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
	AL11968174	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A - KOOLBREEZE CARE BOCA MANOR	10705 ELAND ST BOCA RATON, FL 33428

(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 Complaint Inspection #2012009204 survey was conducted on [redacted]. A Koolbreeze Care Boca Manor, had deficiencies found at the time of the visit.	A 000		
A 120 SS=D	58A-5.021(1) FAC Fiscal - Financial Stability Fiscal Standards. (1) FINANCIAL STABILITY. The facility shall be administered on a sound financial basis in order to ensure adequate resources to meet resident needs. For the purposes of Section 429.47, F.S., evidence of financial instability includes filed bankruptcy by any owner; issuance of checks returned for insufficient funds; delinquent accounts; nonpayment of local, state, or federal taxes or fees; unpaid utility bills; tax or judgment liens against facility or owners property; failure to meet employee payroll; confirmed complaints to the agency or district long-term care ombudsman council regarding withholding of refunds or funds due residents; failure to maintain liability insurance due to non payment of premiums; non payment of rent or mortgage; non payment for essential services; or adverse court action which could result in the closure or change in ownership or management of the ALF. When there is evidence of financial instability, the agency shall require the facility to submit the following documentation: (a) Facilities with a capacity of 25 or less: 1. Payment of local, state or federal taxes; 2. Delinquent accounts, if any; 3. Number of checks returned for insufficient funds during the previous 24 months, if any; 4. Receipt of resident rent payment; 5. Amount of cash assets deposited in the facility bank account; 6. Capability of obtaining additional financing, if	A 120		

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
	AL11968174	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A - KOOLBREEZE CARE BOCA MANOR	10705 ELAND ST BOCA RATON, FL 33428

(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 120	Continued From page 1 needed; and 7. A statement of operations or AHCA Form 3180 1002, 1995, projecting revenues, expenses, taxes, extraordinary items, and other credits and charges for the next 12 months. (b) Facilities with a capacity of 26 or more, shall provide the documentation described in paragraph (a) above, or submit a current asset and liabilities statement or AHCA Form 3180-1003, 1998. This Statute or Rule is not met as evidenced by: Based on interview, the facility failed to provide evidence of financial stability, as required. The findings include: On during a telephone conversation at approximately 12:15 PM, the surveyor requested the Administrator to provide documentation of financial documents including all utility bills, proof that the rent was paid at the facility and proof of income assets and liabilities to determine financial stability. However, the Administrator stated that she did not have the information readily available. Class III	A 120		
A 152 SS=G	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and 2. Must be maintained free of hazards; and 3. Must ensure that all existing architectural, mechanical, electrical and structural systems and	A 152		

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
	AL11968174	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A - KOOLBREEZE CARE BOCA MANOR	10705 ELAND ST BO... RATON, FL 33428

(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 152	Continued From page 2	A 152		

appurtenances are maintained in good working order.
(b) Pursuant to Section 429.27, F.S., residents shall be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident ... sleeping area must have at least the following furnishings:
1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress a comfortable height to ensure easy access by the resident;
2. A closet or wardrobe space for hanging clothes;
3. A dresser, chest or other furniture designed for storage of personal effects;
4. A table, bedside lamp or floor lamp, and waste basket; and
5. A comfortable chair, if requested.
(c) The facility must maintain master or duplicate keys to resident ... to be used in the event of an emergency.
(d) Residents who use portable bedside commodes must be provided with privacy during use.
(e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility shall be free of tears, stains and not be ...

This Statute or Rule is not met as evidenced by:
The facility failed to provide a safe living environment free from hazards, as enforced by the local fire department.

The findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968174	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A - KOOLBREEZE CARE BOCA MANOR	10705 ELAND ST BO . . . RATON, FL 33428

(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 152	Continued From page 3	A 152		

During a review of the most recent fire inspection dated it was revealed the facility was issued several violations with a mandated correction date of . . . . . The violations included:

1). Failure to ensure the ALF was monitored by a fire alarm company (it was shut off in . . . . . due to non-payment) ; 2) Failure to make repairs needed to the fire sprinkler and 3). Failure to ensure the fire alarm system and sprinkler system was inspected quarterly.

During a telephone interview with the Administrator on at approximately 11:15 AM, she informed the surveyor that she hired a new fire alarm company, Advanced Security) last week (exact date unknown) to resolve the issue with the fire alarm monitoring. She stated the new fire alarm company (Company #2) informed her that her fire panel was currently monitored by the initial fire alarm company (Company #1). During a telephone interview on . . . . . at approximately 11:25 AM with an individual of Company #2, he confirmed that he came out to the facility "last week", checked the fire alarm panel and detected that the fire alarm panel was sending a signal to Company #1. However, the individual of Company #2, confirmed that the Administrator failed to disclose that her account with Company #1 was in-fact in default. He stated that he was unaware the fire alarm was not being monitored by a company and inactive on the day of his visit at the facility.

On the date of the complaint inspection, conducted on . . . . . at approximately 9:30

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
	AL11968174	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A - KOOLBREEZE CARE BOCA MANOR	10705 ELAND ST BOCA RATON, FL 33428

(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 152	Continued From page 4	A 152		

AM, there were 6 adults and 1 staff member at the facility 24 hours per day at risk for harm in the event of a fire due to the neglect on behalf of the Administrator ' s failure of compliance with the fire department.

The Administrator was only available by telephone during the complaint investigation. She stated that she was " too busy " to come to the facility to assist with the complaint investigation.

Class II

AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
A - Koolbreeze Care Boca Manor
10705 Eland St
Boca Raton, FL 33428

Dear Administrator:

Re: CCR #2012009204

This letter reports the findings of a state licensure survey that was conducted on 2012 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. 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. Staff from this office will conduct a review after **2012** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 representative. Should you have any questions please call the area office at 561-381-5840.

Sincerely,

Arlene Mayo-Davis (Cres)
Arlene Mayo-Davis
Field Office Manager

AMD/dlt
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