

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967731	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER CHARLES' PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3131 GATLIN DRIVE ROCKLEDGE, FL 32955		
(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 CCR# 2012008708 was conducted on _____. A deficiency was found at the time of the visit pertaining to the complaint.	A 000		
A 167	58A-5.025(1) FAC Resident Contracts Resident Contracts. (1) Pursuant to Section 429.24, F.S., prior to or at the time of admission, each resident or legal representative shall execute a contract with the facility which contains the following provisions: (a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services if the facility is licensed to provide such services. (b) The daily, weekly, or monthly rate. (c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule which shall be attached to the contract. (d) A provision giving at least 30 days written notice prior to any rate increase. (e) Any rights, duties, or _____ of residents, other than those specified in Section 429.28, F.S. (f) The purpose of any advance payments or deposit payments and the refund policy for such advance or deposit payments. (g) A refund policy which shall conform to Section 429.24(3), F.S. (h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or _____ facility. The resident or responsible party shall notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such	A 167		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

5009

N4RL11

If continuation sheet 1 of 3

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967731	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER CHARLES' PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3131 GATLIN DRIVE ROCKLEDGE, FL 32955		
(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 167	Continued From page 1 written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition, such as the resident's being comatose, prevents the resident from giving written notification and the resident does not have a responsible party to act in the resident's behalf. (i) A provision stating whether the organization is affiliated with any religious organization, and, if so, which organization and its relationship to the facility. (j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those the facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, shall be notified in writing that the resident must make arrangements for transfer to a care setting that has services needed by the resident. In the event the resident has no person to represent him, the facility shall refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions as outlined in Section 429.26(8), F.S., shall take effect. (k) A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule. (l) The facility's policies and procedures for self-administration, assistance with self-administration and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule. (m) The facility's policies and procedures related to a properly executed	A 167		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967731	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER CHARLES' PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3131 GATLIN DRIVE ROCKLEDGE, FL 32955		
(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 167	Continued From page 2 This Statute or Rule is not met as evidenced by: Based on record review and interview the facility did not ensure it updated its contract to reflect a provision giving at least 30 days written notice prior to any rate increase to the resident or the resident's responsible party. Findings: Record review revealed a letter dated 2012 written by the owner/administrator to the daughter of resident which stated "Per our conversations, you have voluntarily agreed to the monthly increase for the extra staffing for 2012. Pro-rated for 6 days, the total balance due for is \$3,200.00. The new mandatory monthly rate is \$8,000. This will go into effect starting 2012." During an interview on _____ at approximately 11:00AM the owner/administrator stated that Hospice had determined resident #1 required a two person assist to transfer. She further stated at the time they had to schedule a second staff person on duty at all times around the clock. They called resident #1's daughter and she verbally agreed to the increase and sent the money immediately. The letter was sent to the responsible party for resident #1; however it does not give 30 day notice of rate increase. Class III	A 167		



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Charles' Place
3131 Gatlin Drive
Rockledge, FL 32955

Dear Administrator:

Re: CCR #2012008708

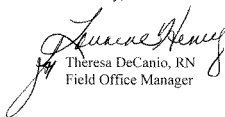
This letter reports the findings of a state licensure survey that was conducted on 2012 by representative(s) of this office.

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 surveyor(s). Should you have any questions please call Lorraine Henry at 407-250-2502.

Sincerely,


Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

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



Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone (407) 420-2502; Fax (407) 245-0998