Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963986	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM HOME INC	158 WEST 8TH STREET HIALEAH, FL 33010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments	{A 000}		
	A Complaint (2012009423) Follow-up Survey was completed at Adam Home Inc with Limited Mental Health (LMH) component. The following deficiency was found uncorrected at the time of survey: A 0025.			
{A 025} SS=D	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	{A 025}		

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{A 025}	Continued From page 1	{A 025}		

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 6 (#3) sampled residents received nursing services for [redacted] administration.

Findings include:

Medication review on [redacted] at 11:48 a.m. found that resident #3 had [redacted] which was stored by the facility. The [redacted] label stated [redacted] 55 units in the morning and 33 units at night.

Record review found that the facility's medication observation records for resident #3 were initialed for [redacted] administration by staff in [redacted] and [redacted] Record review found that the facility did not have any documentation that a nurse or home health agency was providing [redacted] administration to resident #3. Record review found that resident #3's doctor order [redacted] for her on [redacted].

Interview with the administrator on [redacted] at 2:48 p.m. confirmed that resident #3's medication observation record for the months of [redacted] and [redacted] were initialed by the facility for [redacted]. She stated that [redacted] was discharged by the doctor.

Interview with the doctor on [redacted] at 4:47 p.m. revealed that resident #3 was ordered to be on [redacted]. He stated that the [redacted] was not discharged. He stated he would fax her current orders to the agency.

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{A 025}	Continued From page 2 On the facility received a orders for resident #3's doctor which included her order. Uncorrected Deficiency Class III	{A 025}		

AH Form Approved

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11963986	A. Building B. Wing	12/4/2012

Name of Facility	Street Address, City, State, Zip Code
ADAM HOME INC	158 WEST 8TH STREET HIALEAH, FL 33010

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix A0160 Reg. # 58A-5.024(1) FAC LSC		ID Prefix A0162 Reg. # 58A-5.024(3) FAC LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency			Jusorof Quanton	12/12/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Adam Home Inc
158 West 8th Street
Hialeah, FL 33010

CCR#2012009423 f/u

Dear Administrator:

This letter reports the findings of a revisit survey to a complaint conducted on , 2012by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references the uncorrected deficiencies and/or new deficiencies, identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2013.**

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

/s Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

BBT7

Headquarters
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Tallahassee, FL 32308
http://ahca.myflorida.com

Miami Field Office
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Miami, FL 33166
Phone (305) 593-3100; Fax (305) 593-3121