STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910758	**08/14/2015**
NAME OF PROVIDER OR SUPPLIER **WIRICK (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **434 4TH STREET, NORTH SAINT PETERSBURG, FL 33701**	

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

0000 Initial Comments

Assisted Living Facility

Amended

A biennial state licensure survey with limited nursing services (LNS) and limited mental health services (LMH) was done in conjunction with a complaint survey, CCR# 2015006127, and a revisit to CCR# 2015005110 of .../....

The Wirick, assisted living facility, had deficiencies at the time of the visit.

Tags A 054 & A 080 were administratively deleted on .../....

0078 Staffing Standards - Staff

Based on interview and record review the facility failed to ensure the administrator had a current statement from a a health care provider documenting evidence of a negative examination and also failed to ensure the administrator had an annual negative test or chest x-ray.

Finding include:

During a review of staff records on it was revealed the administrators's test had expired. The last documented test was dated ....

Class III

0167 Resident Contracts

Based on record review and interview, the facility failed to ensure it had a completed contract for 2(#4 and #14) of 2 records reviewed for facility contracts.

Findings include:

Record review on ... of the facility contracts for Resident #4 and Resident #14 revealed they had contracts that did not contain a provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility.

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

Record review on of the facility contracts for Resident #4 and Resident #14 revealed the daily,weekly or monthly rate which the facility would be charging the residents were left blank. Resident #4 who had a facility contract signed on and the standard bed rate was checked without any rate written in the blank. Since each resident has different rates allotted by Social Security and medicaid, there is no standard bed rate for a resident. The daily, weekly or monthly rate should be listed in the contract so the resident will know what he is paying each month.

Resident #14 had a facility contract signed on / and the monthly fee was left blank. There was no daily ,weekly or monthly rate listed in the resident's contract. The daily, weekly or monthly rate should be listed in the contract so the resident will know what he is paying each month.
Resident #14 also did not have his contract signed by the facility administrator.

The facility manger on at 1:00 p.m. stated the monthly rates were not listed in the contracts for Resident #4 and Resident #14 and she verified the contract for Resident #14 had not been signed by the facility administrator.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Wirick (The)
434 4th Street, North
Saint Petersburg, FL 33701

Re: Amended

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with limited nursing services (LNS) and limited mental health (LHM) that was conducted on , 2015, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit. Please be advised that Tags A 054 & A 080 were administratively deleted on .

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.

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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