STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910758	08/11/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Wirick (the)	**434 4th Street, North Saint Petersburg, FL 33701**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0167 - 58a-5.025 Fac - Resident Contracts S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

Two complaint surveys, CCR# 2014005625 and CCR# 2014007375, were conducted on /

The Wirick, assisted living facility, had a deficiency at the time of the visit.

0167-Resident Contracts 58A-5.025 FAC

Based on interviews, observations and a review of resident records, the facility failed to execute contracts that contained the monthly rate for 3 of 4 residents whose Agreements for Care (contract) were reviewed (Resident #'s 1,2 and 3).

Although the resident records reviewed for Resident #'s 1, 2 and 3 contained signed contracts in them, there were no documented daily, weekly, or monthly rates.

Interview with the Administrator at 2:00 P.M. on / revealed that he does not know the exact amounts because of the changes in the Assistive Care and Managed Care reimbursements that the facility is supposed to receive on the residents behalf. He stated that all 3 residents get their personal needs allowance each month and that he receives , . . ( ) and/or Social Security funds.

Resident #1 and #3 stated during interviews conducted at 1:00 P.M. and 3:00 P.M. respectively, that they receive their personal needs allowance every month but do not know what they pay the facility.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Wirick (The)
434 4th Street, North
Saint Petersburg, FL 33701

RE: CCR# 2014005625 & CCR# 2014007375

Dear Administrator:

This letter reports the findings of two complaint surveys that were conducted on , 2014, 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. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiency identified on your survey.

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

PRC/kpr

Enclosure: State (5000-3547) Form

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