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
	AL11911437	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLYMOUTH HOME FOR ADULTS	3225 PLYMOUTH STREET JACKSONVILLE, FL 32205

(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 On , 2012 a monitoring visit was conducted and deficiencies were identified.	A 000		
A 152	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 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	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
	AL11911437	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLYMOUTH HOME FOR ADULTS	3225 PLYMOUTH STREET JACKSONVILLE, FL 32205

(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 1 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: Based on observation, interview, and record review, it was determined that the Assisted Living Facility (ALF) failed to ensure all electrical systems, existing architectural structures and buildings were maintained in order to provide a safe environment free from hazards. The findings include: 1) On , 2012 at approximately 10:15 AM, a monitoring visit was conducted. During the initial tour numerous potential building code violations were observed and the Jacksonville Municipal Code Compliance Division was notified. Two inspectors arrived to the ALF at approximately 12:30 PM and conducted an inspection with the following violations identified: Building 1 Entire exterior wall trim deteriorated or otherwise unsound Roof fascia/baseboards are deteriorated, damaged, or otherwise unsound Fascia and eaves need protective coating New surface materials need painting or other protection Front of house has broken or missing window glass Floor covering material is deteriorated or damaged throughout the home Failure to provide paint/paper or other protective	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
	AL11911437	A. BUILDING _____ B. WING _____	10/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLYMOUTH HOME FOR ADULTS	3225 PLYMOUTH STREET JACKSONVILLE, FL 32205

(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 coverings for walls and ceilings throughout the home Building 2 Entire wall trim deteriorated or otherwise unsound Fascia/baseboards are deteriorated, damaged, or otherwise unsound Fascia and eaves needs protective coating Left side with exposed wiring or connections Floor covering material id deteriorated or damaged throughout the home Smoke detectors are or defective Building 3 Exterior doors and screen door is deteriorated, damaged or in otherwise unsafe condition Exterior door does not fit properly with it's frame Entire building wall trim deteriorated or otherwise unsound Fascia/baseboards are deteriorated, damaged, or otherwise unsound Front exit steps, stairway, or landing is deteriorated, damaged, or otherwise unsound Entire building paint or other surface protection is deteriorated Living is insecurely fastened to the sub-structure Building 4 Common area an unsafe and unsanitary condition exists 2) From 10:27 AM-12:30 PM the following was also observed: Building 1-women's section roach in hallway outside kitchen door missing closet door Floors stained and dirty throughout Couches in main living torn and/or	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911437	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLYMOUTH HOME FOR ADULTS	3225 PLYMOUTH STREET JACKSONVILLE, FL 32205

(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 worn areas Living [illegible] and dining [illegible] lacked adequate lighting and residents were observed having difficult completing a questionnaire from mental health worker [illegible] no closet door-just an exposed rod Several large hornet nests noted in stairwell on back of home Large hornet nest on rear eave of home and covered with hornets flying about Sofet vent covered with hornets Two male residents were interviewed at this time in the adjacent yard and indicated the hornets do swarm at times and they have to run into the home. Building 2-3 Numerous wires draped from house to house and touching the ground Class II Correction Date: , 2012	A 152		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Plymouth Home for Adults
3225 Plymouth Street
Jacksonville, FL 32205

Dear Administrator:

This letter reports the findings of a state licensure monitoring visit that was conducted on , 2012 by representatives 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 surveyors. Should you have any questions please call this office at

Sincerely,

Keisha Woods, MPH
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

KW/sm
Enclosure

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

Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone (904) 798-4201; Fax (904) 359-6054