STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967551	05/19/2016
NAME OF PROVIDER OR SUPPLIER **SAN JEAN FACILITY CARE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **815 24TH STREET** **ORLANDO, FL 32805**	

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

0000 Initial Comments

Complaint Investigation #2016005120 was conducted from - / . . San Jean Facility Care, Inc, License #11563, had deficiencies at the time of the visit.

0008 Admissions - Health Assessment

Based on interview and record review, the facility failed to ensure that 1 out of 4 residents (#1) had a completed Agency health assessment form (1823).

Findings:

On at 11:51 AM, a record review was conducted of the resident file for Resident #1. The 1823 was not filled out completely. The area on the form designating if the resident is an elopement risk or not was not filled out. (Photo 3).

On at 11:51 AM, an interview was conducted with the Administrator. The Administrator stated he was not aware the area of the 1823 showing if the resident is an elopement risk was not filled out. The Administrator stated he thought that was the physician's responsibility.

Class III

0025 Resident Care - Supervision

Based on interview, observation, and record review, the facility failed to provide the level of supervision and oversight required for 1 out of 48 sampled residents (#1). Specifically, the facility failed to follow their internal policy related to the security of the facility's gate, leading to Resident #1's elopement from the facility for more than 24 hours and placing him in harm's way.

Findings:

On at 12:28 PM, an interview was conducted with Staff A, who stated a case manager came briefly to the facility at 9:00 AM to pick up a resident for an appointment, and therefore it is believed that at approximately 9:10 AM, Resident #1 eloped from the facility when the case manager left. Resident #1 was not determined to be missing until approximately 11:00 AM, when Staff A stated she noticed he had not arrived at lunch and went looking for him in his . . . . Staff A stated she reviewed the video with law enforcement and verified he had left the facility as the case manager's car was leaving the property.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967551	**05/19/2016**
NAME OF PROVIDER OR SUPPLIER **SAN JEAN FACILITY CARE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **815 24TH STREET ORLANDO, FL 32805**	

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

On at 11:51 AM, a record review was conducted of the Agency health assessment form 1823 for Resident #1. The 1823 had not been filled out completely. The area where it identifies if the resident is an elopement risk or not was not completed. (Photo 3).

On at 11:51 AM, an interview was conducted with the Administrator. The Administrator stated no investigation into how the elopement occurred had been initiated. The Administrator stated he had been told by Staff A that Resident #1 appeared to have left the property when the front gate was opened for a car to leave the gated property. The Administrator stated he was not exactly sure who had let the vehicle out of the facility when Resident #1 eloped. The Administrator stated he found Resident #1 on at 1:30 PM under a bridge. The Administrator stated Resident #1 had been missing from the facility for over 24 hours.

On in a continued interview with the Administrator, he stated no retraining has been completed or planned for the staff to ensure this does not happen again. The Administrator stated no one had been written up or disciplined regarding the incident. The Administrator stated he was not aware that the 1823 had not been filled out completely. The Administrator stated he thought that was the physician's responsibility, not his.

On at 12:43 PM, an interview was conducted with Staff B. Staff B stated she let a car exit the facility though the gate, but she was not sure of the exact time. Staff B was aware she was required to watch the car exit, verify no residents exited, and then watch the gate close. Staff B stated she heard Staff A call for assistance, so she failed to watch the gate and went to assist Staff A. Staff B stated she was not written up, and she was not retrained on any policies or procedures. Staff B stated she told the Administrator she would "be more careful".

On at 1:01 PM, an interview was attempted with Resident #1. Resident #1 did not remember leaving the facility.

On at 3:30 PM, an interview was conducted with Resident #1's case manager. The case manager stated Resident #1 was an elopement risk and Resident #1 had been moved to this facility because the property was gated. The case manager stated Resident #1 had eloped from his previous facility, and the facility was informed of this upon his admission.

On / at 1:23 PM, an interview was conducted with the Administrator of Resident #1's former facility. The Administrator of the previous facility stated Resident #1 had eloped and had been missing for three days.

Class II

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967551	05/19/2016
NAME OF PROVIDER OR SUPPLIER **SAN JEAN FACILITY CARE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **815 24TH STREET** **ORLANDO, FL 32805**	

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

0032 Resident Care - Elopement Standards

Based on interview and record review, the facility failed to ensure the safety of 48 out of 48 residents in the facility. Specifically, the facility failed to follow its own elopement policy and procedure, leading to the elopement of 1 out of 48 sampled residents (#1).

Findings:

On [redacted] at approximately 9:00 AM Resident #1 eloped from the facility. Resident #1 was determined to have eloped at approximately 11:00 AM.

On [redacted] at 11:20 AM a record review was conducted of the facility's elopement policy. An elopement drill was to be completed twice a year on each shift and documented. "The administrator and/or administrator's designee will complete the Elopement/Missing Resident Drill Form and evaluation at the time of the drill. The entire staff will be briefed as to the results of the drill and when applicable, will be in-serviced, as needed." The last documented elopement drill was on [redacted], 2010. The facility's elopement policy also stated "File Adverse Incident Report (1 Day) - to be faxed to Tallahassee within 24 hours by the Administrator or Manager or predetermined staff." (Photos 4-10).

On [redacted] at 11:51 AM, a record review was attempted of the facility's 1-day Adverse Incident Report related to the incident. A 1-day report had not been completed.

On [redacted] at 11:51 AM, an interview was conducted with the Administrator. The Administrator stated he had not completed the 1-day Adverse Incident Report regarding the incident and had not filed it with the Agency. The Administrator stated no investigation into how the elopement occurred had been initiated. The Administrator stated he had been told by Staff A that Resident #1 appeared to have left the property when the front gate was opened for a car to leave the gated property. The Administrator stated he was not exactly sure who had let the vehicle out of the facility when Resident #1 eloped. The Administrator had not conducted any retraining, and had not planned any retraining for his staff.

On [redacted] at 12:15 PM, an interview was conducted with Staff C. Staff C stated he had not received any formal elopement training when hired. Staff C has not participated in any elopement drills since he was hired.

On [redacted] at 12:30 PM, a record review was conducted of the facility's policy on reporting [redacted] neglect, and [redacted]. An addendum handwritten at the bottom of the policy, dated [redacted] read, "If patient of (the facility) has been identified as elopement risk [redacted] will be placed on every 15 minute safety

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967551	05/19/2016
NAME OF PROVIDER OR SUPPLIER SAN JEAN FACILITY CARE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 815 24TH STREET ORLANDO, FL 32805	

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

monitoring checks see attached form." (Photos 5-7).

On [redacted] at 12:43 PM, an interview was conducted with Staff B. Staff B stated she let a car exit the facility though the gate, but she was not sure of the exact time. Staff B was aware she was required to watch the car exit, verify no residents exited, and then watch the gate close. Staff B stated she heard Staff A call for assistance, so she failed to watch the gate and went to assist Staff A.

On [redacted] at 12:43 PM, an interview was conducted with Staff B. Staff B stated she had been employed at the facility for over a year. Staff B stated she had not participated in any elopement drills.

On [redacted] at 1:01 PM, an interview was attempted with Resident #1. Resident #1 was not able to answer any questions regarding the elopement. Resident #1 did not remember leaving the facility.

Class III

0055 Medication - Storage and Disposal

Based on observation and interview, the facility failed to ensure the medications were kept in a locked cart at all times.

Findings:

On [redacted] at 10:15 AM, the medication cart was observed to have all drawers unlocked. The medication cart was in an open [redacted] six residents were observed sitting and watching television. (Photo 1 and 2).

On [redacted] at 3:20 PM, an interview was conducted with the Administrator. The Administrator stated he was aware the medication cart should have been locked.

Class III

0077 Staffing Standards - Administrators

Based on interview, observation, and record review, the facility failed to provide appropriate supervision of the facility's residents, failed to prevent the elopement of a resident of the facility, failed to appropriately train the facility staff to perform their required duties, failed to follow the facility's elopement policy, failed to conduct elopement drills, failed to ensure all residents of the facility have a completed health assessment, failed to maintain an employee roster, failed to ensure all employee files have the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967551	05/19/2016
NAME OF PROVIDER OR SUPPLIER SAN JEAN FACILITY CARE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 815 24TH STREET ORLANDO, FL 32805	

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

compliance attestation form, and failed to file the Adverse Incident Report (1-day) with the Agency.

Findings:

On at 11:51 AM, a record review was attempted of the Adverse Incident Report. The Administrator stated no Adverse Incident Report had been written.

On 11:51 AM, an interview was conducted with the Administrator. The Administrator stated Resident #1 had eloped from the facility on around 9:00 AM. The police were notified and Resident #1 was missing over 24 hours before he was located. The Administrator stated he had not written an Adverse Incident Report, had not filed a 1-day report with the Agency, and had not conducted any investigation into the elopement. The Administrator stated no written statements had been obtained from staff regarding the elopement.

On at 11:05 AM, a review was conducted of the facility's list of all current employees. There were ten employees documented on the list. On at 2:22 PM, a review was conducted of the employee roster for the facility on the Agency for Health Care Administration Care Provider Background Screening Clearinghouse website. One name was located on the employee roster.

On at 3:20 PM, an interview was conducted with the Administrator. The Administrator was not aware of the employee roster on the Care Provider Background Screening Clearinghouse and that he was required to maintain an employee roster with the employment status of all employees of the facility within the Clearinghouse.

On at 1:47 PM, a review was conducted of the employee file for Staff B. Staff B did not have a signed compliance attestation form in the employee file.

On at 1:47 PM, a review was conducted of the employee file for Staff C. Staff C did not have a signed compliance attestation form in the employee file.

On at 3:20 PM, an interview was conducted with the Administrator. The Administrator stated he was not aware the compliance attestation forms were not in the employee files.

On at 12:28 PM an interview was conducted with Staff A, who stated a case manager came briefly to the facility at 9:00 AM to pick up a resident for an appointment, and therefore it is believed that at approximately 9:10 AM Resident #1 eloped from the facility when the case manager left. Resident #1 was not determined to be missing until approximately 11:00 AM, when Staff A stated she noticed he had not arrived at lunch and went looking for him in his . **Staff A** stated she reviewed the video with law

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967551	05/19/2016
NAME OF PROVIDER OR SUPPLIER **SAN JEAN FACILITY CARE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **815 24TH STREET** **ORLANDO, FL 32805**	

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

enforcement and verified he had left the facility as the car was leaving the property.

On at 11:51 AM, a record review was conducted of the Agency health assessment form 1823 for Resident #1. The 1823 had not been filled out completely. The area where it identifies if the resident is an elopement risk or not was not completed. (Photo 3).

On at 11:51 AM, an interview was conducted with the Administrator. The Administrator stated he had not completed the 1-day Adverse Incident Report regarding the incident and had not filed it with the Agency. The Administrator stated an investigation into how the elopement occurred had not been initiated. The Administrator stated he had been told by Staff A that Resident #1 appeared to have left the property when the front gate was opened for a car to leave the gated property. The Administrator stated he was not exactly sure who had let the vehicle out of the facility when Resident #1 eloped. The Administrator stated no retraining has been completed or planned for the staff to ensure this did not happen again. The Administrator stated no one had been written up or disciplined regarding the incident. The Administrator stated the resident had not been an elopement risk. The Administrator stated he was not aware that the 1823 had not been filled out completely. The Administrator stated he thought that was the physician's responsibility, not his.

On at 12:43 PM, an interview was conducted with Staff B. Staff B stated she let a car exit the facility though the gate, but she was not sure of the exact time. Staff B was aware she was required to watch the car exit, verify no residents exited, and then watch the gate close. Staff B stated she heard Staff A call for assistance, so she failed to watch the gate and went to assist Staff A. Staff B stated she was not written up, and she was not retrained on any policies or procedures. Staff B stated she told the Administrator she would "be more careful".

On at 3:30 PM, an interview was conducted with Resident #1's case manager. The case manager stated Resident #1 was an elopement risk and Resident #1 had been moved to this facility because the property was gated. The case manager stated Resident #1 had eloped from his previous facility, and the facility was informed of this upon his admission.

On at 1:23 PM, an interview was conducted with the Administrator of Resident #1's former facility. The Administrator of the previous facility stated Resident #1 had eloped and was missing for three days.

On at 11:51 AM a record review was conducted of the resident file for Resident #1. The 1823 was not filled out completely. The area on the form designating if the resident is an elopement risk or not was not filled out. (Photo 3).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967551	05/19/2016
NAME OF PROVIDER OR SUPPLIER SAN JEAN FACILITY CARE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 815 24TH STREET ORLANDO, FL 32805	

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

On [redacted] at 11:51 AM, an interview was conducted with the Administrator. The Administrator stated he was not aware the area of the 1823 showing if the resident is an elopement risk was not filled out. The Administrator stated he thought that was the physician's responsibility.

On [redacted] at 11:20 AM, a review was conducted of the facility's elopement policy. An elopement drill was to be completed twice a year on each shift and documented. "The administrator and/or administrator's designee will complete the Elopement/Missing Resident Drill Form and evaluation at the time of the drill. The entire staff will be briefed as to the results of the drill and when applicable, will be in-serviced, as needed." The last documented elopement drill was on [redacted], 2010. The facility's elopement policy also stated, "File Adverse Incident Report (1 Day) - to be faxed to Tallahassee within 24 hours by the Administrator or Manager or predetermined staff. " (Photos 4-10).

On [redacted] at 11:51 AM, a review was attempted of the facility's 1-day Adverse Incident Report related to the incident. A 1-day report had not been completed.

On [redacted] at 11:51 AM, an interview was conducted with the Administrator. The Administrator stated he had not completed the 1-day Adverse Incident Report regarding the incident and had not filed it with the Agency. The Administrator stated an investigation into how the elopement occurred had not been initiated. The Administrator stated he had been told by Staff A that Resident #1 appeared to have left the property when the front gate was opened for a car to leave the gated property. The Administrator stated he was not exactly sure who had let the vehicle out of the facility when Resident #1 eloped. The Administrator had not conducted any retraining, and had not planned any retraining for his staff.

On [redacted] at 12:15 PM, an interview was conducted with Staff C. Staff C stated he had not received any formal elopement training when hired. Staff C has not participated in any elopement drills since he was hired.

On [redacted] at 12:30 PM, a review was conducted of the facility's policy on reporting [redacted], neglect, and [redacted]. An addendum handwritten at the bottom of the policy, dated [redacted] read, "If patient of (the facility) has been identified as elopement risk will be placed on every 15 minute safety monitoring checks see attached form." (Photos 5-7).

On [redacted] at 12:43 PM, an interview was conducted with Staff B. Staff B stated she let a car exit the facility though the gate, but she was not sure of the exact time. Staff B was aware she was required to watch the car exit, verify no residents exited, and then watch the gate close. Staff B stated she heard Staff A call for assistance, so she failed to watch the gate and went to assist Staff A. Staff B stated she had been employed at the facility for over a year. Staff B stated she had not participated in any elopement drills.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967551	05/19/2016
NAME OF PROVIDER OR SUPPLIER SAN JEAN FACILITY CARE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 815 24TH STREET ORLANDO, FL 32805	

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

On at 1:01 PM, an interview was attempted with Resident #1. Resident #1 was not able to answer any questions regarding the elopement. Resident #1 did not remember Tuesday, . Resident #1 did not remember leaving the facility.

Class II

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interviews, the facility failed to file the required Adverse Incident Report to the agency for an elopement (#1) reported to law enforcement for investigation, within one day business day.

Findings:

On at 11:51 AM, a record review was attempted of the Adverse Incident Report. The Administrator stated an Adverse Incident Report had not been written.

On 11:51 AM, an interview was conducted with the Administrator. The Administrator stated Resident #1 had eloped from the facility on around 9:00 AM. The police were notified and Resident #1 was missing over 24 hours before he was located. The Administrator stated he had not written an adverse incident report, had not filed a 1-day report with the Agency, and had not conducted any investigation into the elopement. The Administrator stated no written statements had been obtained from staff regarding the elopement.

Class III

Z814 Background Screening Clearinghouse

Based on interview and record review, the facility failed to maintain an employee roster with the employment status of all employees of the facility within the Clearinghouse.

Findings:

On at 11:05 AM, a review was conducted of the facility's list of all current employees. There were ten employees documented on the list.

On at 2:22 PM, a review was conducted of the employee roster for the facility on the Agency

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967551	**05/19/2016**
NAME OF PROVIDER OR SUPPLIER **SAN JEAN FACILITY CARE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **815 24TH STREET ORLANDO, FL 32805**	

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

for Health Care Administration Care Provider Background Screening Clearinghouse website. One name was located on the employee roster.

On [redacted] at 3:20 PM, an interview was conducted with the Administrator. The Administrator was not aware of the employee roster on the Care Provider Background Screening Clearinghouse or that he was required to maintain an employee roster with the employment status of all employees of the facility within the Clearinghouse.

Unclassified

Z816 Background Screening-Compliance Attestation

Based on interview and record review, the facility failed to ensure that 2 out of 3 (B & C) sampled staff who have contact with the residents and require a Level II background screening had signed the compliance attestation form and the facility had failed to place it in their employee files.

Findings:

On [redacted] at 1:47 PM, a review was conducted of the employee file for Staff B. Staff B did not have a signed compliance attestation form in the employee file.

On [redacted] at 1:47 PM, a review was conducted of the employee file for Staff C. Staff C did not have a signed compliance attestation form in the employee file.

On [redacted] at 3:20 PM, an interview was conducted with the Administrator. The Administrator stated he was not aware the compliance attestation forms were not in the employee files.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
San Jean Facility Care, Inc.
815 24th Street
Orlando, FL 32805

Dear Administrator:

This letter reports the findings of a complaint, CCR# 2016005120, inspection survey conducted , 2016 through , 2016, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's request as directives below:

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0025 - 429.26(7) FS; 58a-5.0182(1) Fac- Resident Care - Supervision Class II
St - A -0077 - 429.176 FS; 58A-5.019(1) Fac - Staffing Standard - Administrators Class II
St – A – Z814 -435.12(2) (b-d) FS Background Screening Clearinghouse. Unclassified
St – A – Z816 - 408.809(2) (a-c) FS Background Screening-Compliance Attestation. Unclassified

Directed Corrective Actions:

1. A Registered Nurse who is familiar with the Florida Assisted Living Facility rules and regulations will conduct an elopement risk assessment for all residents in the Assisted Living Facility by , 2016.

2. The Assisted Living Facility Administrator will review and revise the facility elopement/missing person policy and procedure. The policy must contain, at a minimum:

a) specific conditions and timeframes indicating when a resident absence is considered an elopement;
b) specific timeframes for notifying law enforcement and family/responsible party;
c) and specific requirements for all staff on tasks and documentation.

This will be completed by the Assisted Living Facility Administrator no later than , 2016.

3. All Assisted Living Facility staff will be trained on the elopement procedures and will participate in elopement drills. These drills will be conducted on all shifts. This training and these elopement drills will be completed by no later than , 2016. These drills will be held

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

at a minimum every six months from this point going forward. Documentation of the training and elopement drills, including content and sign-sheets must be available at any time for review by the Agency upon request.

4. Facility administration will assess the facility policy and practice of periodic checks of residents, with special emphasis on all new admissions, residents with significant changes, and residents with behavioral patterns of exit seeking. This will be completed by the Assisted Living Facility Administrator no later than , 2016.

5. The facility will develop and implement system(s) to ensure the vehicle gate and exit doors are monitored in order to minimize the risk of resident elopement. The Assisted Living Facility Administrator will continually evaluate the effectiveness of the system(s) utilized to monitor the facility's vehicle gate and exit doors and make changes when necessary to ensure that the system(s) are meeting the needs of the residents. There will be an effective system(s) in place to monitor vehicle exit gates and all exit doors no later than , 2016. Monitoring the effectiveness of the system(s) will be ongoing. Documentation of the monitoring must be available at any time for review by the Agency upon request.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Lorraine Henry, Health Facility Evaluator Supervisor or Theresa DeCanio, Field Office Manager, Orlando Field Office, (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
San Jean Facility Care, Inc
815 24th Street
Orlando, FL 32805

RE: CCR #2016005120

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2016, through , 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 Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

XG90

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com