STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967709	**07/09/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Jenny's Alf	**16116 Tampa Street Lutz, FL 33548**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2014003570, was conducted on .

The Jenny's ALF had a deficiency at the time of the visit.

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based upon record review & interviews, the facility failed to file a Day 1 report for 1 of 1 (#1) resident reviewed who had eloped from the facility.

Findings include:

1. During an interview on (12:30 p.m.) and record review the administrator verified that resident #1 walked out of the facility on and had to be brought back by law enforcement a short time later.

She stated the resident had not previously been exit seeking although believes that changes in behavior of resident #1 were the result of his wife's and attending her funeral. Both the administrator & family member interviewed (11:30 a.m.) said they thought resident #1 was searching for his wife.

The administrator stated (12:30 p.m.) she had not filed a Day 1 & Day 15 report with the agency after this event, she had forgotten.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Jenny's ALF
16116 Tampa Street
Lutz, FL 33548

RE: CCR# 2014003570

Dear Administrator:

This letter reports the findings of a complaint 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 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 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,

For Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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