

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967860		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/08/2012	
NAME OF PROVIDER OR SUPPLIER MIAMI COMFORT COVE, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3511 N W 11 COURT MIAMI, FL 33127			
(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 A Follow-up Survey was conducted on 2012. The Miami Comfort Cove, Inc had deficiencies found at the time of the visit.			{A 000}			
{A 025} SS=D	58A-5.0182(1) FAC Resident Care - Supervision 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 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.			{A 025}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

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93XB12

If continuation sheet 1 of 2

Agency for Health Care Administration

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{A 025}	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to document significant changes in health for 1 out of 1 (SR#1) sampled resident. Findings include: A follow-up visit conducted on _____, 2012 revealed that the facility did not document the significant change in SR#1's health. Record review revealed that SR#1 was admitted to hospice care on _____ and last health assessment was _____. Review of the SR#1's hospice file revealed that on SR#1 had a _____ on left elbow and on _____ the _____ issue was resolved. Further review of SR#1's file revealed no documentation that showed SR#1 had a on left elbow. On _____, 2012 at 10:34am, the surveyor conducted an interview with the administrator. The administrator searched through SR#1's file and provided the surveyor with a progress note dated _____. It is recorded on the progress note that, "perfect skin, no major changes." The administrator acknowledged not documenting the significant change in SR#1's health that occurred on _____ and told the surveyor that SR#1's _____ had healed. Class III	{A 025}			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967860	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 8/8/2012
Name of Facility MIAMI COMFORT COVE, INC		Street Address, City, State, Zip Code 3511 N W 11 COURT MIAMI, FL 33127

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>A0030</u> Reg. # <u>58A-5.0182(6) FAC; 429.28</u> LSC _____	Correction Completed	ID Prefix <u>A0160</u> Reg. # <u>58A-5.024(1) FAC</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
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	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
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
Miami Comfort Cove, Inc
3511 N W 11 Court
Miami, FL 33127

Dear Administrator:

This letter reports the findings of a revisit survey to a biennial 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,

Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

BBT7

