AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910102	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA RETIREMENT HOME, INC.	**149 MAGNOLIA AVENUE SEBRING, FL 33870**

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

0000 Initial Comments

ASSISTED LIVING FACILITY

A complaint investigation (CCR#2015011650) was conducted at Magnolia Retirement Home assisted living facility on / / . The Magnolia Retirement Home had one unrelated deficiency at the time of the investigation.

0125 Fiscal - Suretv Bonds

Based on record review and interview, the facility failed to maintain a surety bond which was equal to twice the average monthly aggregate income of its residents who had made the facility their representative payee.

Findings included:

Record review on / / of the facility's surety bond revealed a surety bond dated , 2015 with an expiration date of , 2016 and it was made out for $10,000.00 dollars.

When the administrator was interviewed on / / at 12:30 p.m. he stated there were 22 residents who had made the facility their representative payee and total amount of the average monthly aggregate income for the 22 residents was $16, 973.30. He sta... that he did not realize the surety bond was to be for twice the income of the residents.

The surety bond should have been made out for $33,946.60.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Magnolia Retirement Home, Inc.
149 Magnolia Avenue
Sebring, FL 33870

RE: CCR #2015011650

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2016 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 , 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,

for Patricia Reid Caufman
Field Office Manager

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

PRC/clt
Enclosure: State (5000-3547) Form
XG90