STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967378	07/29/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
North Miami Angel Gardens Alf Inc	13010 Ne 9th Avenue North Miami, FL 33161	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Repeat Tags:
0123-Fiscal - Resident Trust Funds-58a-5.021(2) Fac

Specific Tag Findings:

0000-Initial Comments

A revisit to a Complaint Investigation (CCR# 2014004829) was conducted on 07/29/2014. North Miami Angel Gardens ALF Inc. had a deficiency identified as uncorrected.

0123-Fiscal - Resident Trust Funds 58A-5.021(2) FAC

Based on interview and record review, the assisted living facility still failed to ensure 1 of 7 (resident #7) sampled residents received a refund after discharge.

Finding include:

The facility's admission and discharge log revealed that resident #7 was admitted to the facility on and was discharged on to an unlicensed location. Record review found that resident #7 received a monthly check from social security in the amount of $1294. The facility was the payee for resident #7's social security check. Record review found that the facility was still receiving $1294 monthly from resident #7 for the months of , , and . The facility did not have any documentation that resident #7 was refunded $3882 for the three months that he was not in the ALF.

Interview during the investigation resident #7's daughter revealed that he was transferred to the hospital on .

On ,2014 an interview with the administrator's husband was conducted. He stated the facility had not yet issued a refund to resident # 7.

Class III
Uncorrected Deficiency

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
North Miami Angel Gardens Alf Inc
13010 NE 9th Avenue
North Miami, FL 33161

Dear Administrator:

This letter reports the findings of a revisit to a Complaint Investigation survey conducted on 29, 2014by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2014.**

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 this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

BBT7

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