| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11967749 | 08/09/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**ANGEL CARE ASSISTED LIVING FACILITY** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**4301 31ST ST SOUTH**<br>**SAINT PETERSBURG, FL 33712** | |

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

**0000 Initial Comments**

Assisted Living Facility

Three complaint surveys, (CCR# 2016006034, CCR# 2016006042, & CCR# 2016009110) were conducted on . The Angel Care Assisted Living Facility had a deficiency at the time of the visit.

(License # 11734)

**0165 Risk Mgmt & QA: Adverse Incident Report**

Based on interview and record review, the facility failed to submit 1 and 15 day Adverse Incident Reports as required for 1 of 1 residents reviewed for being missing from the facility.

Findings included:

Based on a review of facility records, Resident #1 was discovered missing on / during the evening medication pass (8:30 P.M.). He was last seen at 2:30 P.M. The report stated "we will wait for him to come back". An additional note was entered at 8:00 A.M. on / that a local hospital called to say Resident #1 was admitted last night.

The resident record for Resident #1 showed a note stating "resident eloped". A Psychiatrist's note dated / stated he said he wouldn't do it again and that we may need to consider the secure unit if he goes out again without permission. The Form 1823 indicates that the resident needs assistance with medication management, and has and .

The facility did not report the resident missing or complete the required reports even after the resident was missing for approximately 12 hours and was last 17 hours prior.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Angel Care Assisted Living Facility
4301 31st St South
Saint Petersburg, FL 33712

**RE: CCR #2016009110, 2016006042 & 2016006034**

Dear Administrator:

This letter reports the findings of threee state licensure 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
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