State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11964714	A. Building B. Wing	7/9/2012

Name of Facility	Street Address, City, State, Zip Code
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0007 Reg. # 58A-5.0181(1) FAC LSC	Correction Completed 07/09/2012	ID Prefix A0078 Reg. # 58A-5.019(2) FAC LSC	Correction Completed 07/09/2012	ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	Correction Completed 07/09/2012
ID Prefix A0082 Reg. # 58A-5.0191(3) FAC LSC	Correction Completed 07/09/2012	ID Prefix A0090 Reg. # 58A-5.0191(11) FAC LSC	Correction Completed 07/09/2012	ID Prefix A0092 Reg. # 58A-5.020(1) FAC LSC	Correction Completed 07/09/2012
ID Prefix A0152 Reg. # 58A-5.023(3) FAC LSC	Correction Completed 07/09/2012	ID Prefix AZ815 Reg. # 408.809, 435.02(2), 435.06 LSC	Correction Completed 07/09/2012	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MB	8-14-12	M Smith (ACS)	8-14-12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/18/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 This reports the status of the deficiencies issued at Doreen's Assisted Living during the biennial relicensure survey, conducted on 04/18/2012. During the biennial relciensure revisit survey conducted on July 9, 2012, the following deficiencies were corrected, specifically: A 0007 A 0078 A 0081 A 0082 A 0090 A 0092 A 0152 A Z815 The following deficiencies remain uncorrected, specifically: A 0008 A 0025 A 0054 A 0079 A 0080 A 0165 Note: The biennial relicensure revisit survey was conducted in conjunction with the Complaint Inspection ##2011010877 revisit survey. Please refer to the separate report.	{A 000}		
{A 008} SS=D	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a	{A 008}		

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
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 008}	Continued From page 1	{A 008}		

licensed health care provider, as specified in either paragraph (a) or (b) of this subsection.
(a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following:
1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations;
2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living;
3. Any nursing or therapy services required by the individual;
4. Any special diet required by the individual;
5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication;
6. Whether the individual has signs or symptoms of a communicable disease which is likely to be transmitted to other residents or staff;
7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual ' s needs can be met in an assisted living facility; and
8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state.
(b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, October 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the

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
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 008}	Continued From page 2	{A 008}		

Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows:

1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment.

a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion.

b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider.

c. Omitted information received verbally must be documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided.

2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the elements in Section 3. This requirement does not apply for residents receiving:

a. Extended congregate care (ECC) services in facilities holding an ECC license;

b. Services under community living support plans in facilities holding limited mental health licenses;

c. Medicaid assistive care services; and

d. Medicaid waiver services.

(c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 008}	Continued From page 3 1823. (d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule. (f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a do-not-resuscitate order for residents who do not wish cardiopulmonary resuscitation to be administered in the case of cardiac or respiratory arrest. (g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility ' s admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission.	{A 008}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 008}	Continued From page 4	{A 008}		

This Statute or Rule is not met as evidenced by:
Based on interview and record review, the facility failed to ensure resident records contained all required components, specifically 1). ensuring the health assessment was complete and 2). documentation of physician orders for hospice services for 2 out of 4 sampled residents (Resident #2 and #3).

The findings are:

1). Review of Resident #2's record revealed her most recent health assessment dated 07/03/2012 was incomplete. The question of whether the resident requires 24 hour nursing and/or psychiatric care was left blank.

2). Record review and interview with the Administrator on 07/09/2012 at approximately 9:45 AM revealed Resident #2 and #3 are both recipients of hospice services. However, further record review and interview revealed there was no documentation of a physicians order initiating hospice services for both residents, as required.

Class III
This is an uncorrected deficiency.

{A 025} SS=D 58A-5.0182(1) FAC Resident Care - Supervision {A 025}

An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility.
(1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following:
(a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C.
(b) Daily observation by designated staff of the

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
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 025}	Continued From page 5	{A 025}		

activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual.
(c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community.
(d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
(e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to provide appropriate supervision for 1 out of 4 sampled residents (Resident #3).

The findings are:

Review of Resident #3's record revealed on she was admitted to the facility on 04/07/2011. Review of her most recent health assessment dated 07/03/2012 revealed the resident's diagnosis includes Parkinson's disease, anxiety, UTI's weakness, dementia, functional decline, forgetful and requires fall precautions. The health assessment also documented the resident requires "total" assistance with her activities of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 025}	Continued From page 6 daily living. Review of Resident #3's the record revealed the following incident documented by the Administrator: 04/20/2012-"Got up from chair and fell, all intact, fat lip. Niece was called". During a further investigation with the Administrator and the hospice nurse on duty on 07/09/2012 at approximately 10:00 AM, it was reported the resident's niece notified her physician of the incident (exact date and time unknown). Review Resident #3's radiology report dated 04/26/2012 revealed the findings include "a displaced comminuted fracture of the left symphysis pubis, inferior pubic ramus", which was a result from the fall that occurred on 04/20/2012. Class III This is an uncorrected deficiency.	{A 025}		
{A 054} SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider ' s name, the resident ' s name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known allergies the resident may have; the name	{A 054}		

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
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 054}	Continued From page 7	{A 054}		

of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered.
(c) For medications which serve as chemical restraints, the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication.

This Statute or Rule is not met as evidenced by:
Based on record review, the facility failed to ensure the Medication Observation Records (MOR's) were accurate and up-to-date for 2 out of 4 sampled residents (Resident #1 and #4).

The findings are:

Upon review of the current MOR's for Resident #1, #2 and #4 dated 07/2012, it was revealed the MOR's were inaccurate and not up-to-date. The following discrepancies were notified:

1). Resident #1: The MOR read :Fluvoxamine Maleate 50 mg; take 1/2 tablet once daily. However, review of the actual medication bottle revealed the label read: Fluvoxamine Maleate 100 mg; take 1/2 tablet once daily.

2). Resident #4:

a. The MOR read: Klor-Con 10 mg; take 1 tab once daily. However, review of the actual medication bottle revealed the label read: Klor-Con 10 meq.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 054}	Continued From page 8	{A 054}		

b. The MOR read: Metoprolol .25 mg; take 1/2 tablet two times daily. However, review of the actual medication bottle revealed the label read: Metoprolol 25 mg; take 1/2 tablet twice daily.

c. The MOR read: Aspirin 81 mg; take 1 tablet once a day at 8 AM. However, review of the actual medication bottle revealed the label read: Aspirin 81 mg; take t tablet at bedtime.

Class III
This is an uncorrected deficiency.

{A 079} SS=D 58A-5.019(4) FAC Staffing Standards - Levels {A 079}

(4) STAFFING STANDARDS.
(a) Minimum staffing:
1. Facilities shall maintain the following minimum staff hours per week:

Number of Residents	Staff Hours/Week
0-5	168
6-15	212
16-25	253
26-35	294
36-45	335
46-55	375
56-65	416
66-75	457
76-85	498
86-95	539

For every 20 residents over 95 add 42 staff hours per week.
2. At least one staff member who has access to facility and resident records in case of an emergency shall be within the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are

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
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 079}	Continued From page 9	{A 079}		

absent from the facility.
3. In facilities with 17 or more residents, there shall be at least one staff member awake at all hours of the day and night.
4. At least one staff member who is trained in First Aid and CPR, as provided under Rule 58A-5.0191, F.A.C., shall be within the facility at all times when residents are in the facility.
5. During periods of temporary absence of the administrator or manager when residents are on the premises, a staff member who is at least 18 years of age, must be designated in writing to be in charge of the facility.
6. Staff whose duties are exclusively building maintenance, clerical, or food preparation shall not be counted toward meeting the minimum staffing hours requirement.
7. The administrator or manager ' s time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility ' s staffing schedule.
8. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.
(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, shall have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 58A-5.0182, F.A.C.
(c) The facility must maintain a written work schedule which reflects its 24-hour staffing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 079}	Continued From page 10	{A 079}		

pattern for a given time period. Upon request, the facility must make the daily work schedules for direct care staff available to residents or representatives, specific to the resident ' s care.
(d) The facility shall be required to provide staff immediately when the Agency determines that the requirements of paragraph (a) are not met. The facility shall also be required to immediately increase staff above the minimum levels established in paragraph (a) if the Agency determines that adequate supervision and care are not being provided to residents, resident care standards described in Rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents ' contracts. The Agency shall consult with the facility administrator and residents regarding any determination that additional staff is required.
1. When additional staff is required above the minimum, the agency shall require the submission, within the time specified in the notification, of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met. The plan shall be reviewed by the agency to determine if the plan will increase the staff to needed levels and meet resident needs.
2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, modifications may be made in staffing requirements for the facility and the facility shall no longer be required to maintain a plan with the agency.
3. Based on the recommendations of the local fire safety authority, the Agency may require additional staff when the facility fails to meet the fire safety standards described in Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 079}	Continued From page 11 Agency that fire safety requirements are being met. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of Rule 58A-5.029, 58A-5.030, or 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to maintain an up-to-date written work schedule reflecting the facility's 24 hour staffing pattern. The findings are: During a review of the facility's staffing schedule it was noted the facility did not have a current schedule reflecting a 24 hour staffing pattern. The schedule lacked documentation of staff coverage from 11 PM to 7 AM, on a daily basis. Class III This is an uncorrected deficiency.	{A 079}		
{A 080} SS=D	58A-5.0191(1) FAC Training - Core & Competency Test Staff Training Requirements and Competency Test. (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST.	{A 080}		

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
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 080}	Continued From page 12	{A 080}		

(a) The assisted living facility core training requirements established by the department pursuant to Section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test.
(b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to July 1, 1997, and managers who attended the core training program prior to April 20, 1998, shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with Part II of Chapter 468, F.S., are exempt from this requirement.
(c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years as provided under Section 429.52, F.S.
(d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must:
1. Retake the assisted living facility core training; and
2. Retake and pass the competency test.
(e) The fees for the competency test shall not exceed $200. The payment for the competency

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
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 080}	Continued From page 13 test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure the Administrator ' s file included proof of competency test, as required. The findings include: During the biennial relicensure survey conducted on 04/18/2012, the Administrator was mandated to retake the ALF CORE training course Upon record review and interview with the Administrator during the relicensure revisit survey, conducted on 07/09/2012 at approximately 10:00 AM, it was revealed that she retook the ALF CORE training in June of 2012. However,the Administrator reported that she has not taken the the competency test, as of the day of the revisit survey. The Administrator reported that she is scheduled to take the test on 08/04/2012. Class III This is an uncorrected deficiency.	{A 080}		
{A 165} SS=D	429.23 FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to	{A 165}		

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
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 165}	Continued From page 14	{A 165}		

assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences.
(2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, " adverse incident " means:
(a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in:
1. Death;
2. Brain or spinal damage;
3. Permanent disfigurement;
4. Fracture or dislocation of bones or joints;
5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;
6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or
7. An event that is reported to law enforcement or its personnel for investigation; or
(b) Resident elopement, if the elopement places the resident at risk of harm or injury.
(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident.
(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 165}	Continued From page 15	{A 165}		

adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident.
(6) Abuse, neglect, or exploitation must be reported to the Department of Children and Family Services as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.
(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.
(10) The Department of Elderly Affairs may adopt rules necessary to administer this section.

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
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 165}	Continued From page 16 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within one (1) business day after the incident on AHCA Form 3180-1024, Assisted Living Facility Initial Adverse Incident Report-1 Day, January 2006, and incorporated by reference. The form shall be submitted via electronic mail to riskmgmtps@ahca.myflorida.com; on-line at http://ahca.myflorida.com/reporting/index.shtml; by facsimile to (850)922-2217; or by U.S. Mail to AHCA, Florida Center for Health Information and Policy Analysis, 2727 Mahan Drive, Mail Stop 16, Tallahassee, Florida 32308-5403, telephone (850)412-3731. AHCA Form 3180-1024 is available from the Florida Center for Health Information and Policy Analysis at the address stated above. The Initial Adverse Incident Report is in addition to, and does not replace, other reporting requirements specified in Florida Statutes. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported under subsection (1) above, the facility shall submit a full report within fifteen (15) days of the incident. The full report shall be submitted on AHCA Form 3180-1025, Assisted Living Facility Full Adverse Incident Report-15 Day, dated January 2006, and incorporated by reference. The methods for obtaining and submitting the form are set forth in subsection (1) of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide appropriate supervision for 1 out of 4 sampled residents (Resident #3).	{A 165}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964714	A. BUILDING _____ B. WING _____	R 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOREEN'S ASSISTED LIVING HOME	3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435

(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 165}	Continued From page 17	{A 165}		

The findings are:

Review of Resident #3's record revealed on she was admitted to the facility on 04/07/2011. Review of her most recent health assessment dated 07/03/2012 revealed the resident's diagnosis includes Parkinson's disease, anxiety, UTI's weakness, dementia, functional decline, forgetful and requires fall precautions. The health assessment also documented the resident requires "total" assistance with her activities of daily living. Review of Resident #3's the record revealed the following incident documented by the Administrator:

04/20/2012-"Got up from chair and fell, all intact, fat lip. Niece was called".

During a further investigation with the Administrator and the hospice nurse on duty on 07/09/2012 at approximately 10:00 AM, it was reported the resident's niece notified her physician of the incident (exact date and time unknown). Review Resident #3's radiology report dated 04/26/2012 revealed the findings include "a displaced comminuted fracture of the left symphysis pubis, inferior pubic ramus", which was a result from the fall that occurred on 04/20/2012.

During a further interview the Administrator confirmed that she did not submit a preliminary adverse incident report within one (1) business day after the incident, as required.

Class III
This is an uncorrected deficiency.

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

August 14, 2012

Administrator
Doreen's Assisted Living Home
3045 S. Seacrest Boulevard
Boynton Beach, FL 33435

Dear Administrator:

This letter reports the findings of a revisit survey conducted on July 9, 2012 by a representative of this office. Enclosed is the provider's copy of the State Form Revisit Report which identifies the corrected deficiencies found at the time of the revisit. Also enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references uncorrected deficiencies identified during the revisit. **All deficiencies shall be corrected no later than August 30, 2012.**

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 this agency's representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

A.C. Boyles, HFE Supervisor
for Arlene Mayo-Davis
Field Office Manager

AMD/hl
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924