

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965997	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER ASTORIA GARDENS ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 S.E. 7TH STREET POMPAÑO BEACH, FL 33062		
(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 An Assisted Living Facility Monitoring Survey was conducted on Astoria Gardens Assisted Living Facility had a deficiency found at the time of the visit.	A 000			
AZ817 SS=G	408.810(3-4) FS; 59A-35.100(1) FAC Minimum Licensure Requirement - Inform AHCA 408.810, F.S. In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license. (3) Unless otherwise specified in this part, authorizing statutes, or applicable rules, any information required to be reported to the agency must be submitted within 21 calendar days after the report period or effective date of the information, whichever is earlier, including, but not limited to, any change of: (a) Information contained in the most recent application for licensure. (b) Required insurance or bonds. (4) Whenever a licensee discontinues operation of a provider: (a) The licensee must inform the agency not less than 30 days prior to the discontinuance of operation and inform clients of such discontinuance as required by authorizing statutes. Immediately upon discontinuance of operation by a provider, the licensee shall surrender the license to the agency and the license shall be canceled. (b) The licensee shall remain responsible for retaining and appropriately distributing all records within the timeframes prescribed in authorizing	AZ817			

AHCA Form 3020-0001

TITLE

(X8) DATE

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

STATE FORM

0009

0S2T11

If continuation sheet 1 of 3

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965997	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER ASTORIA GARDENS ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 S.E. 7TH STREET POMPANO BEACH, FL 33062		
(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)	
AZ817	Continued From page 1 statutes and applicable rules. In addition, the licensee or, in the event of _____ or dissolution of a licensee, the estate or agent of the licensee shall: 1. Make arrangements to forward records for each client to one of the following, based upon the client's choice: the client or the client's legal representative, the client's attending physician, or the health care provider where the client currently receives services; or 2. Cause a notice to be published in the newspaper of greatest general circulation in the county in which the provider was located that advises clients of the discontinuance of the provider operation. The notice must inform clients that they may obtain copies of their records and specify the name, address, and telephone number of the person from whom the copies of records may be obtained. The notice must appear at least once a week for 4 consecutive weeks. 59A-35.100, F.S. Provider location (1) A licensee must maintain proper authority for operation of the provider at the address of record. If such authority is denied, revoked or otherwise terminated by the local zoning or code enforcement authority, the Agency may deny or revoke an application or license, or impose sanctions. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to inform the agency prior to the		AZ817		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965997	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER ASTORIA GARDENS ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 S.E. 7TH STREET POMPAÑO BEACH, FL 33062		
(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
AZ817	Continued From page 2 discontinuance of operation within the required timeframe. The findings include: A monitoring visit was conducted at the facility on _____ at approximately 9:45 AM. Upon arrival at the facility it was noted that there were no motor vehicles outside of the facility. The surveyor rang the door bell, knocked on the door of the fence and called the facility's main phone number. However, there was no response. The surveyor walked around the property but was unable to gain access into the facility. There were no signs of people inside of the facility. A neighboring individual who was observed walking on the street was interviewed at approximately 9:55 AM. During the interview, the individual stated that she has not seen any activity at the facility for approximately 1 week. As of the day of the monitoring visit, the exact whereabouts and welfare of each individual resident of the facility is unknown, as well as the whereabouts of the operators of the facility. Class II	AZ817			



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Astoria Gardens ALF
3300 S.E. 7th Street
Pompano Beach, FL 33062

Dear Administrator:

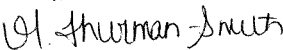
This letter reports the findings of a Monitoring survey that was conducted on 2012 by a representative from this office.

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 (30) 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,


for Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State Form 3020

