AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910805	12/16/2015
NAME OF PROVIDER OR SUPPLIER **CARING ANGELS**	STREET ADDRESS, CITY, STATE, ZIP CODE **6405 40TH AVENUE, NORTH** **SAINT PETERSBURG, FL 33709**	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

A Biennial Re-licensure survey was conducted on / / at Caring Angels assisted living facility. There were deficiencies found at the time off the visit.

0078 Staffing Standards - Staff

Based on observation, interviews and record review, the facility failed to ensure that 2 of 2 staff employed longer than 30 days had evidence of a negative examination, chest X-ray or free from communicable statement from a health care provider on an annual basis.

Findings included;

Staff A, hired and Staff B hired / last received evidence of freedom from communicable as evidenced by a written statement from a health care provider on / / .

Staff B, hired last received evidence of freedom from communicable as evidenced by a written statement from a health care provider on .

An interview with Staff A revealed that he and Staff B get chest X-rays because they have tested positive for in the past. He verified that neither he nor Staff B had been seen by a health care provider since 2013 in order to get a statement that they have no signs or symptoms of communicable .

CLASS III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

December 1, 2015

Administrator
Caring Angels
6405 40th Avenue, North
Saint Petersburg, FL 33709

Dear Administrator:

This letter reports the findings of a beinnial state licensure survey that was conducted on December 1, 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 January 4, 2016.** 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.

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