STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965638	05/20/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Gulf Haven, Inc.	6343 Rowan Road New Port Richey, FL 34653	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D

Specific Tag Findings:

0000-Initial Comments

A biennial state licensure survey was conducted on [redacted].

The Gulf Haven, Inc., assisted living facility, had a deficiency at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on record review and interview, the contracts for two of two residents sampled (#1; 4) did not provide the appropriate time limitations wherein the resident must have a health assessment completed. Findings include:

A resident record review during the [redacted] survey revealed that the [redacted] residency agreement for Resident #1 and the [redacted] contract for Resident #4 both contained the following verbiage: "the resident is responsible for obtaining a health assessment within sixty (60) days prior to admission and/or three (3) days after." This is in conflict with the requirement of 60 days prior to, and/or 30 days after admission to the facility. Interview with the administrator at approximately 1:20pm on [redacted] verified that this clause was present in all of her contracts.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Gulf Haven, Inc.
6343 Rowan Road
New Port Richey, FL 34653

Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on , 2014, by representative(s) 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(s). 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 (5000-3547) Form

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