Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation for allegations contained within complaint #2021006395, was conducted at Angelcare with a Vision Assisted Living Facility on , , 2021. The facility had deficiencies at the time of the survey.	A 000		
A 027 SS=E	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , , , , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on staff interview, interview with the mental health provider and record review, the facility failed to arrange for health care (limited mental health services) for 4 of 4 residents identified as receiving limited mental health services. (#1, #2, #4 and #6) The findings included: On , at approximately 11:18 AM, an interview was conducted with the Administrator requesting an up-to-date admission and discharge log and requesting community living	A 027		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 027	Continued From page 1	A 027		

support plans for limited mental health residents. The Administrator presented a resident roster form which included a census of all residents residing in the facility. The documentation provided had no method to identify limited mental health residents and the Administrator stated she was not sure which residents were limited mental health at the time. The Administrator reported that she did not have an admission and discharge log for limited mental health residents and was not aware that she had to keep a log for them. The Administrator eventually identified resident #1, #2, #4 and #6 as residents receiving limited mental health services. The Administrator reported that mental health case managers stopped providing services to the residents at the beginning of COVID-19 (Coronavirus . . . . . 2019).

A record review was conducted of residents' #1, #2, #4 and #6 records and there was no documentation of community living support plans.

On . . . . . at approximately 12:41 PM, an interview via telephone was conducted with the facility's mental health provider in regard to residents receiving limited mental health services. The Program Supervisor reported that residents #1 and #2 cases were still open, but that they had no community support living plans due to the lack of being able to conduct visits. The Program Supervisor reported that resident #6 had been discharged from mental health services because the facility's administrator had informed them that resident #6 had been admitted to a nursing home. The Program Supervisor was not aware resident #6 was still residing at the facility. The Program Supervisor also reported that resident #4's case was closed due to the Administrator not allowing case managers in the building to render services. She indicated that the Administrator of the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 027	Continued From page 2 had been provided iPADs, so that they could conduct services virtually for residents. She stated iPADs would have allowed the residents to participate in , , , , rehabilitation programs (day treatment), primary care with the physician, medication management, and care management (. . , ,). She reports that Administrator would not use the iPADs anymore, so they had requested she return the iPADs . . . . . to the mental health provider, but the Administrator has not responded to a certified letter or multiple calls. The Program Supervisor revealed again the iPADs are no longer being used and that they would like them if the facility was not going to use the devices. The Program Supervisor stated that the case managers would call the facility, and no one would answer the phone. She also revealed the case managers would visit the facility and the Administrator would tell them that they were not allowed in the building due to COVID-19. . The Program Supervisor reported that the Administrator started making different excuses such as she was short staffed, and no one could come to the door and sign papers. She also indicated the Administrator would not accept documentation at the door for limited mental health residents that required their signatures. She reported that the Administrator was also given the option to send the documents once signed . . . via fax, but still the Administrator was , . . . Class III	A 027		
A 120 SS=F	429.17(3) .275(1); 59A-36.013(1) FAC Fiscal - Financial Stability 429.17	A 120		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 120	Continued From page 3 (3) In addition to the requirements of part II of chapter 408, each facility must report to the agency any adverse court action concerning the facility's financial viability, within 7 days after its occurrence. The agency shall have access to books, records, and any other financial documents maintained by the facility to the extent necessary to determine the facility's financial stability. 429.275 (1) The administrator or owner of a facility shall maintain accurate business records that identify, summarize, and classify funds received and expenses disbursed and shall use written accounting procedures and a recognized accounting system. 59A-36.013 Fiscal Standards. (1) FINANCIAL STABILITY. The facility must be administered on a sound financial basis in order to ensure adequate resources to meet resident needs pursuant to the requirements of chapter 408, part II, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the Assisted Living Facility (ALF) failed to administer the facility on a sound financial basis as manifested by using resident funds account for personal purchases, co-mingling monies from a Homemaker and Companion service, failing to pay building lease account, and numerous over-draft events resulting in charges. At the time of the survey on , the facility had a census of 13 residents. The findings include:	A 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 120	Continued From page 4 1) Review of facility records revealed the facility received an eviction notice from the lessor dated . indicating the facility was indebtedness to lessor as of , . for "$32,656.25 for room lease and $14,193.95 as over payment for utilities which does not include , . Total amount due is $46,850.20." The eviction notice also requested "The total amount is due immediately or no later than the end of the month - , . . Failure to respond immediately to this letter will result in an immediate eviction" Review of facility records revealed on , , , a second eviction notice was received from the lessor by the facility with the above amounts due. This notice detailed receipt of some information provided by the facility, but further requested supportive documentation was not included in the packet such as paid invoices or receipts for any repairs the facility had incurred to offset the outstanding amount owed. This notice stated, "If you desire to stay in this building, the total amount is due immediately or no later than the end of the month - , . ." On at 11:45 AM and 2:50 PM, a telephone interview was conducted with author of the eviction notice that had been provided to the facility. This person was a representative of the church organization and considered to be the lessor. He confirmed the building in which the facility was located was property owned by the church organization, and the local pastor had entered into a verbal agreement for $1,900.00 monthly and a portion of the utilities. He indicated the church had been willing to work with the facility during the pandemic, but they had never received any rent payments as agreed. He	A 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 120	Continued From page 5 confirmed the facility had made some utility payments, but a disclosed amount was not provided. He indicated that he had reviewed a copy of a lease agreement dated , , between the facility and the local pastor which had authority to enter into a lease with the facility, which indicated "None" to be paid by the Lessee for rent payments for the term of the lease (five years). The church representative disputed the validity of the document. On at 1:00 PM, a telephone call was received from the local pastor (lessor). She confirmed a verbal agreement with the facility from but was adamant she never signed any lease. She disputed the signature and stated, "looks like a copy and paste of my signature," and pointed out the notary did not sign or date the document. The local pastor indicated she had tried for months to work with the facility, but the Administrator of the facility was not which was why she had to alert her . On at 3:00 PM, an interview was conducted with the Administrator regarding the 2 eviction notices and the lease dated , . She indicated she did not agree verbally to pay $1,900.00 monthly but did agree to pay part of the utilities. She indicated the lease was valid and she had never been asked for any rent monies prior to receiving the notice. 2) Record review of the bank records (ending 8981) revealed the account to have 20 insufficient funds charges at $35.00 per overdraft charges totaling $2035.00 from - . The Administrator identified this account to be the account used for residents funds.	A 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 120	Continued From page 6 Class III	A 120		
A 123 SS=H	429.27( ) FS; 59A-36.013(2) FAC Fiscal - Resident Trust Funds 429.27 (3) A facility, upon mutual consent with the resident, shall provide for the safekeeping in the facility of personal effects not in excess of $500 and funds of the resident not in excess of $500 cash, and shall keep complete and accurate records of all such funds and personal effects received. If a resident is absent from a facility for 24 hours or more, the facility may provide for the safekeeping of the resident's personal effects in excess of $500. (4) Any funds or other property belonging to or due to a resident, or expendable for his or her account, which is received by a facility shall be trust funds which shall be kept separate from the funds and property of the facility and other residents or shall be specifically credited to such resident. Such trust funds shall be used or otherwise expended only for the account of the resident. At least once every 3 months, unless upon order of a court of competent jurisdiction, the facility shall furnish the resident and his or her guardian, trustee, or conservator, if any, a complete and verified statement of all funds and other property to which this subsection applies, detailing the amount and items received, together with their sources and disposition. In any event, the facility shall furnish such statement annually and upon the discharge or transfer of a resident. Any governmental agency or private charitable agency contributing funds or other property to the account of a resident shall also be entitled to receive such statement annually and upon the discharge or transfer of the resident.	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 123	Continued From page 7 (5) Any personal funds available to facility residents may be used by residents as they choose to obtain clothing, personal items, leisure activities, and other supplies and services for their personal use. A facility may not demand, require, or contract for payment of all or any part of the personal funds in satisfaction of the facility rate for supplies and services beyond that amount agreed to in writing and may not levy an additional charge to the individual or the account for any supplies or services that the facility has agreed by contract to provide as part of the standard monthly rate. Any service or supplies provided by the facility which are charged separately to the individual or the account may be provided only with the specific written consent of the individual, who shall be furnished in advance of the provision of the services or supplies with an itemized written statement to be attached to the contract setting forth the charges for the services or supplies. 59A-36.013 (2) RESIDENT TRUST FUNDS. Funds or other property received by the facility belonging to or due a resident, including personal funds, must be held as trust funds and expended only for the resident's account. Resident funds or property may be held in one bank account if a separate written accounting for each resident is maintained. A separate bank account is required for facility funds; co-mingling resident funds with facility funds is prohibited. Written accounting procedures for resident trust funds must include income and expense records of the trust fund, including the source and disposition of the funds. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 123	Continued From page 8 failed to maintain a separate bank account to prevent co-mingling of residents' funds with facility funds and the Owner/Administrator's personal bank accounts. The facility also failed to show receipts for several transactions debited from the resident's bank account. The facility was the payee for 7 of 13 residents that currently reside at the facility (#1, #11, #3, #6, #2, #10, and #8). The facility was also the payee for resident #15, who has been discharged from the facility. The failure to maintain a seperate bank account for facility funds and resident funds resulted in a Class II deficiency. The findings include: On at approximately 11:00 AM, a request was made to the facility's Administrator to provide resident financial records to include the residents' bank account. She provided the bank account summaries for the month of , , , and , -3rd of 2021. The bank account summaries provided listed 2 accounts: 1) account ending in 7767 was identified by the administrator as her business personal account and 2) account ending in 8981 as the facility business account for residents for Well Care Medicaid payments, Supplemental Security Income, Private Pay, and Social Security Administration. The facility does not have separate accounts for resident funds and facility funds. The Administrator also revealed she keeps her personal funds in this account identified as a resident account. A review of the bank account summaries identified for resident use was reviewed with the Administrator and the review revealed several transactions in which the facility's Administrator could not provide documentation or receipts for the purpose of purchases as it related to residents at the	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 123	Continued From page 9 assisted living facility but was not limited to: On [redacted], debit of $703.00 in a cash withdrawal from an automated teller (ATM). On [redacted], there was a cash withdrawal of $1000.00. The Administrator could not provide receipts and when asked could not provide an explanation of what the cash was used for. On [redacted], there was a cash withdrawal of $2000.00. The Administrator could not provide receipts and when asked could not provide an explanation of what the cash was used for. On [redacted], there was a debit to "J. Enterprise INT Sale" for $14,237.00. The Administrator could not provide receipts and when asked could not provide an explanation of this purchase. A search on sunbiz.org revealed the business to be an active business since [redacted]. A google search of the address provided for the business on sunbiz.org, 8358 West Oakland Park Boulevard, Suite 106, Sunrise, Florida, 333351, revealed a yellow page entry listing the business as a Managment Consultant. On [redacted], Check #1458 withdrawal/debit in the amount of $820.00. The Administrator reported that if was for personal use, and was not able to produce a receipt of what it was used for. On [redacted], Check #1456 withdrawal/debit amount of $2,000 wrote out to unknown name. The Administrator reported it was to fix the bathroom area. There was no comment on the check and no receipt was provided to the surveyor. On [redacted], Check #1001 withdrawal/debit in the amount of $1,000. The receipt indicated the check was wrote out to an unknown name. The Administrator reported that unknown person provided mental health services to resident #12 because resident #12 did not have money to pay. Upon reviewing the residents at the facility who	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 123	Continued From page 10 receives limited mental health, resident #12 was not listed. The above charges totaled $21760.60. At this point during the interview on , the Administrator stated that she would admit that some of the checks were used for personal business but could not identify which ones without receipts. The Administrator stated that she could not produce receipts on her cell phone and the Internet was not working so she could also not produce receipts for the following checks totaling $22,890.90: On : Check #1448, amount of $60.00. Check #1454, amount of $270.00. On : Check #1450, amount of $208.00. Check #1452, amount of $300.00. Check #1446, amount of $63.05. Check #1453, amount of $123.65. On : Check #1447, amount of $325.00. Check #1445, amount of $408.00. Check #1442, amount of $150.00. Check #1443, amount of $450.00. On : Check #1441, amount of $3,500.00. Check #1449, amount of $410.00. On : Check #1437, amount of $2000.00. Check #1420, amount of $120.00. On : Check #1435, amount of $500.00. On : Check #1434, amount of $3000.00. On : Check #1439, amount of $650.00. Check #1429, amount of $165.00.	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 123	Continued From page 11 On . . . . . : Check #1428, amount of $ 371.00. Check #1432, amount of $3,000.00. Check #1436, amount of $300.00. Check #1433, amount of $125.00. On : Check #1424, amount of $388.00. Check #1423, amount of $150.00. On . . . . . : Check #1430, amount of $1552.40. Check #1426, amount of $150.00. On : Check #1422, amount of $650.00. On : Check #1412, amount of $90.00. On : Check #1414, amount of $60.00. Check #1410, amount of $391.00. Check #1417, amount of $240.00. On : Check #1416, amount of $402.00. Check #1411 amount of $ 1706.00. Check #1409, amount of $612.80. A continued record review was conducted of the comingled bank account in which the Administrator revealed she used for resident funds, facility business funds, and some of her personal funds. The bank account listed transactions that appeared to be personal transaction but not limited to which totaled $3889.21 by the Administrator. On . . . , Check #1459 withdrawal of $550.00 for a gift. The Administrator reported that she did not know what the gift was used for. On , Check #1460 withdrawal/debit amount of $121.00. The Administrator reported that she paid a bill for her father. On , there was Nail Salon debit for $145.00. The Administrator indicated the	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 123	Continued From page 12 purchase was for her personal services. On , "WF Payment" in the amount of $368.52 for the Owner/Administrator's husband. On , United of Omaha Insurance Premium in the amount of $130.86. On , Murphy Gas Station in the amount of $25.43. On , Recurring payment authorized for Experian Credit Monitoring in the amount of $24.99. On , Great Western Insurance Premium for the Owner/Administrator's husband, $111.25. On , United of Omaha Insurance Premium in the amount of $36.97. On , debit of $51.75 and $52.78 a payment through PayPal to a church ministry. On , Applebee's restaurant in the amount of $26.85. On , Globe Life Insurance Premium for the Owner/Administrator in the amount of $14.22. On , "Business to Business VSP" in the amount of $11.20 for the Owner/Administrator. Google search of the phone number next to the transaction revealed the business to be a vision service plan. On , Zaxby's restaurant in the amount of $24.99. On , debit of $103.20 through Paypal for "proudmom091696". On , debit of $20.88 through Paypal for "shawhall". On , a debit to Village Inn in the amount of $32.68. On , a debit to OneMain Financial in the amount of $808.11. On , there was a debit for AIRBNB in the amount of $448.77, the Administrator was not able to provide explanation. AIRBNB is a vacation rental company which operates an online marketplace for lodging, primarily homestays for	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 123	Continued From page 13 vacation rentals, and tourism activities. It is based in San Francisco, California (Airbnb.com, reviewed . .). On , a debit to Murphy Gas Station in amount $70.00. On , a debit to Waffle House in the amount of $34.30. On , a debit of $103.20 through Paypal for "proudmom091696". On , a debit to Credit Acceptance in the amount of $672.26. On . . . . at 12:57 PM, an interview with the Administrator was conducted and she revealed that she did not know anything about not co-mingling resident's funds and personal funds together until around , of this year when she saw another administrator in passing and this administrator brought to her attention that resident funds could not be co-mingled with her personal account. The Administrator reported that she would use money from account ending in 8981, which she identified as the business account for residents from time to time for her personal business. The Administrator reported that she has some of her personal money in the account ending in 8981 and was using the resident account for personal use such as paying her home and car insurance, restaurants, and nail salon services. The Administrator reported that she was not aware of state regulations that addressed this issue. She revealed that she only knows how to take care of the residents and does not worry about the paperwork because it was not important to her. The Administrator reported that upon opening her facility she did not read all the regulations for assisted living facilities verbatim and when she took core training, she could not remember all information during the training.	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 123	Continued From page 14 On . . . . . at approximately 10:34 AM, an interview with the Administrator who reported that no residents had received stimulus checks. Upon review of the account summary for account ending in 8981 identified as business account for residents: Resident #10 received from IRS (Internal Revenue Service) treasure funds in the amount of $1,400, Resident #14 received from IRS treasure funds in the amount of $1,400 and Resident #8 received from IRS treasure funds in the amount of $1,400 on date . . . . The Administrator reported that resident #14 no longer lived at the facility. Administrator reported that she returned all money to social security including stimulus check for resident #14. The administrator also admitted she was using the Assisted Living Facility's resident account for depositing of monies from her Homemaker Companion Services, license #235931 and she was paying her companion employees out of the ALF resident account. Record review of a letter dated . . . . by the facility to Social Security revealed the following: "To whom it may concern: This is a reimbursement check for resident #14 who was a resident at the facility. I am asking that his direct deposit be stopped from coming in at the facility. Resident #14 moved to a group home in another city for 8 months and income was given to him while he was there, he was then placed in mental health provider, but his check was still deposited in the facility's business account 8 months of $771.00 total amount owed $6,618.00. Record review of the check in amount of $6,168.00, paid to the order of Social Security. There was no documentation of what the stimulus check was used for or whether the resident used it or whether it was forwarded to resident at the group home.	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 123	Continued From page 15 Review of Facilityhealthfinder.gov on reveals the Administrator to also be the Owner/Administrator of a Homemaker and Companion Service (license #235931). There were deposits made for the Administrator's Homemaker and Companion Service into the Assisted Living Facility resident account (ending in 8991). There were also a check in which the Administrator revealed was to pay companion staff. On .. .... , Check #1464 withdrawal/debit in the amount of $390.00. The Administrator revealed this debt was paid to staff rendering services at her Homemaker and Companion Service. On ..... , there was a deposit of $1151.00 from "WELLCAREFLCAID HCCLAIM". On ..... , there was a deposit of $4763.25 from "WELLCAREFLCAID HCCLAIM". Class II	A 123		
A 152 SS=E	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 16 or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the physical environment was free from hazards and the facility's structural, electrical systems and appurtenances were maintained in good working order. Findings include: On beginning at approximately 10:30 AM, a tour of the facility was conducted. During the tour, it was noted that approximately 50% of the facility's lights were not functioning, including lights in the general hallways, activity room, resident bedrooms, and bathrooms. The facility's	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 17 interior was dimly lit. At the time of the tour, 13 residents and 3 staff members were observed at the facility. During the facility tour on at 10:40 AM, the resident bedrooms were observed. It was noted that several ceiling tiles were hanging loose from ceiling and appeared to be stained. Additional issues included several broken curtain rods, stained carpeting, a hole in the wall of one of the bedrooms, and bedside tables without knobs for opening drawers. The tour of a resident common area revealed a light switch without a cover and exposed wiring. The resident common area was noted to have an exit door with a lighted fire exit sign above. The exit door was blocked by a large wooden fake-fireplace preventing the ability to exit through the door in the case of a fire. (Photographic evidence obtained) On approximately 10:50 AM, the facility Administrator was interviewed about the lack of lighting and other structural concerns and she responded that the lights did not work and that she was not going to pay to fix them since she would be moving to a new facility in . Class III	A 152		
AL241 SS=E	429.075( ); 59A-36.020(2) FAC LMH - Records 429.075 (3) A facility that has a limited mental health license must: (a) Have a copy of each mental health resident's community living support plan and the agreement with the mental health care services provider or provide written evidence that a request for the community living support	AL241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AL241	Continued From page 18 plan and the [illegible] agreement was sent to the Medicaid managed care plan or managing entity under contract with the Department of Children and Families within 72 hours after admission. The support plan and the agreement may be combined. (b) Have documentation provided by the department that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that has a limited mental health license or provide written evidence that a request for documentation was sent to the department within 72 hours after admission. (c) Make the community living support plan available for inspection by the resident, the resident's legal guardian or health care surrogate, and other individuals who have a lawful basis for reviewing this document. (d) Assist the mental health resident in carrying out the activities identified in the resident's community living support plan. (4) A facility that has a limited mental health license may enter into a [illegible] agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager. 59A-36.020 (2) RECORDS. (a) A facility with a limited mental health license must maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required in rule 59A-36.015, F.A.C., satisfies this condition provided that all mental health residents are clearly identified.	AL241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AL241	Continued From page 19 (b) Staff records must contain documentation that designated staff have completed limited mental health training as required by rule 59A-36.011, F.A.C. (c) Resident records must include: 1. Documentation, provided by a mental health care provider within 30 days of the resident's admission to the facility, that the resident is a mental health resident as defined in section 394.4574, F.S., and that the resident is receiving social security , or supplemental security income and , as follows: a. An affirmative statement on the Alternate Care Certification for , , ( ) form, CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-03988, that the resident is receiving SSI or SSDI due to a mental , b. Written verification provided by the Social Security Administration that the resident is receiving SSI or SSDI for a mental . Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information, or c. A written statement from the resident's case manager or other mental health care provider that the resident is an adult with severe and persistent mental . The case manager or other mental health care provider must consider the following minimum criteria in making that determination: (I) The resident is eligible for, is receiving, or has received mental health services within the last 5 years, or (II) The resident has been diagnosed as having a	AL241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AL241	Continued From page 20 severe or persistent mental . . . . . . 2. An appropriate placement assessment provided by the resident's mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment must be conducted by a psychiatrist, clinical psychologist, clinical social worker, , , ... nurse, or an individual supervised by one of these professionals. a. Any of the following documentation that contains the name of the resident and the name, signature, date, and license number, if applicable, of the person making the assessment, meets this requirement: (I) Completed Alternate Care Certification for . , , ... (. . .) form, CF-ES Form 1006, (II) Discharge Statement from a state mental hospital completed no more than 90 days before admission to the assisted living facility provided it contains a statement that the individual is appropriate to live in an assisted living facility, or (III) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility. b. A mental health resident returning to a facility from treatment in a hospital or crisis stabilization unit will not be considered a new admission and will not require a new assessment. However, a break in a resident's residency that requires the facility to execute a new resident contract or admission agreement will be considered a new admission and the resident's mental health care provider must provide a new assessment. 3. A Community Living Support Plan. Each mental health resident and the resident's mental health case manager must, in consultation with the facility administrator, prepare a plan within 30	AL241		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AL241	Continued From page 21 days of the resident's admission to the facility or within 30 days after receiving the appropriate placement assessment in paragraph (2)(c), whichever is later, that: a. Includes the specific needs of the resident that must be met in order to enable the resident to live in the assisted living facility and the community, b. Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the frequency and duration of such services, c. Includes any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities, d. Includes the [illegible] of the facility to facilitate and assist the resident in attending [illegible] and arranging transportation to [illegible] for the services and activities identified in the plan that have been provided or arranged for by the resident's mental health care provider or case manager, e. Includes a description of other services to be provided or arranged by the facility, f. Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms [illegible] to the resident that indicate the immediate need for professional mental health services, g. Is in writing and signed by the mental health resident, the resident's mental health case manager, and the assisted living facility administrator or manager and a copy placed in the resident's file. If the resident refuses to sign the plan, the resident's mental health case manager must add a statement that the resident was asked but refused to sign the plan,	AL241		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AL241	Continued From page 22 h. Is updated at least annually or if there is a significant change in the resident's behavioral health, i. , include the , Agreement described in subparagraph (2)(c)4. If included, the mental health care provider must also sign the plan; and, j. Must be available for inspection to those who have legal authority to review the document. 4. , Agreement. The mental health care provider for each mental health resident and the facility administrator or designee must prepare a written statement, within 30 days of the resident's admission to the facility or receipt of the resident's appropriate placement assessment, whichever is later. The statement: a. Provides procedures and directions for accessing emergency and after-hours care for the mental health resident. The provider must furnish the resident and the facility with the provider's 24-hour emergency crisis telephone number; b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services in section 409.912, F.S.; c. , cover all mental health residents of the facility who are clients of the same provider; and, d. , be included in the Community Living Support Plan described in subparagraph (2)(c)3. 5. Missing documentation will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the appropriate party. A documented request for such missing documentation made by the facility administrator within 72 hours of the resident's	AL241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AL241	Continued From page 23 admission will be considered a good faith effort. The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file. This Statute or Rule is not met as evidenced by: Based on staff interview, interview with the mental health provider and record review, the facility failed to maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The facility failed to ensure that 4 of 4 residents identified as receiving limited mental health had a community living support plan completed and were accessible to their mental health case managers. (#1, #2, #4 and #6) The findings included: On . . . . . at approximately 11:18 AM, an interview was conducted with the Administrator requesting an up-to-date admission and discharge log and requesting community living support plans for limited mental health residents. The Administrator presented a resident roster form which included a census of all residents residing in the facility. The documentation provided had no method to identify limited mental health residents and the Administrator stated she was not sure which residents were limited mental health at the time. The Administrator reported that she did not have an admission and discharge log for limited mental health residents and was not aware that she had to keep a log for them. The Administrator eventually identified residents #1, #2, #4 and #6 as residents receiving limited mental health services. The Administrator reported that mental health case managers stopped providing services to the residents at the	AL241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AL241	Continued From page 24 beginning of COVID-19 (Coronavirus 2019). A record review was conducted of residents' #1, #2, #4 and #6 records and there was no documentation of community living support plans. The facility also did not maintain an up-to-date admission/discharge log containing the names and dates of admission and discharge for all mental health residents. On at approximately 12:41 PM, an interview via telephone was conducted with the facility's mental health provider in regards to residents receiving limited mental health services. The Program Supervisor reported that residents #1 and #2 cases were still open, but that they had no community support living plans due to the lack of being able to conduct visits. The Program Supervisor reported that resident #6 had been discharged from mental health services because the facility's administrator had informed them that resident #6 had been admitted to a nursing home. The Program Supervisor was not aware resident #6 was still residing at the facility. The Program Supervisor also reported that resident #4's case was closed due to the Administrator not allowing case managers in building to render services. She indicated that the Administrator of the facility had been provided iPADs, so that they could conduct services virtually for residents. She stated iPADs would have allowed the residents to participate in , , , , rehabilitation programs (day treatment), primary care with the physician, medication management, and care management (,). She reports that the Administrator would not use the iPADs anymore, so they had requested she return the iPADs to the mental health provider, but the Administrator has not responded to a certified	AL241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AL241	Continued From page 25 letter or multiple calls. The Program Supervisor revealed again the iPADs were no longer being used and that they would like them . . . if the facility was not going to use the devices. The Program Supervisor stated that the case managers would call the facility, and no one would answer the phone. She also revealed the case managers would visit the facility and the Administrator would tell them that they were not allowed in the building due to COVID-19. The Program Supervisor reported that on more than one occasion, the case managers made a visit to the facility and were not allowed to visit residents. The Program Supervisor reported that the Administrator started making different excuses such as she was short staffed, or no one could come to door and sign papers. She also indicated the Administrator would not accept documentation at the door for limited mental health residents that required their signatures. She reported that the Administrator was also given the option to send the documents once signed . . . via fax, but still the Administrator was Class III	AL241		
CZ830 SS=F	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department,	CZ830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ830	Continued From page 26 or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.	CZ830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ830	Continued From page 27 (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to submit an annual comprehensive emergency management plan (CEMP) to the	CZ830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	613 CHATTAHOOCHEE ST CHATTAHOOCHEE, FL 32324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ830	Continued From page 28 county emergency management agency for approval and failed to submit daily information to the Emergency Status System (ESS). The findings included: On . . . to . . . . , a complaint investigation was conducted at the facility and a review of facility records revealed the comprehensive emergency management plan had expired on . . . . On . . . .. a review of the agency's ESS database for the facility revealed no ESS data had been reported since . . . . . . An interview was conducted with the facility's Administrator on at approximately 3:00 PM regarding both her outdated CEMP approval letter and her lack of submission to ESS. She stated, "I missed that, I am not good with paperwork." Class III	CZ830		