Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967749	A. BUILDING: _____ B. WING _____	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE	4301 31ST ST SOUTH SAINT PETERSBURG, FL 33712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number 2026005788) was conducted at Angel Care on . Deficiencies were identified at the time of survey.	A 000		
A 078 SS=G	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their	A 078		

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A 078	Continued From page 1 assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility ˬ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that staff trained in . , ( ) exercised their responsibilities and duties by initiating on one of one sampled resident (Resident #1) that was found unresponsive. The facility's inaction and lack of follow up response to the	A 078		

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A 078	Continued From page 2 event places the remaining 63 residents with a full code status at substantial risk of harm or Findings included: A record review for Resident #1 revealed no evidence of a Florida Department of Health Form 1896 ( ) form was executed. A record review of an incident report dated for Resident #1 signed by Staff A revealed on "Went to give resident morning meds and was found unresponsive". During an interview on at 9:28 a.m. Resident #2 stated she was Resident #1 roommate and when Staff A came in to give Resident #1 her medicines between 7:30 a.m. and 8:00 a.m. Resident #1 was ice and unresponsive to Staff A questions. She stated she did not see any staff perform on Resident #1 when she was in the room. During a phone interview on at 10:27 a.m. Staff B (an unlicensed Medication Technician) stated on at approximately 9:00 a.m. Staff A notified her that Resident #1 wasn't waking up. She and Staff A went into Resident #1's room and Resident #1 wasn't responding and was "ice " to the touch. Staff A and Staff B then got the Administrator. The Administrator checked for , , did not find a , and Resident #1 was not breathing. Staff B stated she did not perform because "she was ice " and she has training. During a phone interview on at 11:22	A 078		

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A 078	Continued From page 3 a.m. Staff A (an unlicensed Medication Technician) stated on at approximately 9:15 a.m. she went to Resident #1's room to give Resident #1 medications. Staff A was unable to wake up Resident #1 and stated Resident #1 was "ice ." Staff A checked Resident #1 for a , and for breathing and found Resident #1 was not breathing had had no , . Staff A then went and got Staff B and the Administrator and returned to Resident #1 within a minute. The Administrator then checked for a , and didn't find one. Staff A called 911 while the Administrator stayed with Resident #1. Then approximately minutes later emergency services arrived. Staff A stated Resident #1 did not have a in place and no was performed. Staff A stated Resident #1 was "ice , there was no point. She was as as an ice box". Staff A stated she was trained in . During an interview on at 11:55 a.m. Assistant Administrator stated it is expected that if a resident that is a full code is found with no , and not breathing, Staff should start and call for rescue. She said the facility does not have any policies or procedures regarding unresponsive residents. During an interview on at 1:04 p.m. Administrator stated on at approximately 9:30 a.m. he had arrived at the facility and was notified that Resident #1 was in their bed . He then got the ( ) and entered the room and placed the on Resident #1 and there was no electrical activity and then called 911. He stated the expectation for finding an unresponsive resident was to perform and call 911 and that none of the staff performed and no	A 078		

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A 078	Continued From page 4 training or in-services regarding unresponsive residents had been conducted since . A record review revealed Staff A and Staff B had current certifications in . A record review of the facility census revealed 63 residents are full code status. Photographic evidence obtained. Class II	A 078		