

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 08/09/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922141	(X3) DATE SURVEY COMPLETED 07/26/2016
NAME OF PROVIDER OR SUPPLIER RENAISSANCE RETIREMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 WEST AIRPORT BLVD. SANFORD, FL 32771	

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

0000 Initial Comments

A Complaint Investigation # 2016005056 was conducted on . Renaissance Retirement Center (License # 5815) had deficiencies at the time of the visit.

0025 Resident Care - Supervision

Based on Observation, Record Review and Interview, that facility failed to follow provider orders for 1 of 4 reviewed records (#2) and did not obtain a urinalysis for a resident as ordered.

Findings:

Record Review on for resident #2 revealed a provider order dated for a Urinalysis, plus Culture and Sensitivity, for a diagnosis of . Further review of the record did not find results from this lab test.

In an interview with the Resident Wellness Director on at 2:44 pm, she stated that she looked everywhere for the results, called the lab, the facility used and called the Home Health Agency, but she is unable to locate results or provide proof that the test was done.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

August 10, 2016

Administrator
Renaissance Retirement Center
300 West Airport Blvd.
Sanford, FL 32771

RE: CCR #2016005056

Dear Administrator:

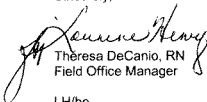
This letter reports the findings of a state licensure complaint investigation survey that was conducted on August 10, 2016 by representative(s) of this office.

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 August 19, 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 (407) 245-2502.

Sincerely,


Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

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