

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966444	(X3) DATE SURVEY COMPLETED 02/02/2016
NAME OF PROVIDER OR SUPPLIER LANGDON HALL, INC INDEPENDENT & ASSISTED	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 33 AVENUE WEST BRADENTON, FL 34205	

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

0000 Initial Comments

Assisted Living Facility

A complaint investigation (CCR#2016000844 & CCR#2015013051) was conducted at Langdon Hall on

Langdon Hall had a deficiency at the time of the investigation.

0167 Resident Contracts

Based on record review and interview the facility failed to provide a refund to the responsible party for resident #1 within 45 days of discharge.

Findings included:

The responsible party for resident #1 requested a refund on . . . 45 days from the refund request would be The responsible party for resident #1 contacted the facility on . . . with a second request for a refund. In record review a refund request was noted and signed by the administrator on In interview with the business office manager on . . . at 2:17 pm she stated she sent an email to the corporate office on . . . requesting the refund. In research after the second request for the refund it was noted that the first emailed request was not sent. The refund was requested from the corporate office on The responsible party received the refund on The refund was received 65 days after discharge. The refund was received 20 days later than the required amount of time.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Langdon Hall, Inc Independent & Assisted Living
1120 33 Avenue West
Bradenton, FL 34205

RE: CCR #2016000844 & 2015013051

Dear Administrator:

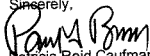
This letter reports the findings of two complaint surveys that was conducted on
, 2016 by representative(s) of this office.

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
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PRC/clt

Enclosure: State (5000-3547) Form

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