STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967056	01/19/2017
NAME OF PROVIDER OR SUPPLIER **KARE ASSISTED LIVING, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2715 UINTAH AVENUE** **ORLANDO, FL 32805**	

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

0000 - Initial Comments

A Complaint Investigation CCR#2016012711 was conducted on / . Kare Assisted Living, LLC (License #11143) had deficiencies at the time of the visit.

0160 - Records - Facility - 58A-5.024(1) FAC

Based on the facility's admission & discharge log and interview, the facility failed to maintain an accurate admission & discharge log by listing 2 of 4 sampled residents (#1 & #3).

Findings:

Resident #1's name was listed on the log, but revealed no admission date and no discharge date documented.

Resident #3 was not listed on the log at all.

On / at 3 PM, an interview with the administrator who confirmed the findings.

Class III

L241 - LMH - Records - 429.075(3-4); 58A-5.029(2) FAC

Based on resident record review and interview, the facility failed to maintain a completed ( ) form, CF-ES Form 1006 for 2 of 4 sampled residents (#1 and #2).

Findings:

Both resident #1 & #2 record reviews revealed no completed CF-ES Form 1006 in their files.

An interview on / at 3 PM with the administrator who confirmed the findings.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Kare Assisted Living, LLC
2715 Uintah Avenue
Orlando, FL 32805

RE: CCR #2016012711

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2017 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 , 2017.** 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) 420-2502.

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

Sincerely,

Theresa DeCanio, RN
Field Office Manager

TDC:clr
Enclosure

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