AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968177	09/14/2015
NAME OF PROVIDER OR SUPPLIER **YOUR HOUSE ALF 2**	STREET ADDRESS, CITY, STATE, ZIP CODE **5816 N GRADY AVE** **TAMPA, FL 33614**	

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

0000 Initial Comments

Assisted Living Facility

A Change of Ownership (CHOW) State Licensure survey was conducted on .

Your House ALF 2, Assisted Living Facility, had deficiencies identified at the time of the visit.

0003 Licensure - Change of Ownership (CHOW)

Based on record review and interview, the facility did not comply with Ch. 429.12, F.S. with respect to at least one of two residents sampled (#1).

Findings Include:

In an interview with the assistant administrator at approximately 2 p.m. on , he stated that "the new owners verbally notified the residents and their family members at the time they took over back in late /early , 2015, but never sent them anything in writing to this effect." He went on to say that "he did not realize this was a state requirement." This was further underscored when said document was requested during the survey but never furnished. In addition, during family interviews, at least one individual stated that the facility never sent them anything in writing regarding the impending change of ownership.

Class III

0162 Records - Resident

Based on record review and interview, the file for one of two residents sampled (#2) did not include documentation of the appointment of this resident's guardian, nor whether the resident had a , DH Form 1986.

Findings Include:

A review of Resident #2's file during the 2015 change of ownership survey revealed that the resident's contract was signed by a 3rd party. Although further review of the record indicated that this individual was referred to as Resident #2's guardian, no official written designation to this effect could be located. Interview with the assistant administrator at approximately 1:20 p.m. on / confirmed that

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968177	09/14/2015
NAME OF PROVIDER OR SUPPLIER **YOUR HOUSE ALF 2**	STREET ADDRESS, CITY, STATE, ZIP CODE **5816 N GRADY AVE** **TAMPA, FL 33614**	

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

said document had not been obtained. In addition, although a blank form pertaining to advance directives was noted in Resident #2's record, there was no documented evidence that the resident had an executed , DH Form 1896, and if this individual had been provided a copy of the facility's policies/procedures. During the same interview referred to above, the assistant administrator provided no clarification.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2015

Administrator
Your House Alf 2
5816 N Grady Ave
Tampa, FL 33614

Dear Administrator:

This letter reports the findings of a Change of Ownership (CHOW) state licensure survey that was conducted on [redacted], 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. Submit summary and documents to the Field Office no later than [redacted], 2015.** 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.

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,

Teresa Ryan RN

for Patricia Reid Caufman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com