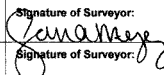


State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11932662	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 8/5/2015
Name of Facility FLORIDA SHORES ASSISTED LIVING	Street Address, City, State, Zip Code 1229 MANGO TREE DRIVE EDGEWATER, FL 32132	

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 codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0007</u> Reg. # <u>429.26(11) FS: 58A-5.0181(</u> LSC _____	Correction Completed	ID Prefix <u>A0025</u> Reg. # <u>429.26(7) FS: 58A-5.0182(1</u> LSC _____	Correction Completed	ID Prefix <u>A0026</u> Reg. # <u>58A-5.0182(2) FAC</u> LSC _____	Correction Completed
ID Prefix <u>A0030</u> Reg. # <u>58A-5.0182(6) FAC: 429.28</u> LSC _____	Correction Completed	ID Prefix <u>A0053</u> Reg. # <u>58A-5.0185(4) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0055</u> Reg. # <u>58A-5.0185(6) FAC</u> LSC _____	Correction Completed
ID Prefix <u>A0078</u> Reg. # <u>58A-5.019(2) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0160</u> Reg. # <u>58A-5.024(1) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0162</u> Reg. # <u>58A-5.024(3) FAC</u> LSC _____	Correction Completed
ID Prefix <u>A0167</u> Reg. # <u>58A-5.025 FAC</u> LSC _____	Correction Completed	ID Prefix <u>AZ815</u> Reg. # <u>408.809, 435.02(2), 435.06</u> LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
Reviewed By _____ State Agency _____ Reviewed By _____ CMS RO _____	Reviewed By _____	Date: _____ Signature of Surveyor: 	Date: <u>8/7/15</u>	Followup to Survey Completed on: _____ Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO	

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 08/07/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932662	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER FLORIDA SHORES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1229 MANGO TREE DRIVE EDGEWATER, FL 32132	

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

0000 Initial Comments

An unannounced revisit to the biennial licensure survey was conducted at Florida Shores Assisted Living on 08/07/2015.
Deficiencies were identified.

0008 Admissions - Health Assessment

Based on resident record reviews and staff interview, the facility failed to obtain complete information for 1 of 4 residents (Resident #6) whose Resident Health Assessments (AHCA form 1823) were reviewed.

The findings included:

Record review for Resident #6 found a Resident Health Assessment dated 08/07/2015 and signed by the examiner. The examiner failed to indicate whether the resident required assistance with the self-administration of medication, and if so, what level of assistance she required. Section 3, which was required to be completed by the Administrator to specify the services offered to the resident, was missing entirely.

An interview was conducted with the Administrator at 12:00 pm. He reviewed the record, and confirmed the missing information on Resident #6's health assessment. He stated he would have it corrected.

Class III



RICK SCOTT
GOVERNOR
ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Florida Shores Assisted Living
1229 Mango Tree Drive
Edgewater, FL 32132

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2015 by a representative 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.

All deficiencies shall be corrected no later than , 2015.

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 (904) 798-4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LL/JM/sm
Enclosure

BB17

