Administrators

Based on record review and interviews, the administrator failed to maintain general oversight of the daily operations of the Assisted Living Facility. The administrator failed to provide a CORE trained manager during his extended absence from the facility. The administrator failed to implement interventions after numerous resident elopements. The administrator's actions placed all of the residents at imminent risk of harm to include or serious injury.

Findings:

On at 10:35 AM, the acting administrator stated the administrator of the facility was out of the country. She stated that he left the country on / and may return in 2 weeks. She stated the administrator was not specific when he would return to the facility.

On at 12:30 PM, the mental health administrator stated the last time her staff actually saw the administrator at the facility was on . She stated the administrator told her during conversations that he spends 2 weeks a month out of the country.

On / / at 12:46 PM, when the acting administrator was asked to produce the written documentation from the administrator of being in charge, she stated the administrator did not leave any written information placing her in charge. She stated she is CORE trained and was waiting to complete the competency test.

Review of the acting administrator's employee file did not include any documentation that the acting administrator had completed the CORE class. The employee file did not include the high school diploma, as required, for the acting administrator.

On at 5:20 PM, when asked, the acting administrator could not provide documentation that she had completed the CORE training.

On at 11 AM, the administrator stated that he was calling to find out if a moratorium was placed on the facility. The administrator asked if this has something to do with, "that missing guy". The administrator stated that he knew about the elopement but, "I just don't understand the concern." He stated that he was aware of the elopement of Resident #1 prior to leaving the country. The administrator did not put any safety plan in place. (See A0025- Resident Care-Supervision). The administrator stated that during the months of , and 2015, he spends the first two weeks in the United States and the second two weeks in Poland.

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Review of the weekly staff schedule revealed that the operator provide only 192 hours of coverage per week. (See A0079 Staff Standards-Levels).

Class I

0079 Staffing Standards - Levels

Based on observation and record review, the facility placed residents at imminent risk of harm by failing to provide adequate staffing levels to ensure a safe environment and prevent reoccurring elopements, failed to provide a work schedule that reflected the actual hours of staff coverage, and failed to provide in writing documentation of the person in charge while the administrator is out of the country.

Findings:

1. On at 10:35 AM, the acting administrator stated the administrator of the facility left to go out of the country on / /. She stated the current census of the facility was 40 residents.

Review of the census log provided by the acting administrator revealed the census was 39 residents in the facility, with 1 resident, Resident #1, on elopement.

Review of the admission and discharge log matched the census. The log revealed the facility had 39 residents in-house with 1 resident, Resident #1, on elopement.

On / / at 12:46 PM, the acting administrator stated she had provided the work schedule that the facility is using for the period of / to .

2. Review of the weekly work schedule for the week of to revealed the facility will provide only 196 hours of staff coverage, which did not meet the required 335 hours of staff coverage for that resident census. The weekly work schedule of to indicated the administrator was scheduled to work 40 hours. The work schedule revealed staff H was scheduled off and staff I was schedule to work.

On / at 2:26 PM, the acting administrator stated the facility does not have enough staff. She stated the administrator will not allow her to hire anyone else to work at the facility. When asked about the work schedule, the acting administrator stated it is the schedule they are using. When asked about the hours for the operator, the acting administrator acknowledged that the schedule was not accurate.

On at 3:49 PM, staff H was provided a copy of the work schedule. After reviewing the

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schedule, staff H stated, "This is not correct. I work today and staff I is off. Who gave you this?"

3. On at 10:35 AM, the acting administrator was requested to provide a copy of the documentation the administrator placed her in charge of the facility. On at 2:26 PM, the acting administrator was again asked to provide a copy of the documentation that the administrator placed her in charge of the facility. The acting administrator stated the administrator did not provide any documentation leaving her in charge of the facility.

Class I

0081 Training - Staff In-Service

Based on record review and interviews, the facility failed to ensure that 3 of 6 staff completed emergency preparedness and evacuation training within 30 days of hire (F, G & H). The facility failed to ensure that 4 of 6 staff completed recognizing and reporting , neglect and training within 30 days of hire (E, F, H & I). The facility failed to ensure that 5 of 6 staff completed elopement response training within 30 days of hire (E, F, G, H & I).

Findings:

1. Review of staff E's employee file revealed the date of hire was . The file revealed staff E completed recognizing and reporting , neglect and training on . The record review of staff E's file revealed staff E completed elopement response training on .

On at 5:20 PM, the acting administrator was asked if she could provide documentation staff E completed recognizing and reporting , neglect and training and elopement response training within the 30 days of date of hire but she stated "No", she could not.

2. Review of staff F's employee file revealed the date of hire was . The file revealed staff F completed emergency preparedness and evacuation training on . The file revealed staff F completed recognizing and reporting , neglect and training on . The file revealed staff F completed elopement training on .

On at 5:20 PM, the acting administrator was asked to provide documentation that staff F completed emergency preparedness and evacuation training, recognizing and reporting , neglect and training and elopement response training within the 30 days of date of hire. She started to look through other files. After a few moments, she stated she could not find the documentation.

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3. Review of staff G's employee file revealed the date of hire was / /. The file revealed staff G completed emergency preparedness and evacuation training on / /. The file revealed staff G completed elopement response training on / /.

On / at 5:20 PM, the acting administrator was asked to provide documentation that staff G completed emergency preparedness and evacuation training and elopement response training within the 30 days of date of hire She stated she could not find the documentation.

4. Review of staff H's employee file revealed the date of hire was . The file revealed staff H completed emergency preparedness and evacuation training on / /. The file revealed staff H completed recognizing and reporting , neglect and training on / /. The file revealed staff H completed elopement response training on / /.

On / at 5:20 PM, the acting administrator was asked to provide documentation that staff H completed emergency preparedness and evacuation training, recognizing and reporting , neglect and training and elopement response training within the 30 days of date of hire. She stated she could not find the documentation.

5. Review of staff I's employee file revealed the date of hire was . The file revealed staff I completed recognizing and reporting , neglect and training on / /. The file revealed staff I completed elopement response training on / /.

On at 5:20 PM, the acting administrator was asked to provide documentation that staff I had completed recognizing and reporting , neglect and training and elopement response training within the 30 days of date of hire. She stated she could not find the documentation.

Class III

0090 Training -

Based on record review and interviews, the facility failed to ensure that 1 of 6 staff completed ( ) training within 30 days of hire (H).

Findings:

Review of staff H's employee file revealed the date of hire was . The file revealed staff H completed training on / .

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On at 5:20 PM, the acting administrator was asked to provide documentation that staff H had completed training within 30 days of hire. She stated she could not find the documentation.

Class III

0125 Fiscal - Suretv Bonds

Based on record review and interviews the facility failed to provide a Surety Bond for 4 of 6 residents who receive Optional State Supplemental ( ) funds and the facility serves as the direct payee (#1, 7, 9 & 10).

Findings:

1. Review of Resident #1's file revealed the facility serves as the direct payee for funds for Resident #1.

2. Review of Resident #7's file revealed the facility serves as the direct payee for funds for Resident #7.

3. Review of Resident #9's file revealed the facility serves as the direct payee for funds for Resident #9.

4. Review of Resident #10's file revealed the facility serves as the direct payee for funds for Resident #10.

On / at 12:21 PM when asked about payments, the acting administrator stated that they are direct payee for some of the residents. She stated she could provide a copy of the Surety Bond.

On / at 5:20 PM, the acting administrator was asked if she could provide a copy of the Surety Bond. The acting administrator asked, "What is that?" After it was explained to her what a Surety Bond was, she stated, "We don't have one."

Class III

0161 Records - Staff

Based on record review and interviews, the facility failed to ensure that 2 of 6 staff had documentation of completing a job application and references (E & I).

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Findings:

1. Review of staff E's employee file revealed the date of hire was / . The file revealed staff E had not completed a job application and reference check.

On / at 5:20 PM when asked, the acting administrator was unable to provide a copy of the job application or reference check for staff E.

2. Review of staff I's employee file revealed the date of hire was . The file revealed staff I had not completed a job application and reference check.

On / at 5:20 PM, when asked, the acting administrator was unable to provide a copy of the job application or reference check for staff I.

Class III

0163 Records - Resident. Penalties for Alteration

Based on record review and interviews, the facility placed a resident at risk by providing false information on progress notes for 1 of 6 residents, indicating they had communicated verbally with to the resident during the time when Resident #1 eloped from the facility and was missing for an extended period of time (#1).

Findings:

On / at 5:15 PM, the brother of Resident #1 stated Resident #1 was sitting on his front yard when he returned from work on at 8:15 PM. He stated he lives in New Jersey. He stated Resident #1 indicated to him that he had taken a bus from Florida to New Jersey.

On / / at 7:20 PM, a local bus transportation representative stated the transportation time by bus between Kissimmee, Florida to New York City is between 26 and 28 hours. He indicated that New York City is the nearest bus station to the home of Resident #1's brother in New Jersey.

On at 11:28 AM, the acting administrator stated the facility became aware Resident #1 was missing when law enforcement from New Jersey contacted the facility on at 8:30 PM. She stated staff E had conducted a medication pass at 8 AM on , knocked on the door of Resident #1 and Resident #1 said he did not want his medication.

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Review of Resident #1's progress notes revealed on at 8 AM, staff E documented she knocked on the door to Resident #1 and he stated, "No, he did not want his medication." On at 8 AM, staff E documented that she knocked on the door to Resident #1's ! he stated, "No, he did not want his medication."

On / at 11:54 AM, staff E indicated on at 7 AM, she knocked on the door of Resident #1's provide Resident #1 with his medication. Staff E indicated Resident #1 did not answer the door and she did not speak to Resident #1. Staff E indicated on / at 7 AM she repeated the same process as on by knocking on the door of Resident #1's . Staff E stated that Resident #1 did not answer the door.

On / at 12:10 PM with the acting administrator, staff E stated to the acting administrator that while on a medication pass on at 7 AM, she had knocked on the door to Resident #1's ! Resident #1 did not answer. Staff E stated she did not speak with Resident #1. Staff E stated to the acting administrator while on a medication pass on at 7 AM, she knocked on the door to Resident #1's ! Resident #1 did not answer. Staff E stated she did not speak with Resident #1.

On / / at 5:20 PM, the acting administrator stated she understood that the information provided by staff E in the progress notes was not what actually happened. The acting administrator stated the facility might have known that Resident #1 was not at the facility if staff E had stated Resident #1 did not answer the door.

Class II

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interviews, the facility failed to file an adverse incident report with the Florida Agency for Health Care (AHCA) for 8 of 8 incidents of resident elopement in which the resident was considered at risk, and law enforcement was called to investigate (#13, 14, 15, 16, 17, 11, 2 & 1).

Findings:

On / at 12:24 PM, when asked about the filing of an adverse incident report, the acting administrator stated she is not sure when to file an adverse incident report.

Review of the facility incident reports revealed the facility had documented 4 incident reports involving elopement by residents of the facility.

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On at 12:24 PM, the acting administrator was asked if a resident was considered at risk while on elopement and stated "Yes". She was asked if the facility had contacted law enforcement to investigate the at-risk elopement and she stated "Yes". She stated the facility filed adverse incident reports for two of the elopements on / and . She could not provide copies of the adverse incident reports and stated, "The facility generally doesn't do them."

On at 9:42 AM, The Agency for Health Care Administration Central Office staff stated the facility had only filed 1 adverse incident report for calendar year 2015 for the elopement on .

1. Review of the facility incident reports revealed that on / / , Resident #13 left the facility at 10 AM. The incident report revealed that Resident #13 was noticed to be missing until 8 PM. The incident report revealed Resident #13 did not sign out of the facility. The incident report revealed Resident #13 was at-risk and local law enforcement was contacted to investigate.

2. Review of the facility incident reports revealed that on / / , Resident #14 left the facility at an unknown time. The incident report revealed that Resident #14 was considered at risk and local law enforcement was contacted to investigate.

3. Review of the facility incident reports revealed on , Resident #15 was picked up by law enforcement in another county. The incident report revealed that the facility was unaware Resident #15 had eloped from the facility.

4. Review of the facility incident reports revealed on , Resident #16 was noticed missing from the facility. The incident report revealed that local law enforcement was called to investigate.

On at 12:24 PM, the acting administrator stated the elopements listed in the incident log were the only incidents of elopement this calendar year. When asked about the other elopements, she stated, "What other elopements?"

Review of local law enforcement calls to service report revealed 3 additional elopements the facility failed to file adverse incident reports.

5. Review of local law enforcement calls to service report revealed local law enforcement was contacted to investigate a missing person at 12:01 AM on . The report revealed Resident #17 left the facility without signing out. The report revealed the facility could not provide a time frame in which the resident was last seen. The report revealed Resident #17 was found at the home of his father.

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NAME OF PROVIDER OR SUPPLIER **HOMESTEAD RETIREMENT**	STREET ADDRESS, CITY, STATE, ZIP CODE **1117 MASSACHUSETTS AVENUE** **SAINT CLOUD, FL 34769**	

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

6. Review of local law enforcement calls to service report revealed local law enforcement was contacted to investigate a missing person at 10:36 PM on . The report revealed Resident #11 was considered at risk due to his diagnosis of . The report revealed local law enforcement found Resident #11 and returned him to the facility.

7. Review of local law enforcement calls to service report revealed local law enforcement was contacted to investigate a missing person at 2:25 PM on . The report revealed Resident #2 had left the facility on . The report revealed Resident #2 was located in Smyrna, Georgia. The report revealed Resident #2 was considered at risk due to a diagnosis of .

8. On at 5:15 PM, the brother of Resident #1 stated that he returned to his home in New Jersey at 8:15 PM on to find Resident #1 sitting in his front lawn. Review of Resident #1's record revealed a diagnosis of .

On at 11:24 AM, the acting administrator stated the facility became aware Resident #1 was missing when law enforcement from New Jersey contacted the facility on at 8:30 PM. She stated that an adverse incident report regarding the elopement of Resident #1 was not completed.

Class III

L243 LMH - Training

Based on record review and interviews, the facility failed to ensure that 2 of 6 staff completed limited mental health (LMH) training (F & acting administrator). The facility failed to ensure that 1 of 6 staff completed LMH training within 6 months of hire (H).

Findings:

1. Staff F's employee file did not contain documentation that staff F completed the required LMH training.

On at 5:20 PM, the acting administrator was asked to provide documentation that staff F completed LMH training but she stated she could not find it in the file.

2. The acting administrator's employee file did not contain documentation the acting administrator completed LMH training.

On / at 5:20 PM, the acting administrator was asked to provide proof she had completed LMH

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training but was unable to.

3. Staff H's employee file revealed a date of hire of but LMH training was completed on //, not within 6 months of hire.

On / at 5:20 PM, the acting administrator was asked to provide documentation that staff H completed LMH training within 6 months of the date of hire but could not provide documentation.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Homestead Retirement
1117 Massachusetts Avenue
Saint Cloud, FL 34769

RE: CCR #2015012858 w/LMH

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2015 and 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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Phone:(407) 420-2502; Fax:(407) 245-0998
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