



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Hampton Manor
1500 S.E. 24th Road
Ocala, FL 34471

Dear Administrator:

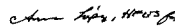
This letter reports the findings of a state licensure survey that was conducted on 2012 by representative(s) of this office.

Attached is the provider's copy of the State (3020) 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. Staff from this office will conduct a review after 2012 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 Anna Lopez at 386-462-6201.

Sincerely,


Kriste J. Mennella
Field Office Manager

KJM/al
Enclosure State Form 3020

XG90



Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964374	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2012
NAME OF PROVIDER OR SUPPLIER HAMPTON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 S.E. 24TH ROAD OCALA, FL 34471		
(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 standard biennial licensure survey was conducted to determine the facilities compliance with Chapter 429, Part, I & 408, Part II, FS; and 58A-5 FAC. The facility's Extended Congregate Care Survey portion of the biennial was completed on The facility was not in compliance with the rules and regulations regarding Assisted Living Facilities.		A 000		
A 005 SS=D	58A-5.0161 FAC Licensure - Inspection Responsibilities Inspection Responsibilities. (1) County health departments shall be responsible for inspecting all license applicants and licensed facilities in matters regulated by: (a) Rule 64E-12.004, F.A.C., and Rule Chapter 64E-11, F.A.C., relating to food hygiene. (b) Chapter 64E-12, F.A.C., relating to sanitary practices in community-based residential facilities. (c) Chapter 64E-16, F.A.C., relating to biomedical waste. (2) The local authority having jurisdiction over fire safety or State Fire Marshall shall be responsible for inspecting all license applicants and licensed facilities in matters regulated by Section 429.41, F.S., relating to uniform fire safety standards and Chapter 69A-40, F.A.C., Uniform Fire Safety Standards for Assisted Living Facilities. (3) The agency shall be responsible for inspecting all license applicants and licensed facilities in all other matters regulated by this rule chapter. This Statute or Rule is not met as evidenced by: Based on facility record review and interview it was determined that the facility failed to have a		A 005		

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6690

7XJ011

If continuation sheet 1 of 2

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964374	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HAMPTON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 S.E. 24TH ROAD OCALA, FL 34471		
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A 005	Continued From page 1 fire inspection completed annually Findings: The fire inspection presented for review was dated . Per interview conducted on _____ at 2:30 PM it was reported that the facility is still working on that and that the fire inspection was not completed the month of _____, 2012. Class III Correction Date: _____	A 005			