AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910758	**08/14/2015**
NAME OF PROVIDER OR SUPPLIER **WIRICK (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **434 4TH STREET, NORTH** **SAINT PETERSBURG, FL 33701**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2015006127, was conducted on 8/14/15 in conjunction with biennial state licensure survey with limited nursing services (LNS) and limited mental health services (LMH), and a revisit to a complaint survey, CCR# 2015005110 of 5/22/15.

The Wirick, assisted living facility, had no deficiencies at the time of the visit.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

August 24, 2015

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

RE: Revisit, Biennial with LNS, CCR# 2015006127

Dear Administrator:

This letter reports the findings of a state licensure revisit survey, a biennial state licensure survey with limited nursing services (LNS), and a complaint survey that were conducted on August 14, 2015, by representative(s) of this office.

Attached are the provider's copies of the Revisit Report, which indicates the deficiencies relative to the revisit were corrected, and the State (5000-3547) Forms, which indicates the deficiencies that were identified on the day of the visit relative to the biennial with LNS and complaint survey. 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than September 3, 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 deficiencies 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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosures: Revisit Report & State Forms 5000-3547