

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1910951	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER DIVINE LIVING IN HIALEAH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 70 EAST 21ST STREET HIALEAH, FL 33010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 000}	Initial Comments A Follow-up Survey was conducted on 5, 2012. The Divine Living In Hialeah LLC with Limited Mental Health and Limited Nursing Services components had deficiencies found at the time of the visit.	{A 000}			
A 054 SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known the resident may have; the name of the resident's health care provider, the health care provider's telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.	A 054			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

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RJH12

If continuation sheet 1 of 2

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910951	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
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A 054	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an up-to date medication observation record (MOR) for 1 out of 19 (SR#16) residents. Findings include: A review of SR#16's MORs revealed no written documentation that showed the residents had received her Sucralfate mediation for the afternoon of 1st thru A review of SR#16's Sucralfate bingo pack medication for 2PM revealed that the medication slots for 1 thru 4 were empty. On at 2:15pm, the staff #3 acknowledged that she had given SR#16 her 2PM mediations for the dates of thru and she acknowledged that SR#16's MORs were not accurately documented. Class III	A 054			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11910951	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 11/5/2012
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Name of Facility DIVINE LIVING IN HIALEAH LLC	Street Address, City, State, Zip Code 70 EAST 21ST STREET HIALEAH, FL 33010
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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>A0030</u> Reg. # <u>58A-5.0182(6) FAC; 429.28</u> LSC _____	Correction Completed	ID Prefix <u>A0052</u> Reg. # <u>58A-5.0185(3) 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
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency _____	Reviewed By _____ Reviewed By _____	Date: _____ Signature of Surveyor: <i>Kristal Ranton</i>	Date: <u>11/16/2012</u> Date: _____
Reviewed By _____ CMS RO _____	Reviewed By _____	Date: _____ Signature of Surveyor: _____	Date: _____
Followup to Survey Completed on: _____		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO	



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Divine Living In Hialeah Llc
70 East 21st Street
Hialeah, FL 33010

Dear Administrator:

This letter reports the findings of a revisit survey to a (CHOW) Change of ownership conducted on 5, 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,

for Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

BBT7

