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
	AL11964534	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULCE HOGAR	120 NW 26 AVENUE MIAMI, FL 33125

(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 Investigation Survey (CCR# 2012010595 and CCR# 2012010842) was conducted on at Dulce Hogar with Limited Mental Health (LMH) and Limited Nursing Services (LNS) components. At the time of the survey, the following allegations were substantiated: Facility failure to provide an appropriate discharge (CCR #2012010595); Facility failure to discharge inappropriately and facility alleged to accept and retain a resident without the ability to meet their needs (CCR# 2012010842). As a result, deficient practice was identified.	A 000		
A 010 SS=G	58A-5.0181(4) FAC Admissions - Continued Residency (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility shall be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a licensed health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. After the effective date of this rule, providers shall have up to 12 months to comply with this requirement. (a) The resident may be bedridden for up to 7 consecutive days. (b) A resident requiring care of a pressure may be retained provided that:	A 010		

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A 010	Continued From page 1 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a licensed health care provider, 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 health care provider, the resident shall be discharged from the facility. (c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed; 2. Continued residency is agreeable to the resident and the facility; 3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility ' s license and total help with the activities of daily living; and 4. Documentation of the requirements of this paragraph is maintained in the resident ' s file. (d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility. (e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident ' s needs, as determined by the facility administrator or	A 010		

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A 010	Continued From page 2 licensed health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that 2 out of 4 (resident #1, resident #2) sampled residents met the continued residency criteria and had a face to face medical examination by a licensed health care provider after a significant change. Findings Include: Record review of the admission and discharge log indicated resident #1 was a current resident and revealed he was admitted to the facility on three separate occasions: {discharged to Nursing home}, and . Record review found a health assessment, dated , with diagnoses that include " s , , , Generalized O/A;" needs assistance with all activities of daily living; and needs can be met in an assisted living facility. Another health assessment dated had the following diagnoses " , , , , and O/A;" needs assistance or supervision for all activities of daily living except eating in which resident #1 was independent. Record review of resident #2 found she was admitted to the facility on . Record review of resident #2's health assessment, dated , with diagnoses that include, "AHTN, , , , o/a, and ." Resident #2 needs assistance with	A 010		

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A 010	Continued From page 3 bathing, self-care ( ), and transferring and needs can be met in an assisted living facility. Progress notes on show first signs and document pressure sores. Documentation revealed resident #2 started a program for the elderly on . In an interview with the husband of the administrator {Operations} on at approximately 10:15 AM, he stated that he has to get resident #1's file from storage because he was discharged on . In a phone interview with the administrator on at approximately 11:05 AM, she stated resident #1 was discharged after speaking to the family and they said they would take him to a nursing home or they asked if they could place him somewhere. She stated resident #2 had wounds and she was being taken care of by the program for the elderly she attended. She stated resident #2 was not on home health or hospice. She stated one was starting to break in the back area and had on her heels; they were a little broken. She stated resident #2 is the only resident with wounds. She stated resident #2 went last week, on Wednesday or Thursday, to the hospital but is not sure which hospital. She stated resident #1 deteriorated over time, going into the position and happened slowly. She stated resident #1 did not have any wounds or any medical conditions that he needed nursing services. Record review of the Hospital's documentation revealed resident #1 was admitted on and was bed ridden, had a , endoscopic ( ) tub, and was dependent. In an phone interview with resident #1's case	A 010		

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A 010	Continued From page 4	A 010		

manager at the nursing home diversion program on at approximately 4:53 PM, she stated she saw resident #1 on . She stated at that point he was living at the facility. She stated she has to see him every two months and every time she went there, he was in the facility. She stated she did not know that he was using home health services until she spoke to the physician. She stated he was receiving home health for the care and home health services. She stated she knows he had a tube in of 2011 and was told this by the home health agency.

In a phone interview with the wife of the nephew of resident #1 on at approximately 5:04 PM, she stated she is married to the nephew of resident #1. She stated the Adult Protective Services (APS) Investigator called her and told her resident #1 was at Hospital. She stated when she first put him in the assisted living facility {ALF} a long long time ago before these people were the owner, he was very capable of moving by himself and she could not keep him at her house because he walked the streets a lot and she was afraid. She stated he was started to have problems with food going through his lungs and had to hospitalize him several times. She stated she does not remember where he was hospitalized but that 's when they put the tube { tube} in.

In a phone interview with the niece of resident #1 on at approximately 9:14 AM, she stated resident #1 has been there for a long, long time. She stated he has been in and out of the hospital. She stated he had a tube and it was taken out and then it was put back in, but lately he has been eating well. She stated this last month he has been excellent. She stated he has

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A 010	Continued From page 5	A 010		

been declining, he went to the ALF then he went to a rehab about two years ago and then he wanted to go back to the ALF. She stated from the ALF he got sick and went to the hospital and then he went back to the ALF. She stated he had a tube at the ALF two or three years ago. She stated she did not know how long it was in the first time, maybe 6 or 7 months, but it was taken out because he always wants to eat. She stated the tube is in now. She stated she would be lying if she told me how long it has been in, maybe a couple of months, and they did it for safety. She stated 6 months or so resident #1 has been bed bound, but able to be in a wheelchair, even about two months ago he has been in a wheelchair.

In a phone interview with the physician of resident #1 on at approximately 9:48 AM, she stated she has been seeing resident #1 since 2011. She stated at the time he did not have a tube. She stated she knows he had a tube prior and way before she provided care and had it {the tube} in 2012. She stated 2012 he had a tube check because he was complaining of discomfort. She stated he might have had it in in late 2011. She stated on - he already had it in and has had it in since. She stated from her understanding it was a different nurse and she had a home health care agency come and see him. She stated she tried physical for resident #1. She stated he has been pretty stable for the last couple of months. She stated he also had wounds but has not had them for several months. She stated when she first met him he had wounds in 2011 he had to his heel and since then he had a surgery for it and care at home and in hospital it was able to heel completely. She stated originally it was a

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A 010	Continued From page 6	A 010		

because it was to the bone. She stated the first time met him was at the hospital. She stated the caregiver who was always there would provide food, medication, aerosol treatment, and change him and feed him. She stated he needed total help since she has met him. She stated since she met him he has been bed bound; he has been contracted.

In a conference call with the Director of Nursing (DON) and the Registered Nurse (RN) who attended to resident #1 from the home health agency on at approximately 10:14 AM, the RN stated then they put the in of 2011. The RN stated he provided care because he had multiple wounds; one of the feet and he monitored his overall health before the . The RN stated he was also getting care at a Hospital for care and for medical monitoring. The RN stated he was following up on the physician orders. The RN stated resident #1 was bed ridden since we opened the case.

In a phone interview with the DON from the home health agency on at approximately 10:45 AM, she stated only provide Home Health Services not hospice {for resident #1}. She believes resident #1 was not receiving any other services.

In a phone interview with the administrator on at approximately 10:55 AM, she stated she was talking to her husband regarding resident #1 because he did not have documentation and he told her he had a tube in the beginning of 2012 or the end of 2011. She stated she asked him why she did not tell her but he said he did not know it had to be documented. She stated she did not know he had a tube until her husband told her yesterday. She stated

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A 010	Continued From page 7	A 010		

she doesn't go to the ALF very often. She stated that resident #1 started eating orally and the liquids were mixed with powder to thicken the liquid. She stated he was able to take medications orally through his mouth. She stated she does not know how medication were given, she needs to ask her husband but medications were taken orally. She stated she knew at some point he would need to use the tube. She stated she would have to ask home health what they did for this resident; she stated she did not know. She stated eventually he did not get out of the bed and that 's why they had the conversation with the family and they wanted him to go to a nursing home.

Record review of home health agency documents for resident #1 revealed documentation signed by resident #1's physician on - stated "patient is bed bound and contracted/ unable to sit or ambulate." Record review of the home health agency's documentation on resident #1 revealed that a prescription dated stated "nurse to teach caregivers how to manage and continuous feeding pump." Physician order dated for "Pulmocare 50 cc/hr daily via #3 month supply." Physician order dated for "Proteinez 20 mL via #1 month supply and 5mL via daily #1 month supply." Home health documentation dated - state "caregiver in need of further and continuous pump feeding instructions requiring 5 more days of teaching." Documentation on revealed "caregiver reported that patient removed today, and was taken to the Hospital. was reinstated in the ER . Patient in the hospital for less than 24 hours," and "Caregiver will continue to perform care as ordered."

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A 010	Continued From page 8 Record review of resident #2's hospital documentation revealed that she was admitted from the facility on : and was admitted to the hospital with "heels and sacral]." Notes also document resident #2 as "bedridden." In a phone interview with the chief compliance officer at the program for the elderly in which resident #2 attends on : at approximately 2:33 PM, she stated the wounds resident #2 had to her heels were unstageable. She stated when she started the program in 2012, she did not have wounds. She stated after being readmitted to the program hospitalization, on : she had unstageable wounds to her heel. She stated the care was provided by the program and improved by the end of 2012. She stated a couple weeks later they got worse and brought her in for more care. She stated she is not on hospice services. She stated that on they were still unstageable and that was the last time they saw her. She stated her wounds were always classified as unstageable; they would just decrease and increase in size. She stated she has been living at the ALF this whole time and needs total assistance with activities of daily living {ADL}. Class II	A 010		
A 011 SS=G	58A-5.0181(5) FAC Admissions - Discharge (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or licensed health care provider, the resident shall be discharged in accordance with Section	A 011		

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A 011	Continued From page 9 429.28(1), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to appropriately discharge 1 out of 4 (resident #1) sampled residents. Findings Include: Record review of the admission and discharge log indicated resident #1 was a current resident and revealed he was admitted to the facility on three separate occasions: , {discharged to Nursing home}, and . Record review found a health assessment, dated , with diagnoses that include, " s , , , Generalized O/A;" needs assistance with all activities of daily living; and needs can be met in an assisted living facility. Another health assessment, dated , had the following diagnoses: " , , , , and O/A;" needs assistance or supervision for all activities of daily living except eating in which resident #1 was independent. In an interview with the husband of the administrator {Operations} on at approximately 10:15 AM, he stated he is the owner of the home in the back and they are renters and they pay separate. He stated that he has to get resident #1's file from storage because he was discharged on . He stated that resident #1 was discharged because he needed to go to the hospital but the family did not want him to go to the hospital. He stated Department of Children and Families (DCF) came here for him. He stated that he needed to go to the hospital because he could not walk. He stated he was out in the back for 3 days because his family	A 011		

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A 011	Continued From page 10 did not want him to go to the Hospital. In a phone interview with the administrator on : at approximately 11:05 AM, she stated resident #1 was discharged after speaking to the family and they said they would take him to a nursing home or they asked if they could place him somewhere. She stated she told them they have : the back but they will not give him any assisted living facility (ALF) services and was in constant communication with his family until he was taken last week on Thursday by Department of Children and Families (DCF). She stated he was already in conditions to be somewhere else, he needed more attention so that 's what we did. She stated we told that to the family. She stated they wanted to take him but they asked us to leave him there for a couple of days. She stated they wanted to wait a couple of days to put him some place. She stated last Monday or Tuesday he was brought to the house in the back. She stated he was not getting as much help as they did. She stated they still changed him and gave him his medications as a favor to the family. She stated he slept in a small : from the couple living there. She stated it was talked about and they gave him plenty of time and they {the family} agreed that he should be at a nursing home. She stated she believes he was on home health but does not know, she will speak to her husband. In a phone interview with the wife of the nephew of resident #1 on : at approximately 5:04 PM, she stated they moved him to the back because they could not keep him in the front because of the , : endoscopic { } tube. She stated she does not know a time that will be wrong.	A 011		

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A 011	Continued From page 11	A 011		

In a phone interview with the niece of resident #1 on at approximately 9:14 AM, she stated his wish was to not go to a nursing home and she respects that. She stated he has been declining, he went to the assisted living facility {ALF} then he went to a rehab about two years ago and then he wanted to go back to the ALF. She stated from the ALF he got sick and went to the hospital and then he went back to the ALF. She stated she would be lying if she told me how long it has been in, maybe a couple of months, and they did it for safety. She stated 6 months or so resident #1 has been bed bound, but able to be in a wheelchair, even about two months ago he has been in a wheelchair. He was never alone there and the wife of his nephew still paid the facility while he was in the back area. She stated the facility never told her that he needed to go to a nursing home. She stated they knew he was in the back and he could have went to another facility.

In a phone interview with the physician of resident #1 on at approximately 9:48 AM, she stated once he had the tube placed, he was transferred to the private home right by there. She stated she has physically been there and she went to see him there. She stated she saw him at the private home. She stated late 2011 he was moved from the ALF to the private home. She stated he needed total help since she has met him. She stated since she met him he has been bed bound; he has been contracted.

In a conference call with the Director of Nursing (DON) and the Registered Nurse (RN) who attended to resident #1 from the home health agency on at approximately 10:14 AM, the RN stated a little house in the back of ALF is where he provided services. The RN stated its

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A 011	Continued From page 12 been more than a year that he provided services for resident #1 but he does not remember. The RN stated resident #1 was bed ridden since we opened the case. Record review {http://www.floridahealthfinder.gov} revealed the address in which the facility discharged resident #1 is not a licensed health care facility. Class II	A 011		
A 025 SS=G	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.	A 025		

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A 025	Continued From page 13 (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. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to provide care and services appropriate to the needs of residents accepted for admission and failed to have a written record, updated as needed, of any significant changes for 1 out of 4 (resident #1) sampled residents. Findings Include: Record review of the admission and discharge log indicated resident #1 was a current resident and revealed he was admitted to the facility on three separate occasions: , {discharged to Nursing home}, and . Record review found a health assessment dated with diagnoses that include " , , , Generalized O/A;" needs assistance with all activities of daily living; and needs can be met in an assisted living facility. Another health assessment, dated , had the following diagnoses: " , , , , and O/A;" needs assistance or supervision for all activities of daily living except eating in which resident #1 was independent. Record review lacked any notes, including any significant changes, documented on resident progress notes. Record review of the Hospital's documentation	A 025		

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A 025	Continued From page 14	A 025		

revealed resident #1 was admitted on and was bed ridden, had a endoscopic ( ) tub, and was dependent.

Observations on at approximately 1:30 PM found resident #1 in in bed A of the hospital. Resident #1 appeared in frail and lying in the position.

In a phone interview with the niece of resident #1 on at approximately 9:14 AM, she stated resident #1 has been there for a long, long time. She stated he has been in and out of the hospital. She stated he had a tube and it was taken out and then it was put back in but lately he has been eating well. She stated he has been declining, he went to the assisted living facility {ALF} then he went to a rehab about two years ago and then he wanted to go back to the ALF. She stated from the ALF he got sick and went to the hospital and then he went back to the ALF. She stated he had a tube at the ALF two or three years ago. She stated she did not know how long it was in the first time, maybe 6 or 7 months, but it was taken out because he always wants to eat. She stated the tube is in now. She stated she would be lying if she told me how long it has been in, maybe a couple of months, and they did it for safety. She stated 6 months or so resident #1 has been bed bound, but able to be in a wheelchair, even about two months ago he has been in a wheelchair.

In a phone interview with the physician of resident #1 on at approximately 9:48 AM, she stated she has been seeing resident #1 since , 2011. She stated at the time he did not have a tube. She stated she knows he had a tube prior and way before she provided care and

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A 025	Continued From page 15	A 025		

had it (the tube) in 2012. She stated 2012 he had a tube check because he was complaining of discomfort. She stated he might have had it in in late 2011. She stated on he already had it in and has had it in since. She stated from her understanding it was a different nurse and she had a home health care agency come and see him. She stated she tried physical for resident #1. She stated he has been pretty stable for the last couple of months. She stated he also had wounds but has not had them for several months. She stated when she first met him he had wounds in , 2011 he had to his heel and since then he had a surgery for it and care at home and in hospital it was able to heel completely. She stated originally it was a because it was to the bone. She stated the first time met him was at the hospital. She stated the caregiver who was always there would provide food, medication, aerosol treatment, and change him and feed him. She stated he needed total help since she has met him. She stated since she met him he has been bed bound; he has been contracted.

In a conference call with the Director of Nursing (DON) and the Registered Nurse (RN) who attended to resident #1 from the home health agency on at approximately 10:14 AM, the RN stated then they put the in of 2011. The RN stated he provided care because he had multiple wounds; one of the feet and he monitored his overall health before the . The RN stated he was also getting care at a Hospital for care and for medical monitoring. The RN stated he was following up on the physician orders. The RN stated resident #1 was bed ridden since we opened the case.

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A 025	Continued From page 16 In a phone interview with the administrator on at approximately 10:55 AM, she stated she was talking to her husband regarding resident #1 because he did not have documentation and he told her he had a tube in the beginning of 2012 or the end of 2011. She stated she asked him why she did not tell her but he said he did not know it had to be documented. She stated she did not know he had a tube until her husband told her yesterday. She stated she doesn't go to the ALF very often. She stated that resident #1 started eating orally and the liquids were mixed with powder to thicken the liquid. She stated he was able to take medications orally through his mouth. She stated she does not know how medication were given, she needs to ask her husband but medications were taken orally. She stated she knew at some point he would need to use the tube. She stated she would have to ask home health what they did for this resident; she stated she did not know. She stated eventually he did not get out of the bed and that 's why they had the conversation with the family and they wanted him to go to a nursing home. Class II	A 025		
A 030 SS=D	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule	A 030		

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58A-5.0181, F.A.C.
(b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.
(d) The statewide toll-free telephone number of the Florida Hotline " 1(800)96- or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas

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or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and

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personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a

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A 030	Continued From page 20 physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to limit the use of physical to half-bed rails, failed to obtain a written order of the resident's physician, and/or failed to obtain consent before the use of bed rails for 2 out of 4 (resident #2, resident #4) current residents sampled. Findings Include: Observations on at approximately 8:20	A 030		

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AM found two half bed rails, in the down position, attached to the bed of resident #4 on the same side of the bed.

Observations on at approximately 8:22 AM, after retrieving the camera, found one half bed rail, in the upright position, attached to the bed of resident #4. Observations found the second half bed rail located under the bed of resident #4.

Observations on at approximately 8:25 AM found a half bed rail attached to the bed of resident #2.

Record review of the admission and discharge log found revealed resident #4 was admitted on . Review of resident #4's health assessment dated , with diagnoses that include "Chronic , , , and ." Record review lacked any documentation of a signed consent or physician order for half bed rail in file of resident #4.

Record review resident #2 found she was admitted to the facility on . Record review of resident #2's health assessment, dated , with diagnoses that include "AHTN, , , , o/a, and ." Record review found documentation of a physician order for half bed rail dated but lacked documentation of a signed resident consent.

In a phone interview with the administrator on at approximately 12:04 PM, she acknowledged the findings and stated that the consents and orders were in the resident files and her husband will find it.

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A 030	Continued From page 22 In an interview with the husband of the administrator {Operations} on at approximately 12:20 PM, he stated resident #4 is currently at a medical center and goes whenever he is scheduled. He stated at this moment he does not have the order for half bed rails but he will call the doctor for it. He stated he does not have a consent but his wife calls the doctor and she will call her for consent. He stated he could not find a signed consent for half bed rails for resident #4. Class III	A 030		
A 053 SS=G	58A-5.0185(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities which provide medication administration a staff member, who is licensed to administer medications, must be available to administer medications in accordance with a health care provider ' s order or prescription label. (b) Unusual reactions or a significant change in the resident ' s health or behavior shall be documented in the resident ' s record and reported immediately to the resident ' s health care provider. The contact with the health care provider shall also be documented in the resident ' s record. (c) Medication administration includes the conducting of any examination or testing such as glucose testing or other procedure necessary for the proper administration of medication that the resident cannot conduct himself and that can be performed by licensed staff. (d) A facility which performs clinical laboratory	A 053		

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A 053	Continued From page 23 tests for residents, including glucose testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Part I of Chapter 483, F.S. A valid copy of the State Clinical Laboratory License and the CLIA Certificate must be maintained in the facility. A state license or CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' own equipment. Information about the State Clinical Laboratory License and CLIA Certificate is available from the Clinical Laboratory Licensure Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)487-3109. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure licensed staff administered medications to 1 out of 4 (resident #1) sampled residents. Findings Include: Record review of home health agency documents for resident #1 revealed documentation signed by resident #1's physician on - stated "patient is bed bound and contracted/ unable to sit or ambulate." Record review of the home health agency's documentation on resident #1 revealed that a prescription dated stated "nurse to teach caregivers how to manage and continuous feeding pump." Physician order dated for "Pulmocare 50 cc/hr daily via #3 month supply." Physician order dated	A 053		

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A 053	Continued From page 24 for "Proteinez 20 mL via #1 month supply and 5mL via daily #1 month supply." Home health documentation dated state "caregiver in need of further and continuous pump feeding instructions requiring 5 more days of teaching." Documentation on revealed "caregiver reported that patient removed today, and was taken to the Hospital. was reinstated in the ER . Patient in the hospital for less than 24 hours," and "Caregiver will continue to perform care as ordered." In an interview with the Registered Nurse (RN) from the Home Health Agency used by resident #1 on at approximately 12:50 PM, he stated at the beginning resident #1 got it he only used the tube but then gradually he was able to eat. He stated the lady from the ALF would feed him from the endoscopic { } tube. He stated they would clean it too. He stated the facility was in charge of medications. He stated they would have have to put the pills in his mouth and he would check on the tube. He stated resident #1 still uses the tube. He then stated that resident #1 was eating "PO" but in the end 2011 everything was through the tube, including medications. The facility was instructed to feed and give medications through the . Caregivers were providing feeding. Class II	A 053		
A 055 SS=D	58A-5.0185(6) FAC Medication - Storage and Disposal	A 055		

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A 055	Continued From page 25 (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises; or in their or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility shall maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents; or 6. The facility ' s rules and regulations require central storage of medication and that policy has been provided to the resident prior to admission as required under Rule 58A-5.0181, F.A.C. (b) Centrally stored medications must be: 1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication	A 055		

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A 055	Continued From page 26	A 055		

requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and
4. Kept separately from the medications of other residents and properly closed or sealed.
(c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident ' s representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident ' s request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked " discontinued medication. " Such medication may be reused if re-prescribed by the resident ' s health care provider.
(d) When a resident ' s stay in the facility has ended, the administrator shall return all medications to the resident, the resident ' s family, or the resident ' s guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident ' s medications are still at the facility, the medications shall be considered abandoned and may disposed of in accordance with paragraph (e).
(e) Medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and disposition shall be documented in the resident ' s record. The medication may be taken

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964534	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULCE HOGAR	120 NW 26 AVENUE MIAMI, FL 33125

(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 055	Continued From page 27 to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (f) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure prescribed medications and over the counter (OTC) products were secured and out of sight of other residents at all times. Findings Include: Observations on at approximately 8:23 AM found # with the door open upon entry and being used for double occupancy. Observations also found a small refrigerator in the corner of the # . Inside the refrigerator found a bottle of Continuum- 180 Capsules. Observations found the bottle was not labeled with a residents' name. Observations on at approximately 8:23 AM found # with a male resident lying inside on the bed to the right and the bed to the left was unoccupied. On the night stand next to the unoccupied bed found a in single dose package and (generic for). The top draw of the night stand was ajar and two 12% lotions were located inside. Also found in the draw was lotion and .4 milligram (mg) capsules. In an interview with the administrator on at approximately 12:04 PM, she acknowledged the findings.	A 055		

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A 055	Continued From page 28	A 055		
	Class III			
A 077 SS=G	58A-5.019(1) FAC Staffing Standards - Administrators Staffing Standards. (1) ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429, F.S., and this rule chapter. (a) The administrators shall: 1. Be at least [illegible]; 2. If employed on or after [illegible], 1990, have a high school diploma or general equivalency diploma (G.E.D.), or have been an operator or administrator of a licensed assisted living facility in the State of Florida for at least one of the past 3 years in which the facility has met minimum standards. Administrators employed on or after [illegible], 1995, must have a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening standards pursuant to Section 429.174, F.S.; and 4. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C. (b) Administrators may supervise a maximum of either three assisted living facilities or a combination of housing and health care facilities or agencies on a single campus. However, administrators who supervise more than one facility shall appoint in writing a separate " manager " for each facility who must: 1. Be at least [illegible]; and	A 077		

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A 077	Continued From page 29	A 077		

2. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C.
(c) Pursuant to Section 429.176, F.S., facility owners shall notify both the Agency Field Office and Agency Central Office within ten (10) days of a change in a facility administrator on the Notification of Change of Administrator, AHCA Form 3180-1006, 2006, which is incorporated by reference and may be obtained from the Agency Central Office. The Agency Central Office shall conduct a background screening on the new administrator in accordance with Section 429.174, F.S., and Rule 58A-5.014, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on observation and interview the administrator failed to be responsible for the operation and maintenance of the facility and the provision of adequate care to all residents.

Findings Include:

Observations on between approximately 8:12 AM and approximately 12:25 PM did not find the administrator at the facility during the investigation despite, on many occasions, the administrator stated via phone that she was coming.

In a phone interview with the administrator on at approximately 11:05 AM, she stated she believes resident #1 was on home health but does not know, she will speak to her husband. She also stated last week on Wednesday or Thursday resident #2 went to hospital but not

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A 077	Continued From page 30	A 077		

sure which hospital.

In a phone interview with the administrator on at approximately 12:04 PM, she stated she did not know resident #1 was on home health.

In a phone interview with the administrator on at approximately 10:55 AM, she stated she was talking to her husband regarding resident #1 because he did not have documentation and he told her he had a endoscopic {} tube in the beginning of 2012 or the end of 2011. She stated she asked him why she did not tell her but he said he did not know it had to be documented. She stated she did not know he had a tube until her husband told her yesterday. She stated she doesn't go to the assisted living facility {ALF} very often. She stated that resident #1 started eating orally and the liquids were mixed with powder to thicken the liquid. She stated he was able to take medications orally through his mouth. She stated she does not know how medication were given, she needs to ask her husband but medications were taken orally. She stated she knew at some point he would need to use the tube. She stated she would have to ask home health what they did for this resident; she stated she did not know. She stated eventually he did not get out of the bed and that 's why they had the conversation with the family and they wanted him to go to a nursing home.

In a phone interview with the DON from the home health agency on at approximately 10:45 AM, she stated only provide Home Health Services not hospice {for resident #1}. She believes resident #1 was not receiving any other services.

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A 077	Continued From page 31 Class II	A 077		
A 160 SS=D	58A-5.024(1) FAC Records - Facility Records. The facility shall maintain the following written records in a form, place and system ordinarily employed in good business practice and accessible to Department of Elder Affairs and Agency staff. (1) FACILITY RECORDS. Facility records shall include: (a) The facility ' s license which shall be displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident ' s: 1. Date of admission, the place from which the resident was admitted, and if applicable, a notation the resident was admitted with a pressure ; and 2. Date of discharge, the reason for discharge, and the identification of the facility to which the resident is discharged or home address, or if the person is , the date of Readmission of a resident to the facility after discharge requires a new entry. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intends to return pursuant to Rule 58A-5.025, F.A.C. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) An up-to-date record of major incidents occurring within the last 2 years. Such record	A 160		

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A 160	Continued From page 32 shall contain a clear description of each incident; the time, place, names of individuals involved; witnesses; nature of injuries; cause if known; action taken; a description of medical or other services provided; by whom such services were provided; and any steps taken to prevent recurrence. These reports shall be made by the individuals having first hand knowledge of the incidents, including paid staff, volunteer staff, emergency and temporary staff, and student interns. (e) The facility ' s emergency management plan, with documentation of review and approval by the county emergency management agency, as described under Rule 58A-5.026, F.A.C., which shall be located where immediate access by facility staff is assured. (f) Documentation of radon testing conducted pursuant to Rule 58A-5.023, F.A.C.; (g) The facility ' s liability insurance policy required under Rule 58A-5.021, F.A.C.; (h) For facilities which have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C. (i) The admission package presented to new or prospective residents (less the resident ' s contract) described in Rule 58A-5.0182, F.A.C. (j) If the facility advertises that it provides special care for persons with ' ' or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (k) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C. (l) All food service records required under Rule 58A-5.020, F.A.C., including menus planned and served; county health department inspection reports; and for facilities which contract for	A 160		

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A 160	Continued From page 33 catered food services, a copy of the contract for catered services and the caterer ' s license or certificate to operate. (m) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last two (2) years. (n) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (o) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (p) Additional facility 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. (q) The facility ' s resident elopement response policies and procedures. (r) The facility ' s documented resident elopement response drills. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain an accurate admission and discharge log. Findings Include: Record review of the facility's admission and discharge log found the log reflected resident #1 was a current resident. Record review also found the facility did not indicate where all residents	A 160		

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A 160	Continued From page 34 where discharged to and the reason for the discharge. In an interview with the husband of the administrator {Operations} on at approximately 10:15 AM, he stated that he has to get resident #1's file from storage because he was discharged on . In a phone interview with the administrator on at approximately 12:04 PM, she acknowledged the finding and stated sometimes the residents do not want to tell us where they are discharged to. Class III	A 160		
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.	A 162		

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(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 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

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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 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.

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A 162	Continued From page 37 (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 have a physician order for 1 out of 4 (resident #3) sampled residents. Findings Include: Record review of resident #3's file found she was admitted to the facility on . Record review of resident #3's health assessment, dated , revealed resident #3 is bedridden and on hospice services, and with diagnoses of " 's , AHTN, , and generalized o/a." Record review of resident #3's observation log revealed resident #3 began hospice services on , however, record review lacked any documentation of a physician order for hospice. In a phone interview with the administrator on at approximately 12:04 PM, she acknowledged the findings and stated that the consents and orders were in the resident files and her husband will find it.	A 162		

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A 162	Continued From page 38 In an interview with the husband of the administrator {Operations} on at approximately 12:20 PM, he stated he could not locate a physician order for hospice for resident #3. Class III	A 162		
AN276 SS=D	58A-5.031(1) FAC LNS - Nursing Services (1) NURSING SERVICES. A facility with a limited nursing license may provide the following nursing services in addition to any nursing service permitted under a standard license pursuant to Section 429.255, F.S. (a) Conducting passive range of motion exercises. (b) Applying ice caps or collars. (c) Applying heat, including dry heat, hot water bottle, heating , aquathermia, moist heat, hot compresses, sitz bath and hot soaks. (d) Cutting the toenails of residents or residents with a documented problem if the written approval of the resident ' s health care provider has been obtained. (e) Performing ear and eye irrigations. (f) Conducting a dipstick test. (g) Replacement of an established self maintained indwelling , or performance of an intermittent (h) Performing stool removal therapies. (i) Applying and changing routine dressings that do not require packing or irrigation, but are for and closed surgical wounds. (j) Care for pressure sores. Care for or 4 pressure sores are not permitted under this rule.	AN276		

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AN276	Continued From page 39 (k) Caring for casts, braces and . Care for head braces, such as a is not permitted under this rule. (l) Conduct nursing assessments if conducted by a registered nurse or under the direct supervision of a registered nurse. (m) For hospice patients, providing any nursing service permitted within the scope of the nurse ' s license including 24-hour nursing supervision. (n) Assisting, applying, caring for and monitoring the application of anti- stockings or hosiery as prescribed by the health care provider and in accordance with the manufacturers ' guidelines. (o) Administration and regulation of portable (p) Applying, caring for and monitoring a transcutaneous electric nerve stimulator (TENS). (q) , , care and maintenance. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure a licensed nurse provide care and services for 1 out of 4 (resident #3) current residents sampled. Findings Include: Observations on at approximately 8:55 AM found a cuff and concentrator in the medication cabinet with resident medications. Record review of resident #3 revealed she was admitted to the facility on . Record review revealed an observation log that documented resident #3 began hospice services on	AN276		

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AN276	Continued From page 40 Additional documentation on and shows resident #3's " , was low." In a phone interview with the administrator on at approximately 11:05 AM, she stated her husband usually takes the and he reports whatever the pressure is to the doctor and the doctor determines what they should do if they should take them to the hospital or not. She stated if the resident looks down and out they will take first. She stated he has also taken other residents when needed. She stated he is not a licensed nurse. In an interview with the administrator on at approximately 12:04 PM, she acknowledged the findings. Class III	AN276		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Dulce Hogar
120 Nw 26 Avenue
Miami, FL 33125

Re: CCR #2012010595 & 2012010842

Dear Administrator:

This letter reports the findings of two state complaints survey that were 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 12/06/2012 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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
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