AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967826	10/12/2015
NAME OF PROVIDER OR SUPPLIER **JUSTIN FAMILY ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **10103 BAY WIND COURT** **TAMPA, FL 33615**	

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

0000 Initial Comments

Assisted Living Facility

On , 2015, a change of ownership (CHOW) with limited mental health (LMH) state licensure survey was conducted at Justin Family ALF.

Deficient practice was identified during the survey.

0003 Licensure - Change of Ownership (CHOW)

Based on record review and interview, the transferee had not provided in writing two of three residents sampled (#2-3) with the name and location of the financial depository he would be holding their funds on a temporary basis.

Findings Include:

A review of resident files during the change of ownership survey found no official notification from the administrator/owner indicating the name and location of the new financial institution he would be using for the assisted living business, including any resident monies that would be received and paid out. Interview with the owner at approximately 11a.m. on / verified that no such letter was distributed to the residents who were at the facility prior to when he took over in , 2015.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, record review and interview, one of two residents sampled (#2) with a half-bed rail in place did not have an annual physician's order for said device.

Findings Include:

Observation during the facility tour at approximately 10:45am on revealed a half-bed rail attached to Resident #2's bed. This resident did not speak English, and, according to staff/the administrator, was somewhat [illegible]. Review of Resident #2's file found no official physician's order for the rails. Further interview with the administrator confirmed that no order for said rails was ever obtained.

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Class III

0078 Staffing Standards - Staff

Based on record review and interview, two of three staff sampled (A; C) had not obtained either a health care provider's statement documenting their freedom from signs or symptoms of communicable , based on an exam no earlier than 6 months, or had their freedom from ( ) documented on an annual basis.

Findings Include:

A personnel file review during the change of ownership survey revealed that although Staff A (hired) had a communicable evaluation from , further review of the record found no current assessment. In addition, review of Staff C's file (hired) indicated that she had a statement from / , but no general evaluation from a health care provider attesting to this individual's freedom from other communicable could be located. Interview with the administrator at approximately 1:10 p.m. on / provided no clarification for these omissions.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2015

Administrator
Justin Family Alf
10103 Bay Wind Court
Tampa, FL 33615

Dear Administrator:

This letter reports the findings of a change of ownership (CHOW) with limited mental health (LMH) 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,

FOR Patricia Reid Caufman
Field Office Manager

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