STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968373	09/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Carmen's Goodcare Alf	**908 W Yukon St Tampa, FL 33604**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tag Cited:

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

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A biennial state licensure survey was conducted on . . . . . .

Carmen's Goodcare ALF 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 facility failed to ensure the residents's health assessment was completed, including the required list of medication for 2 (# 2, # 3) of 2 records reviewed.

Findings include:

During a review of resident records on . at approximately 2:00p.m. it was revealed resident #2, and #3 health assessment did not have the required list of medication completed. The statement "see attrached" was written in place of the list of medication. Further review revealed there was not a list attached.

During an interview with the administrator on . . . . . at approximately 2:30 p.m. it was stated he thought the MOR was attached to the health assessment. The administrator stated that he has the staff attrach a copy of the residents Medication observation record rather than list the medication in the 1823.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Carmen's Goodcare ALF
908 W Yukon St
Tampa, FL 33604

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 t meframe. 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,

Paul J Brown

for Patricia Reid Caufman
Field Office Manager

PRC/clt

Enclosure: State (5000-3547) Form

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