

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965854	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER SUANY'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 20411 SW 116 ROAD MIAMI, FL 33189		
(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 visit for a follow up to an standard biennial survey was conducted on _____ at Suany's Home Assisted Living Facility (ALF) with Limited Mental Health (LMH) component. Deficiencies were found corrected. A new deficiency (A0025) was identified:	{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	A 025			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6000

56W912

If continuation sheet 1 of 3

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A 025	Continued From page 1 the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility admitted a resident (#9) requiring care without documenting the treatment received and progression of the condition for resident. Findings as follow: On at about 10:00 a.m. the facility administrator stated resident #9 was admitted to facility on , also stated resident was receiving home health services for care The facility administrator also stated resident was ordered an injection. The facility administrator added resident had a diagnosis of Record review documented resident #1 admitted to facility on had a diagnosis of perisferial and required care treatment (assessment date). Record review also documented resident #9 was ordered an injection (Doctor's order). Record review documented there was a contract with a home health agency to provide the ordered treatment to resident #9. Record review documented there was no documentation in residents file (facility and home health records) indicating the treatment received by resident #9 and the development of the and general condition of resident. On at about 11:30 a.m. the facility administrator stated the facility failed to have documentation of treatment received by resident #9 including home health nurse visits, observations, and the progression of the resident's #9 condition.	A 025			

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A 025	Continued From page 2 Class III		A 025		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11965854	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/30/2012
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Name of Facility SUANY'S HOME	Street Address, City, State, Zip Code 20411 SW 116 ROAD MIAMI, FL 33189
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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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0054</u> Reg. # <u>58A-5.0185(5) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0078</u> Reg. # <u>58A-5.019(2) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0162</u> Reg. # <u>58A-5.024(3) FAC</u> LSC _____	Correction Completed
ID Prefix <u>AL243</u> Reg. # <u>58A-5.0191(8) FAC</u> LSC _____	Correction Completed	ID Prefix <u>AZ806</u> Reg. # <u>59A-35.040, 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	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 _____ CMS RO	Date: _____	Signature of Surveyor: <i>Kristal Brandon</i>	Date: <u>11/13/2012</u>
Reviewed By _____	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
Suany's Home
20411 Sw 116 Road
Miami, FL 33189

Dear Administrator:

This letter reports the findings of a revisit survey to a biennial 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,

to Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

BBT7

