STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932514	07/20/2015
NAME OF PROVIDER OR SUPPLIER **BROOKSHIRE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **85 BULLDOG BLVD.** **MELBOURNE, FL 32901**	

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

0000 Initial Comments

The re-licensure survey including Limited Nursing Services and Extended Congregate Care was conducted on . The Brookshire Assisted Living Facility had deficiencies found at the time of the visit.

0025 Resident Care - Supervision

Based on observation, record review and interview, the facility failed to ensure that the health care providers were notified of change in condition for 3 of 5 sampled residents (#1, 3 & 5).

Findings:

1. Record review for resident #1 revealed a physician's order date , 2015 that noted the following:
before meals and at bedtime with Sliding Scale:
151-200 sugar (BS) = 2 units
201-250 BS - 4 Units
251-300 BS - 6 Units
301-350 BS - 8 Units
351-400 BS - 10 Units
greater than 400 BS - 12 units and notify physician
Less than 70 BS - notify physician

Review of the medication observation records (MORs) from and revealed the following results.
at 4:30 PM - BS = 406
at ____ - BS = 445
at 9 PM - BS = 492
at 4:30 PM - BS = 471
at ___ - BS = 477
at 9 PM - BS = 417
at ___ - BS = 412
at ___ - BS = 423
There was no documentation to confirm that the physician was contacted for further instructions.

Review of the 2015 MOR revealed the order to contact the physician when the BS was less than 70. On / at 6:30 AM, the BS was 60 but there was no documentation that the physician was contacted. The back of the MOR read, / - 0600 BS = 60 Snack given."

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

On / at 5:10 PM, the administrator reviewed the MOR and stated the order to contact the physician when the BS was less than 70 was not written on the MOR. She stated the staff did not follow the orders to call the physician when the BS results were greater than 400 and less than 70.

2. During the entrance conference on , the administrator indicated resident #3 was receiving Limited Nursing Services for use.
On at approximately 11:15 AM, resident #3 stated, "The nurses check on the when they come here. It should be at 3 liters."
On at approximately 11:30 AM, the concentrator was observed. It was set at 4 liters per minute.
On / at approximately 11:40 AM, the administrator/registered nurse was made aware of the setting.
Resident #3's record review revealed a health assessment report dated / and an updated health assessment dated / that indicated diagnoses including (. The resident was alert and oriented to person, place and time. The health assessment dated indicated at 2 liters per minute continuously but the / updated assessment did not address the resident's use of .
A physician's order dated indicated at 2 liter per minute. A physician's order sheet (POS), signed by a licensed practical nurse and not the physician, indicated at 2 liters per minute. A health assessment report dated indicated at 3 litter per minute. A physician's note dated / read, "His saturation today is 95% on 3 litters with some intermittent coughing and ."
The Limited Nursing Services (LNS)/Extended Congregate Care (ECC) progress notes dated to / / for the 7 AM-3 PM, 3 PM-11 PM and 11 PM -7 AM shifts and on / for the 11 PM-7 AM shift revealed that the notes originally documented the resident had on at 2 liters per minute and all notes had been changed to indicate at 3 liters per minute. The number 3 had been written over the number 2 but the number 2 it was still visible. Evidence to confirm that a physician's order for the use of and 3 liters per minute was not available.
On at approximately 5:30 PM, the administrator stated the resident was on 3 liters of per minute continuously.
The administrator provided an order dated , the day of the survey, that read, "OK for resident to have at 3 liter per minute via nasal cannula."

3. On / at approximately 12:45 PM, resident #5 stated the facility had frequently run out of her medication for pain, and sometimes she did do not get it for 3-4 weeks. She stated on / at 6 PM, she was in severe pain, was not able to sleep at night, her whole body hurt, and had pain when the bedsheets touched her, when she did not have her .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932514	07/20/2015
NAME OF PROVIDER OR SUPPLIER **BROOKSHIRE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **85 BULLDOG BLVD.** **MELBOURNE, FL 32901**	

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

Resident #5's record revealed an Assisted Living Facility Health Assessment form (1823) dated / / that indicated diagnoses of dependent and left leg . The resident needed assistance with self-administration of medications.

Review of the 2015 and 2015 MORs revealed the following:
/ 5-325 milligrams (mg.) at bedtime (9 PM) was not available on / through / /, and on / through / . The boxes on the MOR were circled, and the back of the MOR read the medication was not available. Review of physician order dated revealed / 5-325 mg. at bedtime.
, for lipids, 20 mg. daily was not available at 9 PM on / / and / . The boxes on the MOR were circled, and the back of the MOR stated the medication was not available. Review of the physician's order dated / / revealed 20 mg. daily.
, pain medication, 50 mg. one three times a day was not available on / at 5 PM and on 5 PM and at 9 AM. The boxes on the MOR were circled, and the back of the MOR read the medication was not available. Review of physician order dated revealed 50 mg. three times a day.

On / at approximately 3:45 PM, the administrator said she was not aware the physician orders for the the above medications were not followed.

Class II

0054 Medication - Records

Based on record review and interview, the facility failed to maintain up-to-date medication observation reviews (MORs) for 3 of 5 sampled residents (#1, 2 & 3).
Findings:
1. On at approximately 11:15 AM, resident #3 said that the nurses give him , depending on the sugar (BS) results.

Resident #3's record review revealed a heath assessment report dated / and an updated health assessment dated that indicated diagnoses including . He was alert and oriented to person, place and time. A hospital discharge summary dated / included an order for sliding scale to be obtained before all meals and at bedtime.

The 2015 MOR included daily BS results as ordered but the amount of given to the resident was not documented every time the nurses gave the based on the BS results.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932514	07/20/2015
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

The 2015 MOR dated / to listed injection before meals per sliding scale at 6:30 AM, 11:30 AM and 4:30 PM was follows: 151- 175 BS - 2units (u); 176-200 BS - 3u; 201-225 BS - 4u; 226-250 BS - 5u; 251-275 BS - 6u; 276-300 BS - 7u; 301-325 BS - 8u; 326-350 BS - 9u; greater than (>) 350 -10u.

This MOR indicated the following BS results: at 6:30 AM = 307; at 6:30 AM = 365; at 11:30 AM = 315; at 11:30 AM = 215; 70/3 at 4:30 PM = 498; and at 4:30 PM = 357.

The 2015 MOR listed Novolg sliding scale at bedtime for 9 PM as follows: 201-225 BS - 4u; 226-250 BS - 5u; 251-275 BS - 6u; 276-300 BS -7u; 301-325 BS - 8u; 326-350 BS - 9u; >350 BS -10u.

This MOR indicated the following BS results at 9 PM: = 259, = 428, = 245, = 346, / = 248, and / = 201.

2. Resident #1's record review revealed a physician's order sheet for with the following parameters before meals and at bedtime with Sliding Scale: 151-200 BS - 2u; 201-250 BS - 4u; 251-300 BS -6u; 301-350 BS - 8u; 351-400 BS - 10u; >400 BS - 12u and notify physician; Less than (<) 70 - notify physician.

Review of the MOR for and revealed both MORs had the same order as above. The MORs for and were noted as above with the exception of the order to call the physician when the BS was <70. This was not on the MOR.

The , 2015 MORs revealed times when the BS results required but there was no documentation to confirm that was given at 11:30 AM: BS = 193, BS = 349, BS = 394, BS = 334.

The , 2015 MORs revealed times when the BS results required but there was no documentation to confirm that was given at 4:30 PM: BS = 397, BS = 67, and BS = 294.

The , 2015 MORs revealed times when the BS results required but there was no documentation to confirm that was given at 9 PM: BS = 492 and BS = 445.

The 2015 MOR revealed times when the BS results required but there was no documentation to confirm that was given at 11:30 AM: BS = 292, BS = 377, BS = 259, and BS = 270.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932514	07/20/2015
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

The 2015 MOR revealed times when the BS results required but there was no documentation to confirm that was given at 4:30 PM: BS = 293, BS = 293, and BS = 477.

The 2015 MOR revealed times when the BS results required but there was no documentation to confirm that was given at 9 PM: BS = 335, BS = 341, BS = 330, BS = 423.

The 2015 MOR revealed times when the BS results required but there was no documentation to confirm that was given at at 6:30 AM: BS = 224, BS = 185, BS = 152, and BS = 198.

The 2015 MOR revealed times when the BS results required but there was no documentation to confirm that was given at at 11:30 AM: BS = 199, BS = 192, and BS = 154.

The 2015 MOR revealed times when the BS results required but there was no documentation to confirm that was given at 4:30 PM: BS = 330, BS = 328, BS = 330, BS = 408, and BS = 65.

The 2015 MOR revealed times when the BS results required but there was no documentation to confirm that was given at at 9 PM: BS = 377, BS = 371, BS = 375, BS = 285, BS = 490, BS = 355.

The 2015 MOR revealed times when the BS results required but there was no documentation to confirm that was given at 6:30 AM: BS = 196, / BS = 176.

The 2015 MOR revealed times when the BS results required but there was no documentation to confirm that was given at 11 AM: / BS = 155.

The 2015 MOR revealed times when the BS results required but there was no documentation to confirm that was given at 4 PM: BS = 317, / BS = 261, / BS = 212, and / BS = 239.

On / at approximately 5:10 PM, the administrator stated the residents did receive their as ordered and confirmed the units were not written on the MOR when they received the . She stated the order to call the physician when the BS was <70 for resident #1 was left off the MOR for

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932514	07/20/2015
NAME OF PROVIDER OR SUPPLIER **BROOKSHIRE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **85 BULLDOG BLVD.** **MELBOURNE, FL 32901**	

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

and .

3. Resident #2's record review revealed an Assisted Living Facility Health Assessment form (1823) updated on that indicated diagnoses of head and . The resident needed assistance with self administration of medications.

Review of the 2015 MOR revealed the resident received for 0.25 milligrams (mg.) on / at 6 PM and 7 PM. There were initials in the box on the MOR. Review of the sign out sheet revealed was given once at 7 PM on / / . THE MOR WAS NOT CORRECT, RESIDENT DID NOT GET 6 PM DOSE???

Review of physician order dated / / revealed for 0.25 mg daily as needed for . The MOR was not accurate.

On / at approximately 3:45 PM, the administrator stated the MOR was not accurate and should read, at 6 PM."

Class III

0056 Medication - Labeling and Orders

Based on record review and interview, the facility did not make every reasonable effort to ensure that prescriptions were filled or refilled in a timely manner for 2 of 5 sampled residents (#4 & 5). Resident #5 Suffered pain needlessly. Both residents received assistance with self-administration of medications.

Findings:

1. Resident #4's record revealed that she received assistance with the self-administration of medication. A physicians order dated was seen for Ensure drink 1 can twice daily.
Review of the medication observation record (MOR) for and revealed that the Ensure was not available on the following days: 8 AM and 1 PM on , 10 and / and at 9 AM and 1 PM on .

On / at 5:10 PM, the administrator stated the family was responsible for purchasing the Ensure. She stated the facility would only provide the house shakes. She stated the staff did contact the family to bring it in to the facility and did not document their attempts. She stated the staff did not contact the physician to ask if the resident could have the house shakes that the facility provided. Documentation to confirm that the family was responsible for providing the Ensure was not found in the resident's medical

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932514	07/20/2015
NAME OF PROVIDER OR SUPPLIER **BROOKSHIRE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **85 BULLDOG BLVD.** **MELBOURNE, FL 32901**	

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

record.

2. In an interview on at approximately 12:45 PM, resident #5 stated the facility had frequently run out of her , a pain medication, and sometimes she did do not get it for 3-4 weeks. She stated on at 6 PM that she was in severe pain, was not able to sleep at night, her whole body hurt, and she had pain when the bed sheets touched her, when she did not have her

Resident record review revealed an Assisted Living Facility Health Assessment form (1823) dated that indicated diagnoses of dependent and left leg . The resident needed assistance with self-administration of medications.
Review of the 2015 and 2015 Medication Observation Records (MORs) revealed the following medications:
5-325 milligrams (mg.) at bedtime was not available on through , and on through at 9 PM. The boxes on the MOR were circled, and the back of the MOR stated the medication was not available. The physician's order, dated , read "
5-325 mg. at bedtime."
, for lipids, 20 mg. daily was not available at 9 PM on and . The boxes on the MOR were circled, and the back of the MOR read that the medication was not available. The physician's order, dated , read " (for lipids) 20 mg. daily."
, a pain medication 50 mg. three times a day was not available on at 5 PM and on 5 PM and at 9 AM. The boxes on the MOR were circled, and the back of the MOR read that the medication was not available. The physician's order, dated , read " 50 mg. three times a day."

On at approximately 3:45 PM, the administrator said she was not aware of that the above medications were not refilled in a timely manner.

Class II

0093 Food Service - Dietary Standards

Based on observation and interview, the facility failed to ensure there was a three day emergency supply of non-perishable milk on hand met the requirements.

Findings:

Observation revealed the facility had 158 quarts of non-perishable milk on hand. The facility has 109

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932514	07/20/2015
NAME OF PROVIDER OR SUPPLIER **BROOKSHIRE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **85 BULLDOG BLVD.** **MELBOURNE, FL 32901**	

SUMMARY STATEMENT OF DEFICIENCIES
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residents and needed 3 cups of milk x 3 days for 109 residents. That would require the facility to have 245 quarts on hand. The facility needed an additional 87 quarts of milk.

On at approximately 2 PM, the food service manager said he was not aware the facility did not have the required amount of non-perishable milk in the emergency food supply.

Class III

0163 Records - Resident. Penalties for Alteration

Based on observations, interviews and record review, the facility failed to ensure that 1 of 5 sampled resident record was not altered or defaced (#3).

Findings:

During the entrance conference, the administrator identified resident #3 as receiving Limited Nursing Services for use.

On at approximately 11:15 AM, resident #3 stated, "The nurses check on the when they come here. It should be at 3 liters."

Observation on / at approximately 11:30 AM noted the concentrator set at 4 liters per minute. On / at approximately 11:40 AM, the administrator/registered nurse was made aware of the setting. She stated the nurse would go check on it.

Resident #3's record review revealed a heath assessment report, dated / , and an updated health assessment, dated , that indicated diagnoses of , high , and . He was alert and oriented to person, place and time. The health assessment, dated , indicated at 2 liters per minute continuously. The assessment dated / did not address the use of .

A physician's order dated indicated at 2 liter per minute. A health assessment report dated indicated at 3 litter per minute.

Review of a doctor's visit note on read, "His saturation today is 95% on 3 litters with some intermittent coughing and ."

The review revealed the LNS/ECC (Limited Nursing Services/Extended Congregate Care (ECC)

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932514	07/20/2015
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SUMMARY STATEMENT OF DEFICIENCIES
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progress notes to / for 7 AM-3 PM, 3 PM-11 PM and 11 PM -7 AM shifts, and on / / for the 11 PM-7 AM shift. The notes originally documented the resident had on at 2 liters per minute and all the notes had been changed to indicate at 3 liters per minute. The number 3 had been written over the number 2 but the number 2 was still visible.

On , the day of the survey, the administrator provided an order that indicated it was OK for resident to have at 3 liter per minute via nasal cannula.

On at approximately 5:30 PM, the administrator offered no comment regarding the notes.

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interview, the facility failed to ensure an adverse incident report was submitted within one business day when law enforcement conducted an investigation at the facility for 1 of 5 sampled residents (#2).

Findings:

Review of facility notes revealed on:
/ / at 7:10 PM, resident #2 was talking loud, was agitated, and had a his hand. He was talking about a female resident and how he wanted to do something to her. The resident approached the medication technician (med tech) and asked for a , an anti- medication. The med tech did not have any in the box that time. The resident did not give the med tech time to go to the med get the . "He was very angry and agitated, calling the nurse all kinds of curse words. The administrator was called, and she stated to call the police. Staff was on the phone with the police who said to stay away from him. We kept the resident away. At 7:35 PM, the police was here talking with the resident after he had his ."

/ / at 5:30 PM, the resident was on the smoking porch with a female resident trying to smoke. "Without having been provoked, the resident went in front of the elderly lady's face to her. A female staff stopped him from this elderly lady, and he slammed a door while a female resident was trying to go outside on the porch for smoking. The resident was very agitated. The administrator was called and made aware. While on the phone, the resident jumped toward the elderly lady while she was walking with her walker. Two staff went between the residents. At that time, staff called 911. The med tech gave him a . At 6:15 PM, the resident was talking with police."

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932514	**07/20/2015**
NAME OF PROVIDER OR SUPPLIER **BROOKSHIRE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **85 BULLDOG BLVD. MELBOURNE, FL 32901**	

SUMMARY STATEMENT OF DEFICIENCIES
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On at 3:45 PM, the administrator stated an adverse incident report was not filled out when the police came to the facility on and .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Brookshire (the)
85 Bulldog Blvd.
Melbourne, FL 32901

RE: Relicensure w/ECC/LNS

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 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 , 2015.** 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

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

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[illegible], 2015

Brookshire (the)
85 Bulldog Blvd.
Melbourne, FL 32901
Attention: Antoinette Brown

Dear [illegible]. Brown:

This letter reports the findings of a biennial re-licensure survey conducted on , by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) ***by*** .

The inspection resulted in findings of non-compliance in the following areas:

1) A - 0025 - Resident Care - Supervision Class II
Your Assisted Living Facility failed to ensure the health care providers were notified of change in condition.

2) A - 0056 - Medication - Labeling And Orders Class II
Your Assisted Living Facility failed to make every reasonable effort to ensure that prescriptions were filled or refilled in a timely manner for residents who received assistance with self-administration of medications. One resident suffered pain needlessly.

Your Facility must comply with the following:

1) Your facility must in-service your staff on the importance of documenting residents change in condition and notifying the physician for additional orders or directives. Specifically if there is a physician order to contact them if a residents sugar drops below parameters that the physician has included in his orders. This in-service must be documented, along with the sign in sheet and available upon request by Agency staff ***by*** .

2) Your staff will develop and implement a policy and procedures to follow to ensure resident's medications do not run out. All staff must be in-serviced and trained on this policy and on the importance of making sure that a resident's medication does not run out. This can have an adverse effect such, as experiencing pain and not have pain medication available. Please document the content of the in-service along with the sign in sheet. The in-service documentation and the sign in sheet must available upon request for Agency staff ***by*** .

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

Brookshire (the)
, 2015

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact . Lorraine Henry, Orlando ALF Supervisor at (407) 420-2534.

Sincerely

Theresa DeCanio, RN
Field Office Manager

LH/be

7JR

Headquarters
2727 Mahan Drive
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http://ahca.myflorida.com

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