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 |
|---|---|---|---|
| | AL11967871 | A. BUILDING _____ B. WING _____ | R 10/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PETSHIRL | 8361 N E 3RD AVENUE MIAMI, FL 33138 |

| (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<br><br>A Follow-up to Standard Survey was conducted on , 2012 at Petshirl with Extended Congregate Care (ECC) component. The following deficiencies were found uncorrected at time of survey. | {A 000} | | |
| {A 008} SS=D | 58A-5.0181(2) FAC Admissions - Health Assessment<br><br>(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} | | |

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| {A 008} | Continued From page 1<br><br>number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state.<br>(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:<br>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.<br>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.<br>b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider.<br>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.<br>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 | {A 008} | | |

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|---|---|---|---|---|
| {A 008} | Continued From page 2<br><br>elements in Section 3. This requirement does not apply for residents receiving:<br>a. Extended congregate care (ECC) services in facilities holding an ECC license;<br>b. Services under community living support plans in facilities holding limited mental health licenses;<br>c. Medicaid assistive care services; and<br>d. Medicaid waiver services.<br>(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.<br>(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).<br>(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.<br>(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<br>(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} | | |

Agency for Health Care Administration

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| {A 008} | Continued From page 3<br><br>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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on resident record review and interview the facility failed to have completed health assessment within 30 days of admission for 4 of 4 (#1-4) sampled residents.<br><br>Findings include:<br><br>Record review found that the facility STILL did not have any health assessments completed for residents #1, #2, #3, an d #4.<br><br>On : at 1:30 p.m. staff member #2 stated , " I don't know where to find any of the files you are asking me for. The administrator is more familiar with this and know where the file and paperwork is."<br><br>On : at 10:06 a.m. per phone conversation with administrator stated the health assessment has been given to residents #1, 3, and 4. "I have not recieved it out I should get it by next week."<br><br>Class III | {A 008} | | |

Agency for Health Care Administration

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|---|---|---|---|---|
| {A 181} SS=D | 58A-5.026(2) FAC Emergency Mgmt - Plan Approval<br><br>(2) EMERGENCY PLAN APPROVAL. The plan shall be submitted for review and approval to the county emergency management agency.<br>(a) The county emergency management agency has 60 days in which to review and approve the plan or advise the facility of necessary revisions. Any revisions must be made and the plan resubmitted to the county office of emergency management within 30 days of receiving notification from the county agency that the plan must be revised.<br>(b) Newly-licensed facility and facilities whose ownership has been transferred, must submit an emergency management plan within 30 days after obtaining a license.<br>(c) The facility shall review its emergency management plan on an annual basis. Any substantive changes must be submitted to the county emergency agency for review and approval.<br>1. Changes in the name, address, telephone number, or position of staff listed in the plan are not considered substantive revisions for the purposes of this rule.<br>2. Changes in the identification of specific staff must be submitted to the county emergency management agency annually as a signed and dated addendum that is not subject to review and approval.<br>(d) The county emergency management agency shall be the final administrative authority for emergency management plans prepared by assisted living facilities.<br>(e) Any plan approved by the county emergency management agency shall be considered to have met all the criteria and conditions established in this rule. | {A 181} | | |

Agency for Health Care Administration

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|---|---|---|---|---|
| {A 181} | Continued From page 5 | {A 181} | | |

This Statute or Rule is not met as evidenced by:
Based on record review and interview the facility failed to provide a current approval letter from the county emergency management agency.

Findings include:

During tour on at 9:00 a.m. the was no comprehensive emergency management plan posted anywhere in the facility.

Facility's record review on did not have comprehensive emergency management plan approval letter available.

On at 1:30 p.m. staff member #2 stated , " I don't know where to find any of the files you are asking me for. The administrator is more familiar with this and know where the file and paperwork is."

Per phone conversation with administrator on at 3:29 p.m. confirmed the caretaker can find the paperwork needed to conduct survey and does not know at this time where they are.

Class III

AH Form Approved

## State Form: Revisit Report

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| AL11967871 | A. Building<br>B. Wing | 10/11/2012 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| PETSHIRL | 8361 N E 3RD AVENUE<br>MIAMI, FL 33138 |

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 AE210<br>Reg. # 58A-5.0191(7) FAC<br>LSC | Correction Completed | | | | |

| Reviewed By State Agency | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| | | | Susan Blanton | 10/29/12 |
| 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?

# State Form: Revisit Report

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| AL11967871 | A. Building<br>B. Wing | 10/11/2012 |

| Name of Facility | Street Address, City, State, Zip Code |
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| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix A0009<br>Reg. # 58A-5.0181(3) FAC<br>LSC | Correction Completed | ID Prefix A0051<br>Reg. # 58A-5.0185(2) FAC<br>LSC | Correction Completed | ID Prefix A0052<br>Reg. # 58A-5.0185(3) FAC<br>LSC | Correction Completed |
| ID Prefix A0054<br>Reg. # 58A-5.0185(5) FAC<br>LSC | Correction Completed | ID Prefix A0078<br>Reg. # 58A-5.019(2) FAC<br>LSC | Correction Completed | ID Prefix A0079<br>Reg. # 58A-5.019(4) FAC<br>LSC | Correction Completed |
| ID Prefix A0085<br>Reg. # 58A-5.0191(6) FAC<br>LSC | Correction Completed | ID Prefix A0093<br>Reg. # 58A-5.020(2) FAC<br>LSC | Correction Completed | ID Prefix A0094<br>Reg. # 58A-5.020(3) FAC<br>LSC | Correction Completed |
| ID Prefix A0121<br>Reg. # 58A-5.021(2) FAC<br>LSC | Correction Completed | ID Prefix A0127<br>Reg. # 58A-5.021(8) FAC<br>LSC | Correction Completed | ID Prefix A0160<br>Reg. # 58A-5.024(1) FAC<br>LSC | Correction Completed |
| ID Prefix A0162<br>Reg. # 58A-5.024(3) FAC<br>LSC | Correction Completed | ID Prefix AE201<br>Reg. # 58A-5.030(2) FAC<br>LSC | Correction Completed | ID Prefix AE203<br>Reg. # 58A-5.030(4) FAC<br>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: |

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

*Better Health Care for all Floridians*

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Petshirl
8361 N E 3rd Avenue
Miami, FL 33138

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,

Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

BBT7