

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 07/15/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11968203	(X3) DATE SURVEY COMPLETED 07/06/2015
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH ASSISTED LIVING FACILITY, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7615 BARRY RD TAMPA, FL 33615	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
0000 - Initial Comments Assisted Living Facility A complaint survey, CCR# 2015004729, was conducted on Saint Joseph Assisted Living Facility, Inc. had a deficiency at the time of the visit. 0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC Based upon record review & interview, the facility did not ensure that all required information on the health assessment was completed in entirety for 1 (# 2) of 6 residents reviewed. Findings include: On during a record review it was revealed the health assessment (1823) for Resident #2 did not include information pertaining to the management method of the resident's medications. During interview with the facility owner at approximately 1:00 PM she stated that she had not noticed this information was missing. Class III		



RICK SCOTT
GOVERNOR

ELIZABETH DUKE
SECRETARY

, 2015

Administrator
Saint Joseph Assisted Living Facility, Inc.
7615 Barry Rd
Tampa, FL 33615

RE: CCR# 2015004729

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2015, 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 your corrective action and any additional documentation to support correction of identified deficiency to the Field Office no later than , 2015.** 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.

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,


Patricia Reid Cauffman
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



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