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
	AL11953224	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS GARDEN INC.	8003 NORTH ROME AVENUE TAMPA, FL 33604

(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 Assisted Living Facility A complaint survey, CCR# 2012006529 was conducted on . Angels Garden assisted living facility had a deficiency found at the time of the visit.	A 000		
A 083	58A-5.0191(4) FAC Training - First Aid and . (4) FIRST AID AND . . A staff member who has completed courses in First Aid and . . . and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation of attendance at First Aid or . course offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American . . . . Association, or National Safety Council; or a provider approved by the Department of Health, shall satisfy this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under Part III of Chapter 401, F.S., shall be considered as having met the training requirements for both First Aid and . . This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 3 (Staff A, B and C) of 3 staff who had occasion to work alone and whose personnel files were reviewed, had documentation that they were currently certified in . recussitation . by an approved provider,	A 083		

AHCA Form 3020-0001

TITLE (X6) DATE

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

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A 083	Continued From page 1	A 083		

placing all residents at risk of receiving lifesaving measures incorrectly.

Findings include:

Review of Staff A and Staff C's personnel files revealed they both had approved certification in first aide and CPR . 12/0 12/2 B had documentation of approved first aide and CPR . 03/2 03/2

with the administrator during the survey on 10/0 approximately 12:30pm revealed it was her responsibility for assuring staff had the required training and it was an oversight to have let the staffs CPR expire. She also said that she was aware that there must always (24hrs/7day) be at least one staff member certified in both first aide and CPR . the facility and that she would make arrangements immediately.

Class III

Widespread

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Angels Garden Inc.
8003 North Rome Avenue
Tampa, FL 33604

Dear Administrator:

Re: **CCR# 2012006529**

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

Attached is the provider's copy of the State (3020) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiency 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. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

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