STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967005	02/10/2016
NAME OF PROVIDER OR SUPPLIER **WESLEY HOUSE III**	STREET ADDRESS, CITY, STATE, ZIP CODE **28502 TALL GRASS DRIVE** **WESLEY CHAPEL, FL 33543**	

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

0000 Initial Comments

Assisted Living Facility

A complaint investigation (CCR# 2015012113) was conducted at Wesley House III on / . Wesley House III, Assisted Living Facility, had deficiencies at the time of the investigation.

0008 Admissions - Health Assessment

Based on interview and record review, the facility failed to obtain a complete AHCA Form 1823, based on a medical examination, that determined the appropriateness of continued residency in the facility for 1 (#2) of 4 resident records reviewed.

Findings included:

A review of resident records was conducted on / . A review of Resident #2 ' s AHCA Form 1823, dated , showed blank sections indicating special diet instructions, presence of a communicable which could be transmitted to other residents or staff, whether the resident was bedridden, the presence of , 3, or 4 pressure sores, whether the resident posed a danger to self or others, and whether the resident required 24-hour nursing or care.

A further review of Resident #2 ' s AHCA Form 1823 showed no determination as to whether the individual ' s needs can be met in an assisted living facility which is not a medical, nursing or facility. Additionally, the form showed no indication as to whether the resident needed help taking his medications, or needed assistance with self-administration or administration of medications.

An interview was conducted with the administrator at approximately 1:00 PM on / concerning the lack of the health care provider's assessments on Resident #2 ' s AHCA Form 1823.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on interview and record review, the facility failed to utilize a residential agreement, stating that a 45 day notice of relocation or termination of residency will be given, for 3 (#1, #2, and #4) of 3 residential agreements reviewed.

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967005	**02/10/2016**
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Findings included:

A review of residential agreements was conducted on . It was discovered that the agreements stated that residence may be terminated, including resident discharge, by providing a 30 day written notice.

An interview was conducted with the caretaker at 3:10 PM on and the lack of the required 45 day notice for discharge of residents, to be included within the residential agreement, was discussed.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Wesley House III
28502 Tall Grass Drive
Wesley Chapel, FL 33543

RE: CCR# 2015012113

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016, 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 , 2016.** 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.

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SlideShare.net/AHCAFlorida

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

XG90