STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968726	**10/19/2016**
NAME OF PROVIDER OR SUPPLIER **SPRING PINE LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1324 MILL RD KISSIMMEE, FL 34744**	

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

0000 Initial Comments

A re-licensure Survey was conducted on . Spring Pine LLC Assisted Living Facility (License#12580) had deficiencies at the time of the visit.

0008 Admissions - Health Assessment

Based on resident record review and interview, the facility failed to ensure the original admission Health Assessment AHCA form 1823 for 1 of 3 sampled residents (#4) was dated by the physician.

Findings:

Record review for resident #4 revealed the Health Assessment (1823) was not dated by the physician who completed the form. Date of Admission /

On / at 3 PM, during an interview with the administrator who confirmed that the "no date" on the Health Assessment (1823) was overlooked.

Class III

0010 Admissions - Continued Residency

Based on record review and interview, the facility failed ensure the Health Assessment (1823) was accurately completed and correct by the physician for continued residency regarding Activities of Daily Living (ADLs) and type of assistance for Self-Administration of Medication for 1 of 3 sampled residents (#1).

Findings:

Record review for resident #1 revealed the most recent 1823 dated / did not indicate the type of assistance needed with the resident's Activities of Daily Living (ADLs). , toileting, and transfer were not addressed on the form. The above were left blank on the form.

Furthermore, the 1823 revealed no type of medication assistance documented for #1, that is required for self-administration or administration of medication.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Spring Pine LLC
1324 Mill Rd
Kissimmee, FL 34744

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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