

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966585	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PALM AVENUE BAPTIST TOWER ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 215 EAST PALM AVENUE TAMPA, FL 33602		
(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 Assisted Living Facility A complaint survey, CCR# 2012008692, was conducted on _____ in conjunction with an extended congregate care (ECC) monitoring visit, see (Aspen Event A8VJ11). Palm Avenue Baptist Tower ALF had a deficiency found at the time of the visit.	A 000			
A 007	58A-5.0181(1) FAC Admissions - Criteria Admission Procedures, Appropriateness of Placement and Continued Residency Criteria. (1) ADMISSION CRITERIA. An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing or limited mental health license: (a) Be at least _____ (b) Be free from signs and symptoms of any communicable _____ which is likely to be transmitted to other residents or staff; however, a person who has _____ () may be admitted to a facility, provided that he would otherwise be eligible for admission according to this rule. (c) Be able to perform the activities of daily living, with supervision or assistance if necessary. (d) Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. (e) Be capable of taking his/her own medication with assistance from staff if necessary. 1. If the individual needs assistance with self-administration the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance, and if unlicensed staff will be providing such assistance, obtain the resident ' s or the resident ' s	A 007			

AHCA Form 3020-0001

TITLE

(X8) DATE

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

STATE FORM

0000

RBQD11

If continuation sheet 1 of 4

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A 007	Continued From page 1 s surrogate, guardian, or attorney-in-fact ' s written informed consent to provide such assistance as required under Section 429.256, F.S. 2. The facility may accept a resident who requires the administration of medication, if the facility has a nurse to provide this service, or the resident or the resident ' s legal representative, designee, surrogate, guardian, or attorney-in-fact contracts with a licensed third party to provide this service to the resident. (f) Any special dietary needs can be met by the facility. (g) Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under Chapters 490 or 491, F.S. (h) Not require licensed professional mental health treatment on a 24-hour a day basis. (i) Not be bedridden. (j) Not have any _____ or 4 pressure sores. A resident requiring care of a _____ pressure may be admitted provided that: 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a physician, or the resident contracts directly with a licensed home health agency or a nurse to provide care; 2. The condition is documented in the resident ' s record; and 3. If the resident ' s condition fails to improve within 30 days, as documented by a licensed nurse or physician, the resident shall be discharged from the facility. (k) Not require any of the following nursing services: 1. Oral, _____, or _____ suctioning; 2. Assistance with tube feeding; 3. Monitoring of _____ gases;	A 007			

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A 007	Continued From page 2 4. Intermittent positive pressure breathing ; or 5. Treatment of surgical _____ or wounds, unless the surgical _____ or _____ and the condition which caused it have been stabilized and a plan of care developed. (l) Not require 24-hour nursing supervision. (m) Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C. (n) Have been determined by the facility administrator to be appropriate for admission to the facility. The administrator shall base the decision on: 1. An assessment of the strengths, needs, and preferences of the individual, and the medical examination report required by Section 429.26, F.S., and subsection (2) of this rule; 2. The facility 's admission policy, and the services the facility is prepared to provide or arrange for to meet resident needs; and 3. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established under Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C. (o) Resident admission criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that the health assessments for 2 (#1 & 3) of 3 residents contained all required information. Findings include: 1. A _____ review of the record for resident #1	A 007			

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A 007	Continued From page 3 revealed the health assessment (1823) dated _____ did not include the type of assistance the resident requires with her medications. This portion of the assessment was blank. 2. A review on the same date of the record for resident #3 revealed the health assessment dated _____ was left blank concerning whether the resident is capable of self managing his medications or requires assistance with self administered medications. The facility staff interviewed at about 3 p.m. stated they had not noticed this portion of the assessments was left blank. Class III Pattern	A 007			



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

January 10, 2012

Administrator
Palm Avenue Baptist Tower ALF
215 East Palm Avenue
Tampa, FL 33602

Dear Administrator:

Re: **CCR# 2012008692 & ECC Monitoring Visit**

This letter reports the findings of a complaint survey and extended congregate care (ECC) monitoring visit that were conducted on January 9, 2012, by a representative 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 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. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,
Paul Brown
For Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosures: State Forms 3020

