

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 12/16/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967749	(X3) DATE SURVEY COMPLETED 12/07/2015
NAME OF PROVIDER OR SUPPLIER ANGEL CARE ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 31ST ST SOUTH SAINT PETERSBURG, FL 33712	

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

0000 Initial Comments

Assisted Living Facility

An unannounced Biennial Licensure survey with Extended Congregate Care services was conducted on

The Angel Care Assisted Living Facility had a deficiency at the time of this visit.

0093 Food Service - Dietary Standards

Based on interview and record review, the facility failed to maintain a required file of menu substitutions covering the last 6 month period.

Findings Included:

A meal substitution log, menu cycle and a copy of the registered dietician 's credentials were requested from Assist Administrator. The Assist administrator could not provide documents to include the facility's substitution log.

On 12/16/2015 at 1:25 p.m. During an interview, the facility's Assistant Administrator reviewed the menus with surveyor and confirmed findings. The administrator stated, "I have been here for over a year now and we have never kept a separate substitute log for any substitution. We only put alternative on menus at the bottom nothing else." The assisted Administrator stated, "I will start doing this now, I didn 't know." No further documentation was provided.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

_____, 2015

Administrator
Angel Care Assisted Living Facility
4301 31st St South
Saint Petersburg, FL 33712

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with extended congregate care (ECC) 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. Submit summary and documents to the Field Office no later than _____, 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,

Patricia Reid Cauffman
for Patricia Reid Cauffman
Field Office Manager

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

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