

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 09/27/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911313	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER ALABAMA OAKS OF WINTER PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1759 ALABAMA DRIVE WINTER PARK, FL 32789	

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

0000 Initial Comments

A follow-up visit to a biennial re-licensure survey was conducted at Alabama Oaks of Winter Park (license number 37) on . Alabama Oaks of Winter Park had deficiencies at the time of the visit.

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview, the facility failed to treat 1 in 17 residents with consideration and respect by restraining him in a recliner chair with tray that he was unable to remove (#8). Findings:

On at 10:01AM, Resident #8 was seated in the living a Gerry chair with the tray attached. He was attempting to remove the tray, but was unable. He was not eating breakfast and no one was attending to him. He was positioned in front of the TV. The caregiver on duty called the administrator to let her know we were there, and then removed the tray from resident #8. She then moved him to a reclining position, where he continually and unsuccessfully struggled to sit up. At 10:35 AM on / , the administrator stated that the resident just uses the tray for eating, but confirmed that he was not eating at the time we arrived and saw him in the living . She confirmed that he was unable to remove the tray himself. She said he is ambulatory with assistance and sometimes eats at the dining table with the other residents. She also stated he was receiving hospice services and that his wife lived independently in the back of the property and liked to come visit him every day.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11911313	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
NAME OF FACILITY ALABAMA OAKS OF WINTER PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1759 ALABAMA DRIVE WINTER PARK, FL 32789	

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 A0084	Correction	ID Prefix A0161	Correction	ID Prefix AZ814	Correction
Reg. # 58A-5.0191(5) FAC	Completed	Reg. # 429.275(2) FS; 58A-5.024(2) FAC	Completed	Reg. # 435.12(2)(b-d), FS	Completed
LSC		LSC		LSC	
ID Prefix AZ815	Correction	ID Prefix AZ827	Correction	ID Prefix	Correction
Reg. # 408.809, 435.02(2), 435.06	Completed	Reg. # 408.812, FS	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 9/6/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO	☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 8/7/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
---	--



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Alabama Oaks Of Winter Park
1759 Alabama Drive
Winter Park, FL 32789

RE: Revisit to Re-licensure survey

Dear Administrator:

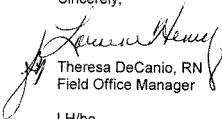
This letter reports the findings of a revisit survey conducted on 26, 2016, by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

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. Should you have any questions please call this office at (407) 420-2502.

Sincerely,



Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0988
AHCA.MyFlorida.com



BBT7

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