STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963963	12/23/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Angeles Residential, Inc	6341 Palm Avenue Hialeah, FL 33012	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D

Specific Tag Findings:

0000-Initial Comments

A Limited Nursing Services Monitoring Survey was conducted on , 2014. Angeles Residential had a deficiency at time of survey.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on observation, record review and interview facility failed to comply with the continuous residency criteria for 1 out of 2 sampled residents (#2).

Findings included:

On , 2014 at 8:18 am during tour of the facility, resident # 2 was observed in # laying in bed with bunny boots on her feet. Attempted to interview resident, but she was physically and verbally unresponsive.

On , 2014 at 8:22 am caregiver stated that resident is not able to do anything on her own, that she needs total assistance with her Activities of Daily Living and needs medication administration.

On , 2014 at 8:30 am spoke to facility owner on the phone and she stated that resident was very independent but was in the hospital and then came back needing total assistance with her Activities of Daily Living and that she spoke to the family and they are planning to place her in hospice.

Record review of resident # 2 revealed that last health assessment was conducted on and states that resident needs assistance with her Activities of Daily Living and self administration of medications.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Angeles Residential, Inc
6341 Palm Avenue
Hialeah, FL 33012

Dear Administrator:

This letter reports the findings of a limited nursing services monitoring survey that was conducted on , 2014 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.

Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies 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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure
XG90

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