STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11953272 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD RETIREMENT CENTER	1220 JIMMY ANN DRIVE DAYTONA BEACH, FL 32117

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0008	Correction	ID Prefix A0052	Correction	ID Prefix A0053	Correction
Reg. # 429.26(4-6) FS; 58A-5.0181(2) FAC	Completed	Reg. # 58A-5.0185 (3)	Completed	Reg. # 58A-5.0185(4) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0056	Correction	ID Prefix A0081	Correction	ID Prefix A0093	Correction
Reg. # 58A-5.0185(7) FAC	Completed	Reg. # 58A-5.0191(2) FAC	Completed	Reg. # 58A-5.020(2) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0161	Correction	ID Prefix A0162	Correction	ID Prefix AZ816	Correction
Reg. # 429.275(2) FS; 58A-5.024(2) FAC	Completed	Reg. # 58A-5.024(3) FAC	Completed	Reg. # 408.809(2)(a-c) FS	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Robert Dubois	4/19/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/8/2016		☑ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☑ YES ☐ NO

EVENT ID: MU7D12

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953272	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD RETIREMENT CENTER	1220 JIMMY ANN DRIVE DAYTONA BEACH, FL 32117

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

0000 Initial Comments

A unnanouced follow up survey to complaint investigations, CCR# 2015012187, 2015012591, and 2015012759, was conducted on , 2016 at Lakewood Retirement Center. Lakewood Retirement Center had deficiencies found at the time of the investigation.

0079 Staffing Standards - Levels

Based on observation, record review and staff interview, the facility failed to maintain a written work schedule that included enough hours to meet the minimum requirement of 253 hours per week for 18 of 18 residents currently living at the facility.

The findings include:

Observation in the facility on at 9:00 AM and review of the resident list provided by the Administrator found the facility had 18 residents.

During an interview with the Administrator on at 9:00 AM she was asked to provide the employee work schedules for the facility. Record review of the employee schedule for through found the total number of hours the Administrator and seven caregivers at the facility were scheduled to work totaled 242.

The hours were added up in front of the Administrator on 4/5//16 at 12:30 PM. The hours for totaled 41: totaled 41; totaled 35; totaled 34; totaled 32; totaled 33 and totaled 26. The number of hours scheduled for the week of through totaled 242. She confirmed the schedule for the week of through had 242 hours. The Administrator was informed that the minimum weekly staffing requirement for 18 residents was 253 hours. She agreed the schedule was 11 hours short.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Lakewood Retirement Center
1220 Jimmy Ann Drive
Daytona Beach, FL 32117

Re: CCR #2015012187; CCR #201501759 & CCR #201501591

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016 by a representative of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies identified during the revisit.

All deficiencies shall be corrected no later than , 2016.

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 (904) 798-4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evacuator Supervisor
Division of Health Quality Assurance

NH/JM/sm
Enclosure

BBT7

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