AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966444	10/04/2016
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

Three complaint surveys, CCR# 2016008044, CCR# 2016010732 and CCR# 2016010336, were conducted at Langdon Hall, Inc. Independent & Assisted Living Facility on . Langdon Hall, Inc. Independent & Assisted Living Facility had deficient practice identified at the time of the visit.

(License: 10661)

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interview the facility failed to ensure a 15-day adverse incident report was filed in a timely manner.

Findings included:

On 11:18 a.m. a interview with the facility administrator confirmed she filed a one day adverse with the state on . The administrator stated she did not file a 15 day follow up report to the state. The administrator admitted a 15 day follow up report should have been filed to the state within 15 days of the initial 1-day report. The administrator confirmed a follow up report wasn ' t filed until .

A record review of the facility adverse records revealed a one-day adverse incident report for Resident #2 was filed on and a follow up report filed on .

The administrator reviewed adverse incident records with surveyor and confirmed findings.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

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

RE: CCR# 2016008044, CCR# 2016010732, & CCR# 20160120336

Dear Administrator:

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

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 the identified deficiency. 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 deficiency 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.

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

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call **Teresa Ryan**, RNC, at 727-552-2000.

Sincerely,

Teresa Ryan RNC

for Patricia Reid Ufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-03547

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