STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964960	06/13/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Alimar Assisted Living	**2933 W. Columbus Drive Tampa, FL 33607**	

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

St - A - 0000 - - Initial Comments
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D

A complaint survey, CCR# 2013003994, was conducted on .

The Alimar Assisted Living Facility had a deficiency at the time of the visit.

0160-Records - Facility 58A-5.024(1) FAC
Based on record review and interview, the facility failed to maintain an up-to-date record of incident reports which addressed all required information with respect to one of three residents whose files were reviewed (#1), as well as at least two (2) randomly selected incident reports.

Findings include:

A resident record review revealed an incident report for Resident #1 from indicating that the individual "was found lying of the floor with and feces...no lacerations or other visible cuts; sent to hospital; son notified." A second incident report was reviewed from pertaining to "the resident falling in their granddaughter notified." Neither report contained any verbiage regarding what steps would be taken to prevent recurrence. Review of two additional random incident reports from 2013 found that neither included the "steps taken to prevent recurrence" element. Interview with the administrator at approximately 11:45 a.m. on confirmed that "she had been using a form apparently issued by AHCA for quite some time, and had not been completely aware of this requirement."

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Alimar Assisted Living
2933 W. Columbus Drive
Tampa, FL 33607

Dear Administrator:

Re: **CCR# 2013003994**

This letter reports the findings of a complaint survey that was conducted on , 2013, by a representative of this office.

Attached is the provider's copy of the State (5000-3547) 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,

Paul Y Brown

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

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