AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910473	06/02/2016
NAME OF PROVIDER OR SUPPLIER **FOREST GLEN LODGES, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **7435 PLATHE ROAD** **NEW PORT RICHEY, FL 34653**	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

A complaint investigation (CCR#2016004420) was conducted at Forest Glen Lodges on . Forest Glen Lodges had a deficiency at the time of the visit. (Lic #5243)

0167 Resident Contracts

Based on record review and interview, the facility failed to provide a refund to the resident's responsible party within forty-five (45) days of discharge for 1 of 3 (#2) residents sampled for refunds.

Findings included:

Record review on of Resident #2's contract dated stated the facility shall provide a refund to the resident or the resident's responsible party within 45 days after the discharge, transfer or of a resident. Resident # 2 on / .

Resident #2 was admitted on / and was discharged on / due to passing away on . Her responsible party was her daughter. The daughter paid in , 2015 for the month of , 2015 the amount of $3720.00. The accounts receivable report for shows the check for $3720.00 was given to the facility on .

On / at 12:15 pm, the accounts payable reports for the past 9 months were reviewed by the administrator and no documentation was found in the reports which stated the facility did refund the advanced rent payment of $3720.00 for , to the daughter.

The administrator stated on at 12:30 pm by phone that Resident #2's family member did not get a refund of $3720.00 within the required 45 days of discharge.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Forest Glen Lodges, Inc.
7435 Plathe Road
New Port Richey, FL 34653

RE: CCR #2016004420

Dear Administrator:

This letter reports the findings of a state licensure 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

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