AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910759	04/18/2016
NAME OF PROVIDER OR SUPPLIER **ATRIA WINDSOR WOODS**	STREET ADDRESS, CITY, STATE, ZIP CODE **13707 DALLAS DRIVE** **HUDSON, FL 34667**	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

A complaint investigation (CCR 2016003436) was conducted at Atria Windsor Woods on . Atria Windsor Woods had a deficiency at the time of the investigation.

0027 Resident Care - Arrangement for Health Care

Based on interview and record review, the facility failed to ensure that residents were provided choices of health care provider services for an annual test (Test) for 3 (Resident #1, Resident #2, and Resident #4) of 3 residents.

Findings included:

On , a copy of facility policies and procedures entitled, " Resident Testing (revised date) was presented. The policy stated that all residents are to be screened for active ( ) at the time of move in and that all residents will be evaluated on an annual basis for the presence of active . The procedures stated that The resident services director ( ) may not administer or read the TST (Skin Test) and that all TST will be completed by an outside provider.

A series of interviews was conducted with the resident services director beginning at 1:03 PM on and she stated that the facility utilized one home health agency (HHA) for the residents ' annual tests. When asked if the residents were provided with a written statement indicating that they could get the test done at a provider of their choice, she stated no. She stated that residents were charged $10.00 for the and the service was provided as a convenience. She stated that the residents were notified verbally, about a week in advance, that they were scheduled for their annual Test with the HHA.

A record review conducted on showed statements entitled, " testing ", signed by Resident #1 and Resident #2 dated with a facility logo on top of the statements, that stated that you will be charges (sic) $10.00 for your (also known as skin test).

An interview was conducted with the administrator at 4:00 PM on concerning the annual Test and he stated that the HHA charged the facility for the tests.

Interviews conducted with Resident #1 (at 3:30 PM), Resident #2 (at 3:06 PM), and Resident #4 (at

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12:23 PM) on indicated that they were not given a choice of other health care providers to utilize for the facility ' s annual test requirement and they believed that they had to follow through with the appointments made for them with the HHA.

An interview was conducted with Resident #2 at 3:06 PM on and she stated that she spoke with her doctor after receiving the test. She stated that her doctor told her that he would have given her the test and that her insurance would have paid for it.

An interview was conducted with the administrator at 4:00 PM on and the residents ' understanding of being required to utilize the HHA for their Tests was discussed.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Atria Windsor Woods
13707 Dallas Drive
Hudson, FL 34667

RE: CCR #2016003436

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 **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

PRC/clt
Enclosure: State (5000-3547) Form
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