AH Form Approved

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number
AL11966254

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
7/23/2012

Name of Facility
GOOD SHEPHERD ALF, LLC

Street Address, City, State, Zip Code
8610 NW 24 COURT
SUNRISE, FL 33322

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **A0008** Reg. # **58A-5.0181(2) FAC** LSC		ID Prefix **A0025** Reg. # **58A-5.0182(1) FAC** LSC		ID Prefix **A0092** Reg. # **58A-5.020(1) FAC** LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:** M.T. Smith (MCS)	**Date:**
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**

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
	AL11966254	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ALF, LLC	8610 NW 24 COURT SUNRISE, FL 33322

(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 during the biennial licensure survey conducted on at Good Shepherd Manor. During the revisit survey, conducted on , the following deficiencies were corrected, specifically: A 0008, A 0025 and A 0092 The following deficiencies remained uncorrected during the revisit, specifically: A 0078, A 0083, 0084, A 0161 and A 0162 The Complaint Inspection #2012007213 was conducted in conjunction with the biennial licensure revisit survey. Please refer to the separate report.	{A 000}		
{A 078} SS=D	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Newly hired staff shall have 30 days to submit a statement from a health care provider, based on a examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable including . Freedom from must be documented on an annual basis. A person with a positive test must submit a health care provider ' s statement that the person does not constitute a risk of communicating . Newly hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in service. If any staff member is later found to have, or is suspected of having, a communicable	{A 078}		

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
	AL11966254	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ALF, LLC	8610 NW 24 COURT SUNRISE, FL 33322

(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 078}	Continued From page 1	{A 078}		

he/she shall be removed from duties until the administrator determines that such condition no longer exists.
(b) All staff shall be assigned duties consistent with his/her level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff shall exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s health care provider in accordance with this rule chapter.
(c) All staff must comply with the training requirements of Rule 58A-5.0191, F.A.C.
(d) Staff provided by a staffing agency or employed by a business entity contracting to provide direct or indirect services to residents must be qualified for the position in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor shall specifically describe the services the staffing agency or contractor will be providing to residents.
(e) For facilities with a licensed capacity of 17 or more residents, the facility shall:
1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and
2. Maintain time sheets for all staff.

This Statute or Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure 2 out of 5 sampled employees records contained documentation the individual does not have any signs or symptoms of a communicable including
(Employee #4 and #5).

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
	AL11966254	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ALF, LLC	8610 NW 24 COURT SUNRISE, FL 33322

(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 078}	Continued From page 2 The findings are: 1. Review of Employee #4's personnel record revealed she was hired in . Further review of the record revealed the file lacked documentation she does not have any signs or symptoms of a communicable including within 30 days of hire, as required. 2. During an interview with the Administrator on at approximately 12:15 PM, she confessed that Employee #5 works at the facility on the weekends. The Administrator stated the employee has worked at the facility for "quite a while". Upon further investigation, it was revealed Employee #5 is an illegal alien and the facility does not have a file nor any type of paperwork for this individual, including documentation of freedom of as required. Class III This is an uncorrected deficiency.	{A 078}		
{A 083} SS=D	58A-5.0191(4) FAC Training - First Aid and (4) FIRST AID AND . A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation of attendance at First Aid or course offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American Association, or National Safety Council; or a provider approved by the Department of Health, shall satisfy this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency	{A 083}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966254	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ALF, LLC	8610 NW 24 COURT SUNRISE, FL 33322

(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 083}	Continued From page 3 medical technician or paramedic currently certified under Part III of Chapter 401, F.S., shall be considered as having met the training requirements for both First Aid and . . . . This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a staff member who has completed courses in holds a currently valid card documenting completion of such courses, must be in the facility at all times. The findings include: During an interview with the Administrator on : at approximately 12:15 PM, she confessed that Employee #5 works at the facility on the weekends. The Administrator stated the employee has worked at the facility for "quite a while". Upon further investigation, it was revealed Employee #5 is an illegal alien and the facility does not have a file nor any type of paperwork for this individual, including documentation of current validation of completion of training in and First Aid, as required. Further interview with the Administrator revealed Employee #5 is left alone and solely in-charge of the residents on the weekends on a routine basis. Class III This is an uncorrected deficiency.	{A 083}		
{A 084} SS=D	58A-5.0191(5) FAC Training - Assis Self-Admin Meds & Med Mgmt (5) ASSISTANCE WITH SELF-ADMINISTERED MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be	{A 084}		

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
	AL11966254	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ALF, LLC	8610 NW 24 COURT SUNRISE, FL 33322

(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 084}	Continued From page 4	{A 084}		

providing assistance with self-administered medications as described in Rule 58A-5.0185, F.A.C., must meet the training requirements pursuant to Section 429.52(5), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria:
(a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises.
(b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates an ability to:
1. Read and understand a prescription label;
2. Provide assistance with self-administration in accordance with Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., including:
a. Assist with oral dosage forms, [illegible] dosage forms, and [illegible] and nasal dosage forms;
b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions;
c. Recognize the need to obtain clarification of an

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
	AL11966254	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ALF, LLC	8610 NW 24 COURT SUNRISE, FL 33322

(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 084}	Continued From page 5 " as needed " prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident ' s health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; and g. Recognize the general signs of adverse reactions to medications and report such reactions. (c) Unlicensed persons, as defined in Section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 4 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training shall only be provided by a licensed registered nurse, or a licensed pharmacist. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 out of 5 sampled employees obtained the training requirements for assisting residents with self-administered medications, as required (Employee #1 and #5). The findings include: 1. Interview with the Administrator on at approximately 12:15 PM revealed Employee #3 assists residents with self-administered medications on a routine basis. Review of Employee #3's personnel record revealed the file lacked documentation indicating the she received	{A 084}		

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
	AL11966254	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ALF, LLC	8610 NW 24 COURT SUNRISE, FL 33322

(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 084}	Continued From page 6 a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility on an annual basis for 2012, as required. 2). During an interview with the Administrator on at approximately 12:15 PM, she confessed that Employee #5 works at the facility on the weekends. The Administrator stated the employee has worked at the facility for "quite a while". She also confirmed the employee assists residents with self-administered medications. Upon further investigation, it was revealed Employee #5 is an illegal alien and the facility does not have a file nor any type of paperwork for this individual, including documentation she obtained the training requirements for assisting residents with self-administered medications. Class III This is an uncorrected deficiency.	{A 084}		
{A 161} SS=D	58A-5.024(2) FAC Records - Staff (2) STAFF RECORDS. (a) Personnel records for each staff member shall contain, at a minimum, a copy of the original employment application with references furnished and verification of freedom from communicable including . In addition, records shall contain the following, as applicable: 1. Documentation of compliance with all staff training required by Rule 58A-5.0191, F.A.C.; 2. Copies of all licenses or certifications for all staff providing services which require licensing or certification; 3. Documentation of compliance with level 1 background screening for all staff subject to screening requirements as required under Rule	{A 161}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966254	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ALF, LLC	8610 NW 24 COURT SUNRISE, FL 33322

(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 161}	Continued From page 7	{A 161}		

58A-5.019, F.A.C.;
4. A copy of the job description given to each staff member pursuant to Rule 58A-5.019, F.A.C., for facilities with a licensed capacity of seventeen (17) or more residents; and
5. Documentation of facility direct care staff and administrator participation in resident elopement drills pursuant to paragraph 58A-5.0182(8)(c), F.A.C.
(b) The facility shall not be required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by a business entity contracting to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 58A-5.019, F.A.C.
(c) The facility shall maintain the facility ' s written work schedules and staff time sheets as required under Rule 58A-5.019, F.A.C., for the last 6 months.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure personnel records were available and contained documentation of all required components, as required for 1 out of 5 sampled employees (Employee #5).

The findings are:

During an interview with the Administrator on [redacted] at approximately 12:15 PM, she confessed that Employee #5 works at the facility on the weekends. The Administrator stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966254	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ALF, LLC	8610 NW 24 COURT SUNRISE, FL 33322

(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 161}	Continued From page 8	{A 161}		

employee has worked at the facility for "quite a while". She also confirmed the employee assists residents with self-administered medications. Upon further investigation, it was revealed Employee #5 is an illegal alien and the facility does not have a personnel file with all of the required components, specifically:

1. Documentation with all staff training requirements.
2. Copies of all certifications of training as required for providing personal services to residents.
3. Documentation of compliance with background screening requirements.
4. Documentation of participation in resident elopement drills.
5. Employment application with references.
6. Verification of freedom from communicable [illegible] including [illegible]

Class III
This is an uncorrected deficiency.

{A 162} SS=D	58A-5.024(3) FAC Records - Resident	{A 162}		

(3) RESIDENT RECORDS. Resident records shall be maintained on the premises and include:
(a) Resident demographic data as follows:
1. Name;
2. [illegible]
3. Race;
4. Date of birth;
5. Place of birth, if known;
6. Social security number;
7. Medicaid and/or Medicare number, or name of other health insurance
8. Name, address, and telephone number of next of kin, responsible party, or other person the resident would like to have notified in case of an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966254	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ALF, LLC	8610 NW 24 COURT SUNRISE, FL 33322

(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 162}	Continued From page 9	{A 162}		

emergency, and relationship to resident; and
9. Name, address, and phone number of health care provider, and case manager if applicable.
(b) A copy of the medical examination described in Rule 58A-5.0181, F.A.C.
(c) Any health care provider ' s orders for medications, nursing services, therapeutic diets, or other services to be provided. supervised, or implemented by the facility that require a health care provider ' s order.
(d) A signed statement from a resident refusing a therapeutic diet pursuant to Rule 58A-5.020, F.A.C.
(e) The resident record described in paragraph 58A-5.0182(1)(e), F.A.C.
(f) A weight record which is initiated on admission. Information may be taken from the resident ' s health assessment. Residents receiving assistance with the activities of daily living shall have their weight recorded semi-annually.
(g) For facilities which will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident ' s contract.
(h) For facilities which manage a pill organizer, assist with self-administration of medications or administer medications for a resident, the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C.
(i) A copy of the resident ' s contract with the facility, including any addendums to the contract, as described in Rule 58A-5.025, F.A.C.
(j) For a facility whose owner, administrator, or staff, or representative thereof serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction

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
	AL11966254	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ALF, LLC	8610 NW 24 COURT SUNRISE, FL 33322

(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 162}	Continued From page 10	{A 162}		

made on behalf of the resident as required under Section 429.27, F.S.
(k) For any facility which maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required under Section 429.27, F.S.
(l) A copy of Alternate Care Certification for Form, CF-ES 1006, 1998, if the resident is an recipient. The absence of this form shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Family Services.
(m) Documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney where applicable.
(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required under Rule 58A-5.0181, F.A.C.
(o) For apartments, duplexes, quadruplexes, or single family homes that are designated for independent living but which are licensed as assisted living facilities solely for the purpose of delivering personal services to residents in their homes, when and if such services are needed, record keeping on residents who may receive meals but who do not receive any personal, limited nursing, or extended congregate care service shall be limited to the following:
1. A log listing the names of residents participating in this arrangement;
2. The resident demographic data required under this subsection;
3. The medical examination described in Rule 58A-5.0181, F.A.C.;
4. The resident ' s contract described in Rule

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
	AL11966254	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ALF, LLC	8610 NW 24 COURT SUNRISE, FL 33322

(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 162}	Continued From page 11 58A-5.025, F.A.C.; and 5. A health care provider ' s order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (p) Except for resident contracts which must be retained for 5 years, all resident records shall be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents shall be provided a copy of their resident records upon departure from the facility. (q) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 out of 4 sampled resident records contained all of the required components (Resident #1, #2 and #4). The findings are: 1). Review of Resident #1's record revealed there was no documentation of a demographic form with the required data, as required. 2). Review of Resident #2 and #4's demographic sheet revealed the form lacked documentation of the required components,specifically both of their primary physician's name, phone number and address, as required. Class III	{A 162}		

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
	AL11966254	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ALF, LLC	8610 NW 24 COURT SUNRISE, FL 33322

(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 162}	Continued From page 12 This is an uncorrected deficiency.	{A 162}		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

. 7, 2012

Administrator
Good Shepherd ALF, LLC
8610 N.W. 24th Court
Sunrise, FL 33322

Dear Administrator:

This letter reports the findings of a revisit survey conducted on . 2012 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 . 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,

M 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