

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 These are the results of a follow up survey conducted at Hogar Dulce Hogar, an Assisted Living Facility, on _____ and _____. Several deficiencies were identified as uncorrected and new deficiencies were identified at the time of this survey.		{A 000}		
{A 004}	58A-5.016 FAC Licensure - Requirements License Requirements. (1) SERVICE PROHIBITION. An ALF may not hold itself out to the public as providing any service other than a service for which it is licensed to provide. (2) LICENSE TRANSFER PROHIBITION. Licenses are not transferable. Whenever a facility is sold or ownership is transferred, including leasing, the transferor and transferee must comply with the provisions of Section 429.41, F.S., and the transferee must submit a change of ownership license application pursuant to Rule 58A-5.014, F.A.C. (3) CHANGE IN USE OF SPACE REQUIRING CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity shall not be made without prior approval from the Agency Central Office. Approval shall be based on the compliance with the physical plant standards provided in Rule 58A-5.023, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation requirements as referenced in Rule 58A-5.0161, F.A.C. (4) CHANGE IN USE OF SPACE REQUIRING FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, shall not be made without prior approval from the Agency Field Office.		{A 004}		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6899

EXBJ12

If continuation sheet 1 of 27

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 004}	Continued From page 1 Approval shall be based on the compliance with the physical plant standards provided in Rule 58A-5.023, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation standards as referenced in Rule 58A-5.0161, F.A.C. (5) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on contiguous property. "Contiguous property" means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Part I, Chapter 429, F.S., and this rule chapter. (6) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 58A-5.0161, F.A.C., shall be submitted annually to the Agency Central Office. The annual inspections shall be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to Section 429.14, F.S., and Rule 58A-5.033, F.A.C. (7) MEDICAID WAIVER RESIDENTS. Upon request, the facility administrator or designee must identify Medicaid waiver residents to the agency and the department for monitoring purposes authorized by state and federal laws. (8) THIRD PARTY SERVICES. (a) In instances when residents require services from a third party provider, the facility administrator or designee must take action to assist in facilitating the provision of those services and coordinate with the provider to meet the specific service goals, unless residents or their representatives decline the assistance. The	{A 004}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 004}	Continued From page 2 declination of assistance must be reviewed at least annually. These actions must be documented in the resident ' s record. (b) In instances when residents or their representatives arrange for third party services, the facility administrator or designee, when requested by residents or representatives, must take action to assist in facilitating the provision of those services and coordinate with the provider to meet the specific service goals. These actions must be documented in the resident ' s record. (c) The facility ' s facilitation and coordination as described under this subsection does not represent a guarantee that residents will receive third party services. If the facility ' s efforts at facilitation and coordination are unsuccessful, the facility should include this documentation in the resident ' s record, explaining the reason or reasons its efforts were unsuccessful, which will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to notify and obtain needed approval, from the Agency Central Office, to increase the facility's resident capacity that involved a change in the use of the facility space. The facility was found to be over capacity by 1 resident (Resident #10). The findings include: 1. On _____ at approximately 4:50 a.m., a tour of the facility was conducted. The surveyor observed a total of 9 beds and 8 residents in the facility; one of which qualified to be a daycare resident.	{A 004}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112			
(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)	
{A 004}	Continued From page 3 2. A review of the facility's licenses on _____ confirmed the facility is only licensed for 6 beds/residents. 3. The Administrator was interviewed on _____ at 6:16 a.m. The Administrator admitted Resident #10 has been at the facility for "two to three days." He claimed Resident #10 is staying at the facility temporarily until Resident #10's case manager finds a place for him to stay. Resident #10 was interviewed on _____ at 6:20 a.m. Resident #10 stated, "I just arrived 3 days ago at 2:30 p.m. I came Monday at 2:30 p.m., exactly." Resident #10 reports receiving reminders for taking showers and receiving meals at this facility. Resident #10 states he paid a total of \$868 for a full month rent. On _____ at 9:00 a.m., an interview was conducted with Resident #10's Case Manager (CM). The CM explained his resident had been kicked out of one facility and needed to be placed in another facility. He reported calling the Administrator of this facility to see if they had availability. The CM went on to say, "I know that they are licensed but the number of beds he [the administrator] can have; I don't know, but they said they had an available bed. All I said to him is that I have this guy that needs placement." Class III A 008 58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in		{A 004}		
			A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 008	Continued From page 4 either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F. S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or _____ services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable _____ which is likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual ' s needs can be met in an assisted living facility; and 8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state. (b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, _____ 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 008	Continued From page 5 www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_C are/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows: 1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment. a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion. b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider. c. Omitted information received verbally must be documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided. 2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the elements in Section 3. This requirement does not apply for residents receiving: a. Extended congregate care (ECC) services in facilities holding an ECC license; b. Services under community living support plans in facilities holding limited mental health licenses; c. Medicaid assistive care services; and d. Medicaid waiver services. (c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823.	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 008	Continued From page 6 (d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule. (f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a _____ order for residents who do not wish _____ to be administered in the case of _____ or _____ (g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility's admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission.	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 008	Continued From page 7 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 (Resident #2 and Resident #9) of 7 residents observed in the facility had a complete Agency for Health Care Administration (AHCA 1823) Health Assessment on file within 30 days of their admission. The findings include: 1. On _____ the facility's Admission and Discharge Register (log) was reviewed. The log revealed Resident #2 was admitted to the facility on _____ and Resident #9 was admitted to the facility on _____. On _____ Resident #2's facility health record was reviewed. The record contained an AHCA 1823 Health Assessment form which was dated as completed on _____. Page #4 of the health assessment states, "Note: medical certification is incomplete without the following information: Name of examiner (please print), signature of examiner, medical license number, address of examiner, telephone number, title of examiner and date of examination. Page #4 of Resident #2's AHCA 1823 health contains signature (from an unknown person) where the medical examiner should sign and a date of the exam. Resident #2's health assessment is incomplete. Resident #9's facility health record was reviewed on _____. The record contained an AHCA 1823 Health Assessment form dated as completed on _____. This form was not signed by the Medical examiner. This form is incomplete. 2. The Administrator was interviewed on _____ at 10:35 a.m. He stated, "I try to do the best I		A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 008	Continued From page 8 can, but I make mistakes." Class . . .	A 008			
{A 009}	58A-5.0181(3) FAC Admissions - Admission Package (3) ADMISSION PACKAGE (a) The facility shall make available to potential residents a written statement(s) which includes the following information listed below. A copy of the facility resident contract or facility brochure containing all the required information shall meet this requirement. 1. The facility 's residency criteria; 2. The daily, weekly or monthly charge to reside in the facility and the services, supplies, and accommodations provide by the facility for that rate; 3. Personal care services that the facility is prepared to provide to residents and additional costs to the resident, if any; 4. Nursing services that the facility is prepared to provide to residents and additional costs to the resident, if any; 5. Food service and the ability of the facility to accommodate special diets; 6. The availability of transportation and additional costs to the resident, if any; 7. Any other special services that are provided by the facility and additional cost if any; 8. Social and leisure activities generally offered by the facility; 9. Any services that the facility does not provide but will arrange for the resident and additional cost, if any; 10. A statement of facility rules and regulations that residents must follow as described in Rule 58A-5.0182, F.A.C.; 11. A statement of the facility policy concerning	{A 009}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112	
(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 009}	Continued From page 9 pursuant to Section 429.255, F.S. and Rule 58A-5.0186, F.A.C., and Advance Directives pursuant to Chapter 765, F.S. 12. If the facility also has an extended congregate care program, the ECC program's residency criteria; and a description of the additional personal, supportive, and nursing services provided by the program; additional costs; and any limitations, if any, on where ECC residents must reside based on the policies and procedures described in Rule 58A-5.030, F.A.C.; 13. If the facility advertises that it provides special care for persons with _____'s _____ and related _____ a written description of those special services as required under Section 429.177, F.S.; and 14. A copy of the facility's resident elopement response policies and procedures. (b) Prior to or at the time of admission, the resident, responsible party, guardian, or attorney in fact, if applicable, shall be provided with the following: 1. A copy of the resident's contract which meets the requirements of Rule 58A-5.025, F.A.C.; 2. A copy of the facility statement described in paragraph (a) of this subsection if one has not already been provided; 3. A copy of the resident's bill of rights as required by Rule 58A-5.0182, F.A.C.; and 4. A Long-Term Care Ombudsman Council brochure which includes the telephone number and address of the district council. (c) Documents required by this subsection shall be in English. If the resident is not able to read, or does not understand English and translated documents are not available, the facility must explain its policies to a family member or friend of the resident or another individual who can communicate the information to the resident.	{A 009}	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 009}	Continued From page 10 This Statute or Rule is not met as evidenced by: Based on interview the facility failed to provide a complete admission packet for 1 (Resident #10) of 7 residents in the facility. The findings include: On _____ at 6:20 a.m., Resident #10 was interviewed. He stated he has been at the facility for three days and denied signing a contract to stay there. He stated he receives meals and reminders to do things, such as showering. He admitted to paying rent for one month in the amount of \$868. On _____ at 6:38 a.m., the Administrator was interviewed. He confirmed Resident #10 does not have a contract with the facility. Class _____	{A 009}			
{A 026}	58A-5.0182(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility shall provide an ongoing activities program. The program shall provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility shall consult with the residents in selecting, planning, and scheduling activities. The facility shall demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, suggestion box, group discussions, questionnaires, or any other form of	{A 026}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 026}	Continued From page 11 communication appropriate to the size of the facility. (c) Scheduled activities shall be available at least six (6) days a week for a total of not less than twelve (12) hours per week. Watching television shall not be considered an activity for the purpose of meeting the twelve (12) hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required twelve (12) hours per week of scheduled activities. An activities calendar shall be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to three (3) hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on record review, observation, and interviews, the facility failed to provide all 7 residents in the facility with regularly structured activities. The findings include: 1. On _____ a review of the facility's _____ 2012 activity calendar list the Dominoes games and music from 2:00 p.m., to 4:00 p.m., as the activity for 2. Observation on _____ between the hours of 2:00 p.m., and 4:00 p.m., revealed residents moving independently throughout the facility. The Administrator did not offer or announce the start	{A 026}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 026}	Continued From page 12 of an activity. 3. On 4:27 p.m., Resident #2 was interviewed. When questioned about the facility's activities he stated, "They play chess; they play cards." He reports not having activities on a daily basis and confirmed no activities were offered today. Resident #6 was interviewed on at 5:19 p.m. When asked about the activities the facility offers, Resident #6 stated, "We never have them." Resident #6 stated being aware of an activity schedule posted on the board. Resident #6 said, "The activity schedule is posted on the board, but the facility never follows it." Resident #9 was interviewed on at approximately 5:30 p.m. He denied being offered activities by the facility. He stated "I just sit around all day." Resident #9 expressed he would like to be offered activities by the facility. Class III		{A 026}		
{A 083}	58A-5.0191(4) FAC Training - First Aid and (4) FIRST AID AND A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation of attendance at First Aid or course offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American Association, or National Safety Council; or a provider approved by the Department of Health, shall satisfy this requirement.		{A 083}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112	
(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 13 (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under Part III of Chapter 401, F.S., shall be considered as having met the training requirements for both First Aid and . . . This Statute or Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure there was a staff member who completed . . . and First Aid at the facility at all times. The findings include: 1. On . . . a review of the facility's schedule (dated from . . . reflected the Administrator works Sunday through Saturday from 7 a.m., until 7 p.m., and the Relief Administrator works Sunday through Saturday from 7 p.m., until 7 a.m. 2. Observation on . . . at approximately 4:45 a.m., revealed one staff member working at the facility (Staff A). The Administrator arrived at the facility at 5:07 a.m. 3. Staff A was interviewed on . . . She denied having any training or certification to work at an Assisted Living Facility. The Administrator was interviewed on . . . at 6:05 a.m. He confirmed Staff A was not a resident and that she has been working at this facility for, "about one month." He reported she works at the facility between two to three nights a week. At 7:12 a.m., of the same day, the Administrator admitted Staff A did not have any	{A 083}	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 14 training including training for _____ and First Aid. The Administrator also confirmed Staff A is not a licensed nurse. Class II	{A 083}			
{A 084}	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	{A 084}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112	
(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 15 an ability to: 1. Read and understand a prescription label; 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 interview and record review, the facility failed to ensure 1 Staff A) of 3 staff members	{A 084}	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 16 reviewed received the 4 hour medication training before assisting with the self-administration medications to 1 (Resident #9) of 7 residents sampled. The findings include: 1. On _____ at 6:20 a.m., an interview was conducted with Resident #10. Resident #10 stated, "I saw [Staff A] deliver medications to my _____ in his bed ...yes, I've seen her hand out pills to my _____ [Resident #9] exactly." The administrator was interviewed on _____ at 7:12 p.m. He denied Staff A received the 4 hour medication training. He also denied Staff A had an application and/or background screening or a nursing license. On _____ at 8:47 a.m., Resident #9 was interviewed. He confirmed Staff A assisted him with the self-administration of his medication. He stated, "It's been a night or two. It might have been last night actually." 2. A review of Resident #9's record revealed Resident #9 is a Limited Mental Health resident who takes _____ and _____. Class III		{A 084}		
A 161	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 employment application with references furnished and verification of freedom from communicable _____ including _____. In addition,		A 161		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112	
(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 17 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 observation and interview, the facility failed to have a personnel record for 1 (Staff A) of 3 staff member records reviewed.	A 161	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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)	
A 161	Continued From page 18 The findings include: 1. Observation on _____ at 4:45 a.m., revealed Staff A was working at the facility by supervising the residents. 2. The Administrator was interviewed on _____ at 7: 12 a.m. The Administrator confirmed Staff A was at the facility to supervise the residents and stated Staff A did not have a personnel record with an application, references, and training documentation to be reviewed. Class III		A 161		
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		AZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112	
(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 19 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 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	AZ815	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 20 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 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	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 21 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 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,	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 22 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 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: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 23 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 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	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 24 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 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		AZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2012
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112	
(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 25 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 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 and interview the facility failed to ensure 1 (Staff A) of 3 staff members reviewed completed a level II background screening before coming in direct contact with residents. The findings include: 1. On _____ at 4:45 a.m., Staff A was observed to be the only staff at the facility. She was alone with 8 residents. 2. An interview was conducted with Staff A on _____ at 5:39 a.m. She reported working at the facility two or three nights within this week. The Administrator was interviewed several times	AZ815	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967975	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/06/2012
NAME OF PROVIDER OR SUPPLIER HOGAR DULCE HOGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 5597 WENDY LN NAPLES, FL 34112		
(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 26 At 6:47 a.m., the Administrator confirmed Staff A is there to supervise the residents and Staff A has worked at the facility for about one month. At 7:12 p.m., the Administrator denied conducting a background screening on Staff A before she began working at the facility. Unclassified		AZ815		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967975	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 12/6/2012
---	--	-----------------------------------

Name of Facility HOGAR DULCE HOGAR	Street Address, City, State, Zip Code 5597 WENDY LN NAPLES, FL 34112
---------------------------------------	--

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0007 Reg. # 58A-5.0181(1) FAC LSC	Correction Completed	ID Prefix A0030 Reg. # 58A-5.0182(6) FAC; 429.28 LSC	Correction Completed	ID Prefix A0052 Reg. # 58A-5.0185(3) FAC LSC	Correction Completed
ID Prefix A0054 Reg. # 58A-5.0185(5) FAC LSC	Correction Completed	ID Prefix A0055 Reg. # 58A-5.0185(6) FAC LSC	Correction Completed	ID Prefix A0057 Reg. # 58A-5.0185(8) FAC LSC	Correction Completed
ID Prefix A0076 Reg. # 58A-5.0186 FAC LSC	Correction Completed	ID Prefix A0078 Reg. # 58A-5.019(2) FAC LSC	Correction Completed	ID Prefix A0085 Reg. # 58A-5.0191(6) FAC LSC	Correction Completed
ID Prefix A0160 Reg. # 58A-5.024(1) FAC LSC	Correction Completed	ID Prefix A0162 Reg. # 58A-5.024(3) FAC LSC	Correction Completed	ID Prefix A0167 Reg. # 58A-5.025(1) FAC LSC	Correction Completed
ID Prefix AL241 Reg. # 58A-5.029(2) FAC LSC	Correction Completed	ID Prefix AZ827 Reg. # 408.812, FS LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency Reviewed By CMS RO	Reviewed By J. J. HFS	Date: 1-9-13	Signature of Surveyor: Jasmine Hares	Date: 1-9-13
--	--------------------------	-----------------	---	-----------------

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Hogar Dulce Hogar
5597 Wendy Lane
Naples, Florida 34112

Dear Administrator:

This letter reports the findings of a revisit survey completed on _____, 2012 by a representative 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 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.**

Due to uncorrected citations as well as a class II citation on this follow-up survey this facility is required to implement the following directed plan of correction:

Tag A004: The facility will immediately get its census down to no more than its licensed capacity of 6. The facility will maintain its census at no more than 6 residents.

Tag A008: The facility will obtain a complete Health Assessment (AHCA Form 1823 Health Assessment) for Resident #2 and Resident #9. The facility will review all other residents' health assessments and make sure they are complete.

Tag A009: The facility will execute a valid contract that meets all of the requirements in the Assisted Living Facility regulations for Resident #10. The facility will review all other resident contracts to make sure they are up to date and meet the Assisted Living Facility requirements.

Tag A026: The facility will work with all residents to determine the type of activities they wish to participate in. The facility will develop activities based on the residents' interest. The facility will develop an activities calendar based on the residents' input that meets at least the minimum requirements of activities at least 6 days per week for a total of not less than 12 hours per week. The facility will post this activities calendar. The facility will implement and follow this calendar.

Tag A083: The facility will immediately implement a schedule that ensures that there is at least 1 staff in the facility that has a current, valid First Aid and _____ certification at all times that there is at least 1 resident in the facility. The facility will review all staff First Aid and _____ certificates to ensure that they are not expired.





RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

Tag A084: The facility will immediately allow only staff that has completed the required Assistance With Self Administration of Medication in an Assisted Living Facility training to assist residents with self-administration of medications. The facility will review the records of all staff who assist with the self-administration of medications to assure that their training is up to date and all continuing education requirements are met.

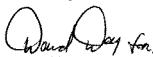
Tag A161: The facility will develop a personnel record for Staff A that meets all of the requirements for an Assisted Living Facility. The facility will review all staff records to ensure that their personnel record meet all requirements.

Tag Z815: The facility will immediately remove Staff A from all resident access and contact until Staff A has completed a Level II background screening that determines Staff A is eligible. The facility will review all staff records to ensure that they each have a Level II background screening determination of eligible.

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 (239) 335-1315.

Sincerely,


Harold D. Williams
Field Office Manager

Enclosures: State Form and Revisit Report

