

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 05/23/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910538	(X3) DATE SURVEY COMPLETED 05/10/2016
NAME OF PROVIDER OR SUPPLIER ROBINSONS RESIDENTIAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 11921 CARUSO DRIVE PANAMA CITY, FL 32404	

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

0000 Initial Comments

A complaint investigation (CCR 2016002528) was conducted at Robinson's Residential Care facility on 5/10/2016. Robinson's Residential Care facility had deficient practice at the time of the investigation.

0162 Records - Resident

Based on interview and record review, the assisted living facility failed to retain 1 of 4 (Resident #8) residents' records for two years after being discharged as required.

Findings include:

A review of the Admission and discharge log revealed that Resident #8 was admitted to the facility on 11/1/2013 and discharged on 11/1/2013.

During an observation on 5/10/2016 at 12:30 pm, the Administrator and Staff A were searching in records, desk drawers, and a closet across from the Administrators office for Resident #8's record to no avail.

During an interview on 5/10/2016 at 12:30 PM, the Administrator stated that Resident #8's record should be in the closet with the other discharged resident's records. She confirmed that she and Staff A could not locate Resident #8's records.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Robinsons Residential Care
11921 Caruso Drive
Panama City, FL 32404

RE: CCR #2016002528

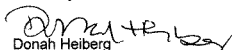
Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative 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. Should you have any questions please call me at 850-412-4540.

Sincerely,


Donah Heiberg
Field Office Manager

DH/dh
Enclosure

XG90

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