AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966666	03/24/2016
NAME OF PROVIDER OR SUPPLIER **LAKESHORE LIVING INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **10919 MISTLETOE DRIVE** **THONOTOSASSA, FL 33592**	

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

0000 Initial Comments

Assisted Living Facility

An unannounced Biennial licensure survey was conducted on .

The Lakeshore Living, Assisted Living Facility, had a deficiency at the time of this visit.

Z816 Background Screening-Compliance Attestation

Based on record review and interview, the facility failed to ensure that Level II background rescreening was conducted every 5 years following employment for 1 of 3 employees whose record were review (Staff C).

Findings included:
Surveyors conducted a Biennial licensure survey at the facility on . Per employee record reviews, Staff C was hired by the facility as a Resident Care Aide on . Per record review and interview with facility's Administrative Assistant, the facility accepted Staff C ' s Level II eligibility effective / due to Staff C ' s ongoing employment in positions requiring Level II background eligibility. Staff C was due for 5-year rescreening by ; as of , there was no record in Staff C ' s file of completion of the required rescreening. Per Surveyor review of AHCA Background Screening Clearinghouse, Staff C had screening completed on and " A New Screening Is Required. " On at 3:00 pm, the facility ' s Administrative Assistant stated she was unaware of the 5-year rescreening requirement.

Unclassed

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Lakeshore Living Inc
10919 Mistletoe Drive
Thonotosassa, FL 33592

Dear Administrator:

This letter reports the findings of a biennial 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.

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/clt
Enclosure: State (5000-3547) Form

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