STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968478	09/08/2016
NAME OF PROVIDER OR SUPPLIER **CARING HOUSE ASSISTED LIVING FACILITY, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3090 RUSSELL RD** **GREEN COVE SPRINGS, FL 32043**	

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

0000 Initial Comments

A complaint investigation (CCR #2016007013) was conducted at Caring House Assisted Living Facility (License #12453) on . Caring House Assisted Living Facility had deficiencies at the time of the investigation.

0167 Resident Contracts

Based on record review and staff interview the facility failed to ensure one resident (#1) out of 3 sampled residents' rights were protected by not providing a pro-rated refund to the resident after discharge.

The findings include:

A complaint investigation was conducted at the facility on . A record review of Resident #1's medical record revealed she was discharged from the facility on . She was transported to a hospital for an acute .

During an interview with the administrator on at 10:25 am she stated she had many text messages and emails from the resident's two daughters regarding taking her mother back from the hospital and why she could not. She stated she was assessing her from when she was admitted to the hospital until when she was ready for discharge from the rehabilitation Center. She stated, she had been advised by the nursing staff at the rehabilitation center that she should not take her back because she needed to be in a skilled unit to meet her needs. She stated, she made this clear to the residents' daughters and she discharged her on . She stated, she had not sent the family a pro-rated refund yet.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[illegible], 2016

Administrator
Caring House Assisted Living Facility, LLC
3090 Russell Road
Green Cove Springs, FL 32043

RE: CCR #2016007013

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on [illegible] 2016 by a 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 [illegible] 20, 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 this office at [illegible]-4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor

JD/JM/sm
Enclosure
XG90

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