

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER A-1 ASSISTED LIVING FACILITY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9410 SW 52 TERRACE MIAMI, FL 33165		
(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 Survey was conducted on 10, 2012. The A-1 Assisted Living Facility LLC had deficiencies found at the time of the visit.	{A 000}			
{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 administration, or other changes which resulted in the provision of additional services.	{A 025}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0000

JTF112

If continuation sheet 1 of 11

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{A 025}	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to maintain a written record that showed 1 out of 2 (SR#2) sampled resident 's physician was notified of a significant health change. Findings include: On _____ at 10am, the administrator acknowledged speaking to SR#2's physician on _____ regarding SR#2's issue with eating. The administrator acknowledged receiving a prescription for puree food dated _____ Record review of SR#2 ' s file revealed a prescription for puree food but no documentation that showed SR#2 ' s problems with her _____ had been addressed. On _____ at 10:34am, the administrator acknowledged that SR#2 have not seen a Dentist said that he have tried to find a Dentist who accepts Medicaid. Class III	{A 025}			
{A 054} SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider ' s name, the resident ' s name, the date dispensed, the name and strength of the drug, and the	{A 054}			

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{A 054}	Continued From page 2 directions for use. (b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known _____ the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical _____ the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an accurate medication observation record (MOR) for 1 out of 2 (SR#1) residents. Findings include: On _____ at 10:45AM the administrator acknowledged that since _____ SR#1 had been hospitalized and is scheduled to return back to the facility on _____ Record review of SR#1 ' s MORs revealed employee #2 ' s initials are present for the dates of _____, 2012 and _____, 2012.	{A 054}			

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{A 054}	Continued From page 3 On at 10:48AM, the administrator acknowledged the findings and stated that employee #2 had made "an honest mistake." Class III	{A 054}			
{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 an 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 to the resident's health care provider in accordance with this rule chapter.	{A 078}			

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{A 078}	Continued From page 4 (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 facility failed to ensure that 1 out of 4 (#4) employees submitted a statement from a health care provider that employee #4 is free from communicable _____ including _____. Findings include: Record review revealed that employee #4 (caretaker, hired _____ had no documentation from a health care provider that showing employee #4 was free from communicable _____ including _____. On _____ at 11:10 AM the administrator acknowledged the findings. Class III	{A 078}			

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{A 162} SS=D	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records shall be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2. ; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance 8. Name, address, and telephone number of next of kin, responsible party, or other person the resident would like to have notified in case of an emergency, and relationship to resident; and 9. Name, address, and phone number of health care provider, and case manager if applicable. (b) A copy of the medical examination described in Rule 58A-5.0181, F.A.C. (c) Any health care provider ' s orders for medications, nursing services, therapeutic diets, or other services to be provided, supervised, or implemented by the facility that require a health care provider ' s order. (d) A signed statement from a resident refusing a therapeutic diet pursuant to Rule 58A-5.020, F.A.C. (e) The resident record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A weight record which is initiated on admission. Information may be taken from the resident ' s health assessment. Residents receiving assistance with the activities of daily living shall have their weight recorded semi-annually. (g) For facilities which will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed	{A 162}			

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{A 162}	Continued From page 6 consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract. (h) For facilities which manage a pill organizer, assist with self-administration of medications or administer medications for a resident, the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract, as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, or staff, or representative thereof serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required under Section 429.27, F.S. (k) For any facility which maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required under Section 429.27, F.S. (l) A copy of Alternate Care Certification for _____ Form, CF-ES 1006, _____ 1998, if the resident is an _____ recipient. The absence of this form shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Family Services. (m) Documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required under Rule 58A-5.0181, F.A.C. (o) For apartments, duplexes, quadruplexes, or single family homes that are designated for	{A 162}			

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{A 162}	Continued From page 7 independent living but which are licensed as assisted living facilities solely for the purpose of delivering personal services to residents in their homes, when and if such services are needed, record keeping on residents who may receive meals but who do not receive any personal, limited nursing, or extended congregate care service shall be limited to the following: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required under this subsection; 3. The medical examination described in Rule 58A-5.0181, F.A.C.; 4. The resident ' s contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider ' s order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (p) Except for resident contracts which must be retained for 5 years, all resident records shall be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents shall be provided a copy of their resident records upon departure from the facility. (q) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that 4 out of 4 (#1, #2, #3, & #4) residents who are receiving home health agency	{A 162}			

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AZ821	Continued From page 9 (a) Insurance coverage renewal, (b) Bond renewal, (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider, (d) Annual sanitation inspections, (e) Fire inspections, (f) Approval of revisions to emergency management plans. (2) Electronic submission of information. (a) The following required information must be reported through the Agency's Internet site at http://www.ahca.myflorida.com/reporting/index.shtml: 1. Nursing homes: a. Semi-annual staffing ratios required pursuant to Section 400.141(1)(o), F.S., and Rule 59A-4.103, F.A.C. b. Adverse incident reports required pursuant to Sections 400.147(7) and (8), F.S., and Rule 59A-4.123, F.A.C. c. Liability claim reports required pursuant to Section 400.147(10), F.S., and Rule 59A-4.123, F.A.C. 2. Assisted living facilities: a. Adverse incident reports required pursuant to Sections 429.23(3) and (4), F.S., and Rule 58A-5.0241, F.A.C. b. Liability claim reports required pursuant to Section 429.23(5), F.S., and Rule 58A-5.0242, F.A.C. (b) The licensee must retain the receipt issued from the Internet site indicating that their transaction was accepted. (c) If the Agency's Internet site is temporarily out of service, the required reports may be submitted by mail or facsimile as follows: 1. Semi-annual staffing ratios and liability claim reports are sent to the Agency for Health Care	AZ821			

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{A 162}	Continued From page 8 services, records ' contained a contract that is between the residents and the home health agency or the residents ' legal guardian and the home health agency. Findings include: Record review of the facility's home health agency binder for residents ' #1, #2, #3, & #4 revealed no documentation of a contract between residents ' #1, #2, #3, & #4 and the home health agency or between the residents ' legal guardian and the home health agency. Further review of the binder revealed that it contain contracts for services between the ALF and the home health agency on behalf of residents ' #1, #2, #3, & #4. On _____ at 11:32 am, the administrator acknowledged the findings and said that he was told by the owner of the home health agency that the contracts were created by an attorney and is the same contract that the owner of the home health agency provides to all residents. Class III	{A 162}			
AZ821 SS=D	59A-35.110, FS Reporting Requirements; Electronic Submission (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including:	AZ821			

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AZ821	Continued From page 10 Administration, Central Systems Management Unit, 2727 Mahan Drive, 47, Tallahassee, FL 32308 or facsimile to (850)487-0470. 2. Adverse incident reports are sent to the Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis, 2727 Mahan Drive, 16, Tallahassee, FL 32308 or facsimile to (850)922-2217. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to submit an adverse incident report to the Agency. Findings include: Observation of SR#3 on at 9:35AM revealed stitches on her right eye a bandage wrap on her arm and her eye was shut close. On at 10:23AM, the administrator said that over the weekend SR#3 was sitting at the kitchen table, when staff#2 left to retrieve SR#3 's food, SR#3 tried to stand up and walk with her walker when she felled down. The administrator said that SR#3 went to the hospital and was released the same date. He denied completing/submitted an adverse incident report to the Agency and stated that he had documented the incident in the SR#3's progress report. Record review of SR#3 's file revealed the resident suffered a concussion and was discharged from the hospital on		AZ821		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967137	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/10/2012
Name of Facility A-1 ASSISTED LIVING FACILITY LLC		Street Address, City, State, Zip Code 9410 SW 52 TERRACE MIAMI, FL 33165

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 <u>A0008</u> Reg. # <u>58A-5.0181(2) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0055</u> Reg. # <u>58A-5.0185(6) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0081</u> Reg. # <u>58A-5.0191(2) FAC</u> LSC _____	Correction Completed
ID Prefix <u>A0090</u> Reg. # <u>58A-5.0191(11) FAC</u> LSC _____	Correction Completed 10/10/2012	ID Prefix <u>A0160</u> Reg. # <u>58A-5.024(1) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0161</u> Reg. # <u>58A-5.024(2) FAC</u> LSC _____	Correction Completed 10/10/2012
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ 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: _____	Date: <u>Oct 26 2012</u>
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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967137	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/10/2012
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Name of Facility A-1 ASSISTED LIVING FACILITY LLC	Street Address, City, State, Zip Code 9410 SW 52 TERRACE MIAMI, FL 33165
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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).

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ID Prefix <u>A0090</u> Reg. # <u>58A-5.0191(11) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0160</u> Reg. # <u>58A-5.024(1) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0161</u> Reg. # <u>58A-5.024(2) FAC</u> LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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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: _____	Date: _____
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

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2012

Administrator
A-1 Assisted Living Facility Llc
9410 Sw 52 Terrace
Miami, FL 33165

Dear Administrator:

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

Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

BBT7

