

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1912047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER CAPRICORN RETIREMENT HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 13720 NW 1ST AVENUE MIAMI, FL 33168		
(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 An follow up Standard Biennial was conducted at Capricorn Retirement Home Assisted Living Facility (ALF) with Limited Mental Health (LMH) component on , 2012. The following deficiencies were found at the time of the visit.	{A 000}		
{A 077} SS=D	58A-5.019(1) FAC Staffing Standards - Administrators Staffing Standards. (1) ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429, F.S., and this rule chapter. (a) The administrators shall: 1. Be at least 2. If employed on or after , 1990, have a high school diploma or general equivalency diploma (G.E.D.), or have been an operator or administrator of a licensed assisted living facility in the State of Florida for at least one of the past 3 years in which the facility has met minimum standards. Administrators employed on or after , 1995, must have a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening standards pursuant to Section 429.174, F.S.; and 4. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C. (b) Administrators may supervise a maximum of either three assisted living facilities or a combination of housing and health care facilities or agencies on a single campus. However, administrators who supervise more than one facility shall appoint in writing a separate "	{A 077}		

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 2

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11912047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER CAPRICORN RETIREMENT HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 13720 NW 1ST AVENUE MIAMI, FL 33168		
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{A 077}	Continued From page 1 manager" for each facility who must: 1. Be at least _____; and 2. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C. (c) Pursuant to Section 429.176, F.S., facility owners shall notify both the Agency Field Office and Agency Central Office within ten (10) days of a change in a facility administrator on the Notification of Change of Administrator, AHCA Form 3180-1006, _____, 2006, which is incorporated by reference and may be obtained from the Agency Central Office. The Agency Central Office shall conduct a background screening on the new administrator in accordance with Section 429.174, F.S., and Rule 58A-5.014, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have documentation of the administrator having a high school education diploma on file or a general equivalency diploma. Findings includes: 1. Record review revealed that the administrator did not have her high school diploma in her file. There was no documentation of a general equivalency diploma (G.E.D) in her file. 2. Interview with the administrator on _____ at 11:00am confirmed she did not have her high school diploma in her file; and there was no documentation of a G.E.D. in her file. Class III	{A 077}			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11912047	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/30/2012
Name of Facility CAPRICORN RETIREMENT HOME INC	Street Address, City, State, Zip Code 13720 NW 1ST AVENUE MIAMI, FL 33168	

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 <u>A0052</u> Reg. # <u>58A-5.0185(3) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0078</u> Reg. # <u>58A-5.019(2) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0081</u> Reg. # <u>58A-5.0191(2) FAC</u> LSC _____	Correction Completed
ID Prefix <u>A0082</u> Reg. # <u>58A-5.0191(3) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0090</u> Reg. # <u>58A-5.0191(11) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0152</u> Reg. # <u>58A-5.023(3) FAC</u> LSC _____	Correction Completed
ID Prefix <u>A0160</u> Reg. # <u>58A-5.024(1) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0161</u> Reg. # <u>58A-5.024(2) FAC</u> LSC _____	Correction Completed	ID Prefix <u>AL242</u> Reg. # <u>58A-5.029(3) FAC</u> LSC _____	Correction Completed
ID Prefix <u>AL243</u> Reg. # <u>58A-5.0191(8) FAC</u> LSC _____	Correction Completed	ID Prefix <u>AZ815</u> Reg. # <u>408.809, 435.02(2), 435.06</u> 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: <i>Rustal Banton</i>	Date: <u>8/13/2012</u>
Reviewed By _____ CMS RO _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Followup to Survey Completed on: _____		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Capricorn Retirement Home Inc
13720 Nw 1st Avenue
Miami, FL 33168

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2012 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references the uncorrected deficiencies and/or new deficiencies, identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 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 the surveyor. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

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