STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968351	**06/22/2016**
NAME OF PROVIDER OR SUPPLIER **HOUSE OF LIGHT SENIOR LIVING, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2638 JUPITER BLVD SW** **PALM BAY, FL 32908**	

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

0000 Initial Comments

Re-licensure survey was conducted on . . House of Light Senior Living, LLC (License #12240) had a deficiency found at the time of the visit.

0162 Records - Resident

Based on record review and interview, the facility failed to ensure a 6-month weight records were obtained for 1 out of 2 sampled resident records reviewed (R2).

Findings:
Resident #2's record review revealed a health assessment (AHCA 1823) dated / . The current health assessment indicated that the resident needed assistance for all categories of activities of daily living (ADL). The resident's record showed only 3 weight records. They were taken on / , the resident weighed 102.5 pounds (lbs.), 84 lbs., and / 84 lbs.
On at 4:30 PM the administrator stated that the facility stopped weighing the resident in 2014. The resident was weighed at her doctor's office when she had been assessed. The administrator further stated that the facility could not weigh the resident because the resident could not stand up. The resident had been under hospice services. The administrator could not locate weight records from the hospice file.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
House Of Light Senior Living, LLC
2638 Jupiter Blvd SW
Palm Bay, FL 32908

RE: Re-licensure survey

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.

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

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