

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 (2012012019) Investigation Survey was completed at De'Blanca Home with Limited Mental Health on . There were deficiencies identified at the time of survey.	A 000			
A 011 SS=D	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 429.28(1), F.S. This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview the assisted living facility failed to ensure that 1 out of 5 (#4) sampled residents who no longer met the continued residency criteria were discharged. Findings include: Observations on at 12:00 p.m. found that resident #4 responded to staff prompts but she was unable to get out of the chair without the staff #3's help. Staff #3 lifted her from the chair, held her up while staff #2 brought the walker to her. While holding the walker resident #4's feet were not grounded on the floor and she was not able to stand up without staff #3 holding her. She was unable to walk or move her legs. Staff members placed her in a wheelchair as she ate lunch. Although the tray was in front of her was not able to feed herself, staff #2 place food into her mouth. On at 12:10 p.m., staff #3 passed medication to resident #4 which were -LEVO. The medication was observed	A 011			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0099

HYKV11

If continuation sheet 1 of 44

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 011	Continued From page 1 in the cup, the cup was place in resident#4 's mouth by staff #3. The manager administered the medication to resident #4 and the label was not read to her. Review record found that resident #4 was admitted to the facility on . Record review revealed that resident #4 had a doctor's order for care on and the facility did not have any documentation regarding her or the care. Record review found that resident #4 had a doctor's order for a hospice evaluation dated . Record review revealed that the facility did not have any documentation that resident #4 was evaluated for hospice services. Personal record review found that staff #3 was not a licensed nurse and based on that information could not administer medications to residents. Interview with staff #3 (staff member in charge) on at 12:50 p.m. confirmed that resident #4 had an order to have a hospice evaluation. She stated that hospice has not seen her because her daughter lives in Orlando. She (resident #4) can 't hold medication, I helping her. She take the water like a baby but medicine no she needs help. She can 't eat by herself just the water liquid. When she coming had on foot and back I. She confirmed there were no notes on care and activities of daily living (ADL) levels. Class III	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.	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 025	Continued From page 2 (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 the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview the assisted living facility failed to provide care and services to 1 out of 5 (#5) sampled residents who required emergency services, care, and nursing services. The facility failed to ensure that 2 out of 5 (#3 and #5) sampled residents had written notes regarding care, changes in activities of daily living levels, and incidents.	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 025	Continued From page 3 Findings include: Record review found that resident #5's last health assessment dated _____ stated that she needed assistance with all activities of daily living. The health assessment stated that resident #5 had _____. Record review found that resident #5's home health folder from Miami United revealed that the agency only provided _____ care to her left arm which had injuries that were sustained by a fire. Record review found that that the home health did not have any evidence of giving resident #5 _____ care for her multiple _____. Record review found that the facility did not have any documentation that resident #5 was receiving _____ care for her multiple _____ from the facility's limited nursing services nurse. Record review found that resident #5 had a doctor's order for a hospice evaluation on _____. Record review found that the facility did not have any documentation that resident #5 was evaluated for hospice services. Record review found that the facility did not have any written documentation regarding resident #5's _____ care, decline in activities of daily living, or hospital admissions. Record review found that the facility did not have any documentation regarding resident #5 on _____. The facility did not have any documentation regarding resident #5's body condition, breathing problems, and the fact that 911 was not called by the facility's staff member to transfer resident #5 to the hospital. The home health agency documented that resident #5 had a hematoma from her back to her right _____ and resident #5 was not transferred to the hospital. Record review found the facility's last progress	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 025	Continued From page 4 note for resident #5 was dated Hospital records revealed that resident #5 was transferred to Baptist Hospital and arrived on at 7:24 p.m. by ambulance for chief complaint Appearance at arrival was and patient was in moderate distress. of the right and left lower extremity; extreme skin and joint Physical assessment on locations: left leg, left anterior elbow, and pressure with shallow crater noted located on sacral area. in various stages of healing in right chest and right arm. On after clinical impression was that resident #5 had Health Failure (.). (.), Acute Failure, possible Record review found that on the attending physician documented that resident #5 had on lower back, heel and elbow. The are classified as and unstable. Interview with staff #3 (staff in charge) on at 12:57 p.m. revealed that resident #5 received home health services for care because she had an accident which burnt her body and have forever and every two days they need to change. She had it on the left arm. Saturday, I don't work then staff #1 worked and another woman. No record for the other woman at the facility and she does not know her last name. Staff schedule not completed from to and the other woman's name is not listed. On , what she understood that happened when the nurse came to take care of her (resident #5) the nurse called one of her daughters to let her know that the did not look good but they did not	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 025	Continued From page 5 answer and he left them a message. Nurse stated that the employee, she watch the Daughter does not want call 911 and daughter prefer her not to go to the hospital. Several times the called 911 and they take her to Kendall hospital and they did not like it. They finally got to talk to them and both daughter and grandson came maybe around 6 p.m. They came but staff #3 was not sure who to called 911 or an ambulance. They called 911 and they took her to Baptiste. She came in but they had already taken her to the hospital. The reason for the hospital was because of the and her breathing was not doing well. In the last couple of weeks she was showing bad conditions. She was in the hospital because she was getting black and blue on her body then went to Baptiste. Beside the her body was showing welts in right arm. She has machine in , not sure if nurse place on her on Saturday. On at 1:24 p.m. staff #3 stated that resident #5 no walk, not on hospice, and I don't know why she was not on hospice. Weights last taken and notes last documented , she confirmed. Phone interview with staff #1 on at 1:15 p.m. She says the lady (resident #5) was there and daughter came in blow it out of portion and they started this whole problem when the called the police. She says she only works here one day and this has been an ongoing problem with the family. She keeps repeating that resident #5's family was the problem. The family was not happy when they switch employees. She does not know Carmen 's last name. Three months ago they change employees the family was upset and not sure. Phone interview with the home health nurse on	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 025	Continued From page 6 at 4:04 p.m. Nurse stated he was from Miami United Home Health Care Inc, licensed practical nurse (LPN) for resident #5. He provided care she had on left arm, daily care. On the , she had hematoma on upper back and extending to right break which happened before when she was sent to the hospital. The family was not happy with my decision we called them before for that and they stated that was normal. Family member stated at that time they had cause it (). She had not all day called daughter and she did not pick up the phone. Left message to take her to nearest hospital they do not like Kendal they like Baptiste. Every time we call to take to the hospital they said no. I waited for 15 to 20 minutes for call back but they did not call back. I believe they came to the facility around 8-8:30 p.m. and they sent her to the hospital. Not aware of breathing problem, breathing was normal when I was there. I did not like discoloration on her back. Left a message on doctor's answering service and I have not spoken to him. My vitals were ok. She had fragile skin. Major body years ago skin in bad shape. Ambulation extending assistance; need total assistance. Last day total care and deteriorating, she was able to speak. She needed care for everything needed someone to do things for her. This from the last 3.5 to 4 weeks this was going on (note around that time that hospice order was given). Family interview with resident #5's grandson over the phone on at 3:20 p.m. revealed that on that his mother arrived to the facility and found that resident #5 was having problems with her breathing. He arrived shortly after his mother called him. He stated that the staff member working did not know who to use	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 025	Continued From page 7 the machine for resident #5 at the facility. Staff member present did not know where that resident records where. He stated that his mother and himself called 911 to have resident #5 was rushed to the hospital around 6:05 p.m. He stated that his family never told the facility not to send resident #5 to the hospital but they had a bad experience with Kendall Regional and preferred Baptist Hospital. He stated that she had on her back and chest areas. He stated that he called the police to report that the facility was not providing care to the residents. He stated that resident #5 at the hospital on Thursday. He stated that he was not aware that resident #5 had an order to be evaluated by hospice and that the facility did not tell his mother that. Resident interview on at 11:50 a.m. revealed that resident #3 at the facility. Interview on at 12:45 p.m. with staff #3 revealed that resident #3 had mark on right arm. Staff #3 stated that she has problem with the legs and she is always getting something on the bed or closet and she slips. Resident #3 is always on the floor and she has Daughter in law and son knows it. Can't remember when she but will ask mom (staff member #2) if she thinks mark on right eye- not taken to the hospital but went two months ago had 5 stitches on the head at Kendall. I contacted the family but we don't have notes. Record review found that the facility did not have any written notes on the incident. Record review found that the facility did not document any of resident #3's	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 025	Continued From page 8	A 025			
	Class II				
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 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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 030	Continued From page 9 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 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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 030	Continued From page 10 429.28 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 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.	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED /2012
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 030	Continued From page 11 (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 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 ill, 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.	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 030	Continued From page 12 This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview the assisted living facility failed to ensure that 1 out of 5 (#4) sampled residents shall be limited to half (1/2) bed rails. The facility failed to have a doctor's order for bed rails and did not have a signed consent for bed rails by the resident or her representative. Findings include: Facility tour on _____ at 8:40 a.m. with staff #3 found resident #4 in _____ # _____ with full bed rails on both sides of her bed. Observations found that resident #4 would be unable to remove the full bed rails from her bed. She stated on _____ at 8:40 a.m. she had the full bed rails on the bed to help take her a bath but she had 1/2 bed rails in the closet. Which were observed in the closet and not on the resident's bed. Interview with staff #3 (staff member in charge) on _____ at 12:50 p.m. confirmed that resident #4 did not have a doctor's order and did not have a signed consent form for the bed rails. Record review found that resident #4 did not have a doctor's order for the bed rails and she did not have a signed consent form to have bed rails on her bed. Class III	A 030			
A 079 SS=D	58A-5.019(4) FAC Staffing Standards - Levels (4) STAFFING STANDARDS.	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED																							
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174																									
(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 079	Continued From page 13 (a) Minimum staffing: 1. Facilities shall maintain the following minimum staff hours per week: <table border="1"> <thead> <tr> <th>Number of Residents</th> <th>Staff Hours/Week</th> </tr> </thead> <tbody> <tr><td>0-5</td><td>168</td></tr> <tr><td>6-15</td><td>212</td></tr> <tr><td>16-25</td><td>253</td></tr> <tr><td>26-35</td><td>294</td></tr> <tr><td>36-45</td><td>335</td></tr> <tr><td>46-55</td><td>375</td></tr> <tr><td>56-65</td><td>416</td></tr> <tr><td>66-75</td><td>457</td></tr> <tr><td>76-85</td><td>498</td></tr> <tr><td>86-95</td><td>539</td></tr> </tbody> </table> For every 20 residents over 95 add 42 staff hours per week. 2. At least one staff member who has access to facility and resident records in case of an emergency shall be within the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 3. In facilities with 17 or more residents, there shall be at least one staff member awake at all hours of the day and night. 4. At least one staff member who is trained in First Aid and , as provided under Rule 58A-5.0191, F.A.C., shall be within the facility at all times when residents are in the facility. 5. During periods of temporary absence of the administrator or manager when residents are on the premises, a staff member who is at least 18 years of age, must be designated in writing to be in charge of the facility. 6. Staff whose duties are exclusively building maintenance, clerical, or food preparation shall not be counted toward meeting the minimum staffing hours requirement.			Number of Residents	Staff Hours/Week	0-5	168	6-15	212	16-25	253	26-35	294	36-45	335	46-55	375	56-65	416	66-75	457	76-85	498	86-95	539	A 079			
Number of Residents	Staff Hours/Week																												
0-5	168																												
6-15	212																												
16-25	253																												
26-35	294																												
36-45	335																												
46-55	375																												
56-65	416																												
66-75	457																												
76-85	498																												
86-95	539																												

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 079	Continued From page 14 7. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 8. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, shall have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 58A-5.0182, F.A.C. (c) The facility must maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules for direct care staff available to residents or representatives, specific to the resident's care. (d) The facility shall be required to provide staff immediately when the Agency determines that the requirements of paragraph (a) are not met. The facility shall also be required to immediately increase staff above the minimum levels established in paragraph (a) if the Agency determines that adequate supervision and care are not being provided to residents, resident care standards described in Rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The Agency shall consult with the facility administrator and residents regarding any determination that	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 079	Continued From page 15 additional staff is required. 1. When additional staff is required above the minimum, the agency shall require the submission, within the time specified in the notification, of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met. The plan shall be reviewed by the agency to determine if the plan will increase the staff to needed levels and meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, modifications may be made in staffing requirements for the facility and the facility shall no longer be required to maintain a plan with the agency. 3. Based on the recommendations of the local fire safety authority, the Agency may require additional staff when the facility fails to meet the fire safety standards described in Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the Agency that fire safety requirements are being met. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of Rule 58A-5.029, 58A-5.030, or 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview the	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 079	Continued From page 16 assisted living facility failed to ensure that the had a staffing pattern available. The facility failed to have a written designation of authority during periods of absence of the administrator. Findings include: Record review found that the facility did not have a staff pattern available from _____ to _____. Record review found that the facility did not have a designation of authority letter at the facility during periods of absence of the administrator. Interview with staff #3 (staff member in charge) on _____ at 1:15 p.m. revealed that she did not know where that administrator was. Staff #3 provided copies of the staff schedule which was dated but it was not filled out. She confirmed that the facility did not have a designation of authority letter for her. She stated that she took the CORE training test but had not received the results which she needed to be the administrator. Class III	A 079			
A 081 SS=D	58A-5.0191(2) FAC Training - Staff In-Service (2) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions, and facility sanitation procedures before providing personal care to residents. Documentation of	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 081	Continued From page 17 compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting major incidents. 2. Reporting adverse incidents. 3. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/05/2012
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 081	Continued From page 18 the facility 's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide or arrange in-service training to 1 out of 4 (#1) direct care staff within 30 days of employment. Findings include: Personnel record review on _____ at 9:15 a.m. revealed that staff #1, (hire date unknown) who provides direct care to residents had no documentation of in-service training's in the following: 1. Activity of Daily Living (ADLs) and Behavioral Needs Training a minimum of 3 hours needed 2. Elopement Response Training 3. Emergency Preparedness & Evacuation training plus Incident Report Training a minimum of 1 hour needed 4. Resident Rights Training, Recognizing / Reporting _____, Neglect & _____ a minimum of 1 hour needed On _____ at 1:25 p.m. the findings were reviewed with staff #3 (staff member in charge) and she confirmed that staffs #1 complete record was not kept at the ALF due to staff #1 being a floater between the other three De' Blanca's ALFs. She stated that staff members started about three months ago at the facility. Class III	A 081			

If continuation sheet 20 of 44

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 083	Continued From page 20 Aid and : training. Class III	A 083		
A 084 SS=D	58A-5.0191(5) FAC Training - Assis Self-Admin Meds & Med Mgmt (5) ASSISTANCE WITH SELF-ADMINISTERED MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with self-administered medications as described in Rule 58A-5.0185, F.A.C., must meet the training requirements pursuant to Section 429.52(5), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates an ability to: 1. Read and understand a prescription label;	A 084		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/05/2012
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 084	Continued From page 21 2. Provide assistance with self-administration in accordance with Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., including: a. Assist with oral dosage forms, _____ dosage forms, and _____ and nasal dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; and g. Recognize the general signs of adverse reactions to medications and report such reactions. (c) Unlicensed persons, as defined in Section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 4 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training shall only be provided by a licensed registered nurse, or a licensed pharmacist. This Statute or Rule is not met as evidenced by: Based on record review and interview the assisted living facility failed to ensure that 1 out of 4 (#1) sampled staff members who assisted with self administration of medication had minimum of	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 084	Continued From page 22 2 hours of medication training annually. Findings include: Record review found that staff #1's last medication training certificate at the facility was dated _____. Record review found that the facility did not have any evidence of staff #1 having medication training annually. Interview with staff #3 (staff member in charge) on _____ at 1:25 p.m. revealed that staff #1 worked on the weekends with the residents and she did not have a complete record at the facility. Class III	A 084			
A 085 SS=D	58A-5.0191(6) FAC Training - Nutrition & Food Service (6) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. A certified food manager, licensed dietitian, registered dietary technician or health department sanitarians are qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on record review and interview the assisted living facility failed to ensure 1 out of 4 (#1) sampled staff members have a minimum of 2 hours of nutrition training annually.	A 085			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 085	Continued From page 23 Findings include: Record review found that staff #1's last nutrition training was dated _____. The facility did not have documentation that staff #2 had 2 hour nutrition training annually. Interview with staff #3 (staff member in charge) on _____ at 1:25 p.m. revealed that staff #1 worked on the weekends with the residents and she did not have a complete record at the facility. Class III	A 085			
A 090 SS=D	58A-5.0191(11) FAC Training - Do Not Orders (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility ' s policies and procedures regarding _____ within 60 days after the effective date of this rule. (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility ' s policy and procedures regarding _____ within 30 days after employment. (c) Training shall consist of the information included in Rule 58A-5.0186, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and staff interview the	A 090			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 090	Continued From page 24 assisted living facility failed to ensure that 1 out of 4 (#1) sampled staff members received Do Not Orders () training. Findings include: Record review revealed that staff # did not have any documentation of having () training within 30 days of employment. Interview with staff #3 (staff member in charge) on at 1:25 p.m. revealed that staff #1 worked on the weekends with the residents and she did not have a complete record at the facility. She stated that staff members started about three months ago at the facility. Class III	A 090			
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	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/05/2012
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 160	Continued From page 25 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 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.	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 160	Continued From page 26 (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 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.	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/05/2012
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 160	Continued From page 27 (r) The facility 's documented resident elopement response drills. This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview the assisted living facility failed to have an up to date admission and discharge log. Findings include: Facility tour on _____ at 8:35 a.m. with staff #3 found that the facility had a census of 6 residents. Record review found that the facility admission log did not have residents #1, #2, and #4 listed as current residents on the log. Record review found that resident #5 was not discharged from the log. Record review found that the facility did not have an up to date admission and discharge log. Staff #3 (staff member in charge) stated on _____ at 8:50 a.m. resident #5 who _____ on Thursday _____. Staff #3 stated on _____ at 12:39 p.m. revealed resident #1 was admitted on _____, resident #2 admitted on _____ started as daycare now is resident, and resident #4 was admitted _____. Staff #3 confirmed that the log was not correct. Class III	A 160			
A 161 SS=D	58A-5.024(2) FAC Records - Staff (2) STAFF RECORDS. (a) Personnel records for each staff member shall contain, at a minimum, a copy of the original	A 161			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 161	Continued From page 28 employment application with references furnished and verification of freedom from communicable including . In addition, records shall contain the following, as applicable: 1. Documentation of compliance with all staff training required by Rule 58A-5.0191, F.A.C.; 2. Copies of all licenses or certifications for all staff providing services which require licensing or certification; 3. Documentation of compliance with level 1 background screening for all staff subject to screening requirements as required under Rule 58A-5.019, F.A.C.; 4. A copy of the job description given to each staff member pursuant to Rule 58A-5.019, F.A.C., for facilities with a licensed capacity of seventeen (17) or more residents; and 5. Documentation of facility direct care staff and administrator participation in resident elopement drills pursuant to paragraph 58A-5.0182(8)(c), F.A.C. (b) The facility shall not be required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by a business entity contracting to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 58A-5.019, F.A.C. (c) The facility shall maintain the facility 's written work schedules and staff time sheets as required under Rule 58A-5.019, F.A.C., for the last 6 months. This Statute or Rule is not met as evidenced by: Based on record review and interview the	A 161			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/05/2012
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 161	Continued From page 29 assisted living facility failed to ensure that 3 out of 4 (#1, #2 & #3) sampled staff members have a completed application with references. Findings include: Record review found that staff #1, #2 and #3 did not have a completed application with references documented. On at 12:20 p.m. the findings were reviewed with staff #3 (staff member in charge during survey) and she confirmed that herself, staff #1 & #2 did not have a completed application with references documented. Class III	A 161			
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. (c) Any health care provider's orders for	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 162	Continued From page 30 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 quarterly written statement of funds or other	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 162	Continued From page 31 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. (p) Except for resident contracts which must be	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174			
(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 162	Continued From page 32 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 observations, record review, and interview the assisted living facility failed to have doctor orders for 2 out of 5 (#4 and #5) sampled residents. The facility failed to document weights for 1 out of 5 (#5) sampled residents every 6 months. The facility failed to have a signed informed consent for unlicensed staff to assistance with medications for 1 out of 5 (#4) sampled residents. The facility failed to have documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney for 1 out of 5 (#4) sampled residents. Findings include: Lunch observations on _____ at 12:00 p.m. found that resident #4 was served a puree (blended) diet by staff #2. Record review found that the facility did not have a doctor's order to serve resident #4 a puree diet. Record review found that resident #4's daughter signed her contract but the facility did not have			A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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 162	Continued From page 33 any documentation that she was a health surrogate, guardian, or had a power of attorney. Record review also found that the facility did not have signed informed consent for unlicensed staff to assist with self administration of medications. Interview with staff #3 (staff member in charge) on _____ at 12:50 p.m. revealed that the facility did not have the orders for resident #4. She stated that her daughter works in Orlando so that were not able to get the power of attorney from her. And she confirmed that the daughter did not sign the all admission forms. Record review found that resident #5 had multiple _____ concentrators delivered to her at the facility. Record review found that the facility did not have a doctor's order with the _____ concentrator's instructions and orders for usage. Record review also found that the last weight taken for resident #5 was in _____ 2011 for 136 pounds. Record review revealed that resident #5's last health assessment dated _____ indicated she needed assistance with all activities of daily living. Interview with staff #3 on _____ at 12:57 p.m. revealed that the facility did not have the doctor's order for the _____. She also confirmed that resident #5's last weight recorded by the facility was _____ 2011 about a year old. Class III	A 162			
AL243 SS=D	58A-5.0191(8) FAC LMH - Training (8) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to Section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a	AL243			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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	
AL243	Continued From page 34 licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Staff in "direct contact" means direct care staff and staff whose duties take them into resident living areas and require them to interact with mental health residents on a daily basis. The term does not include maintenance, food service or administrative staff, if such staff have only incidental contact with mental health residents. c. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to Section 429.52(4), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and b. Mental health treatment such as mental health needs, services, behaviors and appropriate interventions; resident progress in achieving treatment goals; how to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and crisis services and the procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of	AL243			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED /2012
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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
AL243	Continued From page 35 continuing education required biennially pursuant to Section 429.52(4), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on record review and interview the assisted living facility failed to ensure that 1 out of 4 (#4) sampled staff members received a minimum of 3 hours of continuing education in limited mental health training biennially. Findings include: Record review found that staff #4 (the listed administrator) did not have any documentation of having a minimum of 3 hours of continuing education training in limited mental health in the last two years. Staff #4's last limited mental health training was dated Interview with staff #3 (staff member in charge) on : at 1:25 p.m. confirmed that the facility did not have all the training for the employees.	AL243			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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
AL243	Continued From page 36	AL243			
	Class III				
AZ815	408.809, 435.02(2), 435.06 Background Screening; Prohibited Offenses 408.809, F.S. (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest if the agency has reason to believe that such person has been convicted of any offense prohibited by s. 435.04. For each controlling interest who has been convicted of any such offense, the licensee shall submit to the agency a description and explanation of the conviction at the time of license application. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, contracting with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients. Evidence of contractor screening may be retained by the contractor's	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/05/2012
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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	
AZ815	Continued From page 37 employer or the licensee. (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's fingerprints to the Federal Bureau of Investigation for a national criminal history record check. If the fingerprints of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g), the person must file a complete set of fingerprints with the agency and the agency shall forward the fingerprints to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The fingerprints may be retained by the Department of Law Enforcement under s. 943.05(2)(g). The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person fingerprinted. Proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the agency, the Department of Health, the Agency for Persons with , the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 satisfies the requirements of this section if the person subject	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED _____
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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	
AZ815	Continued From page 38 to screening has not been unemployed for more than 90 days and such proof is accompanied, under penalty of perjury, by an affidavit of compliance with the provisions of chapter 435 and this section using forms provided by the agency. (3) All fingerprints must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 817.034, relating to fraudulent acts	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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	
AZ815	Continued From page 39 through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (g) Section 817.234, relating to false and fraudulent insurance claims. (h) Section 817.505, relating to patient brokering. (i) Section 817.568, relating to criminal use of personal identification information. (j) Section 817.60, relating to obtaining a credit card through fraudulent means. (k) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (l) Section 831.01, relating to forgery. (m) Section 831.02, relating to uttering forged instruments. (n) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (o) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (p) Section 831.30, relating to fraud in obtaining medicinal drugs. (q) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. A person who serves as a controlling interest of, is employed by, or contracts with a licensee on , 2010, who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by 31, 2015. The agency may adopt rules to establish a schedule to stagger the implementation of the required rescreening over the 5-year period, beginning , 2010, through , 2015. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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	
AZ815	Continued From page 40 or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: - Does not have an active professional license or certification from the Department of Health; or - Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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
AZ815	Continued From page 41 may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining fingerprints pursuant to s. 943.05(2). (8) There is no unemployment compensation or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06, F.S. (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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
AZ815	Continued From page 42 grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been _____ for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the _____ is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including fingerprints if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no unemployment compensation or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or _____ for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965837	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED /2012
NAME OF PROVIDER OR SUPPLIER DE' BLANCA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 125 SW 103 COURT MIAMI, FL 33174		
(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	
AZ815	Continued From page 43 regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02(2), F.S. "Employee" means any person required by law to be screened pursuant to this chapter. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure 1 out of 4 (#3) sampled staff were in compliance with a Level 2 Background screening. Findings include: On _____ at 9:15 a.m. observed staff #2 doing the residents laundry, cleaning facility and cooking meals. Other observations during the survey found that staff #2 was providing care to residents and feeding resident #4 lunch. Record review on _____ for staff #2 revealed she had no documentation of completed level II background screening available at time of survey. Her files contained a receipt for background screening and the results indicate the "Screening in Process" for current status. On _____ at 12:25 p.m. the findings were reviewed with staff #3 who was in charge, she confirmed that staff #2 background screening was submitted but as of _____ were still pending.	AZ815			



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
De' Blanca Home
125 Sw 103 Court
Miami, FL 33174

Re: CCR #2012012019

Dear Administrator:

This letter reports the findings of a state complaint survey that was 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 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
XG90

