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
	AL11967322	A. BUILDING _____ B. WING _____	R 09/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING, INC	12735 NORTH MIAMI 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 A follow up biennial Survey was completed at Caring Hands Assisted Living, Inc with Limited Nursing Services on . The following deficiencies were found uncorrected at the time of survey: A 025, 078, and 081.	{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 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 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 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	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
	AL11967322	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING, INC	12735 NORTH MIAMI 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 008	Continued From page 1	A 008		

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, 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967322	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING, INC	12735 NORTH MIAMI 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 008	Continued From page 2 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 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- order for residents who do not wish to be administered in the case of or (g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967322	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING, INC	12735 NORTH MIAMI 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 008	Continued From page 3 415.1051, 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. This Statute or Rule is not met as evidenced by: Based on record review and interview the assisted living facility failed to have a completed health assessment for 1 out of 3 (#3) sampled residents and failed to ensure that the health assessment was completed by a licensed healthcare provider. Findings include: Record review found that resident #3's health assessment was left blank for activities of daily living including: ambulation, bathing, dressing, eating, self care ( ), toileting, and transferring. Record review found that the examiner's information on the health assessment was not readable and the nurse practitioner license number was not located on the department of health's providers list website. Reviewed the health assessment with the administrator and staff member on : at 3:17 p.m. who confirmed that the health assessment's ADL portion for resident #3 was blank.	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967322	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING, INC	12735 NORTH MIAMI 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 008	Continued From page 4 The facility faxed a copy of resident #3's health assessment on : and the ADL levels were check off as total care but the facility did not provide any documentation as to when the licensed health provider completed the assessment. Class III	A 008		
{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	{A 025}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967322	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING, INC	12735 NORTH MIAMI 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 025}	Continued From page 5 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 assisted living facility STILL failed to ensure that 1 out of 3 (#1) sampled residents had a written record of the resident's that cause an injury to her left arm. Findings include: Facility tour on at 12:55 p.m. with female caretaker found that resident #1 was laying in her bed. Observations revealed that resident #1's left arm was in a sling. Interview with the resident #1 revealed that she had , was taken to the hospital, and that she now has a sling on her left arm. Interview with the caretaker on at 1:48 p.m. stated that resident #1 on Thursday night, last week. She was taken to Jackson North Hospital and discharge the same day with a sling on her left arm. The notes were reviewed with the staff member, she stated that she was not working that night, she confirmed that the notes regarding the and injury were not documented at the facility. She stated that resident #1's daughter in law had the discharge papers from the hospital. Review and interview with the administrator on at 3:30 p.m. revealed that the facility's progress notes for resident #1 did not have any information regarding her and injury at the time of survey.	{A 025}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967322	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING, INC	12735 NORTH MIAMI 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 025}	Continued From page 6 Record review found that the facility did not have any documentation regarding resident #1's , her injury, or that fact that she had a sling on her left arm. Uncorrected Deficiency. Class III	{A 025}		
{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 , 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	{A 078}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967322	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING, INC	12735 NORTH MIAMI 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 078}	Continued From page 7 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 assisted living facility STILL failed to ensure that staffing standards were met. The facility failed to ensure that 2 out of 2 (#1 and #2) sampled staff members had a freedom from communicable including ( ) statement with 30 days of employment. Findings include: Record review found that staff #1 (application date) did not have a freedom from communicable statement at the facility at the time of survey. Record review found that staff #1 had been working at the facility at least since based on initialed medication observation records where she initialed "R". Record review found that staff #1's level 2 background screening was submitted and	{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
	AL11967322	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING, INC	12735 NORTH MIAMI 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 078}	Continued From page 8 approved by the agency on Interview with the administrator on at 3:35 p.m. confirmed that staff #1 did not have a freedom from communicable including statement at the facility. The facility's faxed copy of staff #1's physical examination was dated after the survey date. And also the screening result questions were left blank. Record review found that staff #2 (application date)'s physical examination was dated , the screening result questions were left blank, and that portion was not signed by the physician. Record review found that the facility failed to ensure that staff #2 who had been working there at least since based on initialed medication observation records where she initialed "MR". Record review found that staff #2's level 2 background screening was submitted and approved by the agency on Interview with the administrator on at 3:35 p.m. confirmed that staff #2 did not have a completed freedom from communicable including statement at the facility. The facility's faxed copy of staff #2's physical examination is still dated , the screening is left blank, and there are two different physician signatures on the form. Uncorrected Deficiency. Class III	{A 078}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967322	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING, INC	12735 NORTH MIAMI 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 081}	Continued From page 9	{A 081}		
{A 081} SS=D	58A-5.0191(2) FAC Training - Staff In-Service (2) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions, and facility sanitation procedures before providing personal care to residents. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting major incidents. 2. Reporting adverse incidents. 3. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the	{A 081}		

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
	AL11967322	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING, INC	12735 NORTH MIAMI 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 081}	Continued From page 10 following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility ' s resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility ' s resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview the assisted living facility STILL failed to ensure that 1 out of 2 (#2) sampled staff members who provided direct care to residents received in-service training within 30 days of employment. Findings include: Record review found that staff #2 (application date) applied for a Caregiver position did not have the required in-service training within 30 days of employment. Record review found that staff #2's level 2 background screening was submitted and approved by the agency on . The facility failed to ensure that staff	{A 081}		

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
	AL11967322	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING, INC	12735 NORTH MIAMI 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 081}	Continued From page 11	{A 081}		

#2 who had been working there at least since based on initialed medication observation records (MORs) where she initialed "MR" had the following:

-a minimum 1 hour in-service training that covers the following subjects:
1. Reporting major incidents.
2. Reporting adverse incidents.
3. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.

-a minimum of 1 hour in-service training that covers the following subjects:
1. Resident rights in an assisted living facility.
2. Recognizing and reporting resident ,
neglect, and .

-receive 3 hours of in-service training that covers the following subjects:
1. Resident behavior and needs.
2. Providing assistance with the activities of daily living.

-Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices.

-All facility staff shall receive in-service training regarding the facility ' s resident elopement response policies and procedures within thirty (30) days of employment.

Interview with a caregiver on at 2:05 p.m. revealed that staff #2 works on the weekends and initials the MORs.

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
	AL11967322	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING, INC	12735 NORTH MIAMI 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 081}	Continued From page 12 The administrator stated to the surveyor and ALF supervisor on at 3:17 p.m. that staff #2 is only "training" at the facility, he was not sure if he was going to keep her, and he did not have training records for her. He stated that he would contact her to see if she had any training that he could provide to the agency. He made it clear during the exit that he had no documentation that she completed or had any training documents for her. On the agency received training certificates for a learning center and training which were signed for staff #2 by the administrator. The training which were signed by the administrator for staff #2 were dated from to , after the administrator stated on that he did not have any training documentation for staff #2. Uncorrected Deficiency. Class III	{A 081}		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11967322	A. Building B. Wing	9/11/2012

Name of Facility	Street Address, City, State, Zip Code
CARING HANDS ASSISTED LIVING, INC	12735 NORTH MIAMI 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 A0026 Reg. # 58A-5.0182(2) FAC LSC	Correction Completed	ID Prefix A0030 Reg. # 58A-5.0182(6) FAC; 429.28 LSC	Correction Completed	ID Prefix A0052 Reg. # 58A-5.0185(3) FAC LSC	Correction Completed
ID Prefix A0055 Reg. # 58A-5.0185(6) FAC LSC	Correction Completed	ID Prefix A0079 Reg. # 58A-5.019(4) FAC LSC	Correction Completed	ID Prefix A0083 Reg. # 58A-5.0191(4) FAC LSC	Correction Completed
ID Prefix A0084 Reg. # 58A-5.0191(5) FAC LSC	Correction Completed	ID Prefix A0090 Reg. # 58A-5.0191(11) FAC LSC	Correction Completed	ID Prefix A0092 Reg. # 58A-5.020(1) FAC LSC	Correction Completed
ID Prefix A0162 Reg. # 58A-5.024(3) FAC LSC	Correction Completed	ID Prefix A0182 Reg. # 58A-5.026(3) FAC LSC	Correction Completed	ID Prefix AZ815 Reg. # 408.809, 435.02(2), 435.06 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: Krystal Granton	Date: 9/17/2012
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

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Caring Hands Assisted Living, Inc
12735 North Miami Avenue
Miami, FL 33168

Revise Letter

Dear Administrator:

This letter reports the findings of a revisit survey to a biennial conducted on , 2012by 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

BBT7

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

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone (305) 593-3100; Fax (305) 593-3121