STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11967289 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AJR LOVING CARE ASSISTED LIVING	5900 DEAN ROAD OVIEDO, FL 32765

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 A0010	Correction	ID Prefix A0078	Correction	ID Prefix A0079	Correction
Reg. # 429.26(1&9) FS; 58A-5.0181(4) FAC	Completed	Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.019(3) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0082	Correction	ID Prefix A0084	Correction	ID Prefix	Correction
Reg. # 58A-5.0191(3) FAC	Completed	Reg. # 58A-5.0191(5) FAC	Completed	Reg. #	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	
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 7/21/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
3/29/2016	

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967289	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJR LOVING CARE ASSISTED LIVING	5900 DEAN ROAD OVIEDO, FL 32765

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

0000 Initial Comments

A 2nd revisit to the relicensure survey was conducted on . AJR Loving Care Assisted Living (License #11356) had deficiencies found at the time of the visit.

0054 Medication - Records

Based on observation, record review and interview, the facility failed to ensure resident#2's medications were not pre-poured and the medication observation records (MOR) were not initialed prior to giving medications to the resident.
Findings:
On at 9:45 a.m. Staff D/care giver who worked from 8 am-8am (24-hr shift) on was observed sitting in the owner's office. In front of Staff D was a plastic cup filled with pills. Staff D was putting her initials on the MOR. When asked what she was doing, she stated that she was preparing the 8 AM medications for Resident #2. She stated that she had always pre-poured medications and initialed the MOR when she took each pill out of its original container. Then she would take the cup to the resident. She stated that she initialed the MOR in advance to make sure she took the correct pill out. She said that she was not aware that she should not pre-pour medications and she should initial the MOR only after the resident taking each pill.
On / at 9:50 a.m. the owner walked in and observed the same. She confirmed that Staff D had not followed proper medication pass procedure.
Class III

0077 Staffing Standards - Administrators

DEFICIENCY REMAINED UNCORRECTED.

Based on record review and interview, the facility did not make sure the Manager satisfied all the assisted living core training requirements. "Manager" means an individual who was authorized to perform the same functions of the administrator, and was responsible for the operation and maintenance of an assisted living facility while under the supervision of the administrator of that facility.

Findings:

The manager's personnel file was reviewed again on / . It still did not have evidence she had attended the core training.

On at 11:55 a.m. the owner/manager stated that she was not the manager. She was a

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	AL11967289	R
NAME OF PROVIDER OR SUPPLIER **AJR LOVING CARE ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **5900 DEAN ROAD** **OVIEDO, FL 32765**	

SUMMARY STATEMENT OF DEFICIENCIES
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co-owner who filled in among her 3 assisted living facilities.

Class III

0093 Food Service - Dietary Standards

DEFICIENCY REMAINED UNCORRECTED.

Based on observation, record review and interview, the facility still did not 1) date the menus for the week in use 2) keep substitutions menus on file in the facility for 6 months.

Findings:

On observation was made on at 9:30 a.m. in the kitchen. It revealed the following:
1) The menus used by the facility for the week still did not have dates on them. The one posted on the refrigerator indicated it was Cycle 2. Also there were 2 menus posted on a bulletin board by the dining table. Both showed Cycle 1.

2) The facility still could not provide 6-month substitution menus.

On at 10:15 a.m. the owner/manager stated that her staff knew what menus cycle to use for what week. She also stated that she could not locate the substitution menus that her staff had used.

Class III

0167 Resident Contracts

DEFICIENCY REMAINED UNCORRECTED.

Based on record review and interview, the facility still failed to ensure that 2 of 2 sampled residents (1&2) contracts contained all the required components.

Findings:

On / Resident#1's and #2's contracts were reviewed again.

Resident#1's record review revealed the contract dated / . It did not contain a refund policy; bed hold policy; a provision indicating the residents must be assessed upon admission pursuant to

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SUMMARY STATEMENT OF DEFICIENCIES
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subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change; what services were included in the monthly rate; the Limited Nursing Services (LNS) the facility would provide and the cost of those services; and whether or not the facility had any religious affiliations.

Resident#2's record review revealed the contract dated I/ . . It did not indicate whether or not the facility had any religious affiliations; a provision indicating the residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change; what services were included in the monthly rate; the Limited Nursing Services (LNS) the facility would provide and the cost of those services.

On . . at 10:45 a.m. the owner/manager confirmed the findings.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Ajr Loving Care Assisted Living
5900 Dean Road
Oviedo, FL 32765

RE: Relicensure with Limited Nursing Services

Dear Administrator:

This letter reports the findings of a **second** State Licensure Revisit Survey conducted on 13, 2016 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **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(s). Should you have any questions please call Lorraine Henry at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

YOSF

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