

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# 2012005177 was conducted on A deficiency found at the time of the visit not pertaining to the complaint.	A 000		
A 004	58A-5.016 FAC Licensure - Requirements License Requirements. (1) SERVICE PROHIBITION. An ALF may not hold itself out to the public as providing any service other than a service for which it is licensed to provide. (2) LICENSE TRANSFER PROHIBITION. Licenses are not transferable. Whenever a facility is sold or ownership is transferred, including leasing, the transferor and transferee must comply with the provisions of Section 429.41, F.S., and the transferee must submit a change of ownership license application pursuant to Rule 58A-5.014, F.A.C. (3) CHANGE IN USE OF SPACE REQUIRING CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility ' s capacity shall not be made without prior approval from the Agency Central Office. Approval shall be based on the compliance with the physical plant standards provided in Rule 58A-5.023, F.A.C. , as well as documentation of compliance with applicable fire safety and sanitation requirements as referenced in Rule 58A-5.0161, F.A.C. (4) CHANGE IN USE OF SPACE REQUIRING FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, shall not be made without prior approval from the Agency Field Office. Approval shall be based on the compliance with the physical plant standards provided in Rule	A 004		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

5899

XYLT11

If continuation sheet 1 of 5

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 004	Continued From page 1 58A-5.023, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation standards as referenced in Rule 58A-5.0161, F.A.C. (5) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on contiguous property. "Contiguous property" means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Part I, Chapter 429, F.S., and this rule chapter. (6) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 58A-5.0161, F.A.C., shall be submitted annually to the Agency Central Office. The annual inspections shall be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to Section 429.14, F.S., and Rule 58A-5.033, F.A.C. (7) MEDICAID WAIVER RESIDENTS. Upon request, the facility administrator or designee must identify Medicaid waiver residents to the agency and the department for monitoring purposes authorized by state and federal laws. (8) THIRD PARTY SERVICES. (a) In instances when residents require services from a third party provider, the facility administrator or designee must take action to assist in facilitating the provision of those services and coordinate with the provider to meet the specific service goals, unless residents or their representatives decline the assistance. The declination of assistance must be reviewed at least annually. These actions must be	A 004		

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 004	Continued From page 2 documented in the resident ' s record. (b) In instances when residents or their representatives arrange for third party services, the facility administrator or designee, when requested by residents or representatives, must take action to assist in facilitating the provision of those services and coordinate with the provider to meet the specific service goals. These actions must be documented in the resident ' s record. (c) The facility ' s facilitation and coordination as described under this subsection does not represent a guarantee that residents will receive third party services. If the facility ' s efforts at facilitation and coordination are unsuccessful, the facility should include this documentation in the resident ' s record, explaining the reason or reasons its efforts were unsuccessful, which will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on record review, interview and observations the facility failed to obtain prior approval from the agency's central office for change in use of space that increased the facility's capacity. Findings: Review of the facility admission/discharge log revealed the following: Resident #3 date of admission _____ continues to reside in facility. Resident #5 date of admission _____ continues to reside in facility Resident #2 date of admission _____ continues to reside in facility Resident #4 date of admission _____ continues	A 004		

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 004	Continued From page 3 to reside in facility. Resident #6 date of admission _____ Resident #1 date of admission _____ discharged _____ From _____ the facility had 6 residents. They are licensed for 5. Telephone interview with daughter of resident #1's daughter stated that she begged the facility owners Mike and Fran Lorig to take her mother into the facility because she had heard good things from Hospice of St. Frances about the facility. She was aware they were only licensed for five residents. The daughter further stated that they cleaned out the office by the front door and put her mother in that _____. When the lady ____ they moved her mother into _____. Observation on General Tour on _____ that the first _____ looked into was empty of furniture. Staff member A stated that resident #1 had moved out on Sunday _____. It was clearly a _____. The _____ double doors near the front door off the living _____ also empty of furniture at the time of the visit. During interview on _____ at approximately 3:00 PM with the administrator/owner who stated that she did have six residents for about two weeks. The Social Worker at Hospice of St. Francis's and the resident's daughter kept begging her. Resident #1 was no longer able to remain in her home and they did not want to move her twice. Resident #6 was near therefore they decided to empty the office and make it a _____. Resident #1 was moved in there until; resident #6 _____ and then resident #1 was moved into that _____.	A 004		

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 004	Continued From page 4 The administrator/owner confirmed the above findings. Class III		A 004		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Charles' Place
3131 Gatlin Drive
Rockledge, FL 32955

Dear Administrator:

Re: CCR #2012005177

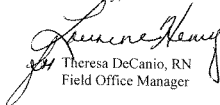
This letter reports the findings of a state licensure survey that was conducted on , 2012 by representative(s) of this office.

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

Sincerely,



Theresa DeCanio, RN
Field Office Manager

LJH/be
Enclosure
XG/90

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