

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966564	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER CAROLINA CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2460 KATHI-KIM STREET COCOA, FL 32926		
(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 inspection CCR#2012009413 was conducted on _____. There were no deficiencies found at the time of the visit.	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. 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	A 004		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6899

1S9011

If continuation sheet 1 of 5

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966564	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER CAROLINA CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2460 KATHI-KIM STREET COCOA, FL 32926		
(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 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 declination of assistance must be reviewed at least annually. These actions must be documented in the resident ' s record.	A 004		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966564	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED _____
NAME OF PROVIDER OR SUPPLIER CAROLINA CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2460 KATHI-KIM STREET COCOA, FL 32926		
(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 (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, interview and record review, it was determined the assisted living facility exceeded their license capacity. Findings: During the entrance conference on _____ at approximately 10:30 AM staff B was asked for a list of the current resident's. Staff B provided a hand written list of 9 names. The Facility's licensed capacity is 8. During tour of facility on _____ at approximately 10:45AM the following was observed: Resident #1 and resident #6 residing in _____ #1. Resident #5 and resident #8 resided in _____ Resident #2 and Resident #4 resided in _____ Resident #7	A 004		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966564	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER CAROLINA CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2460 KATHI-KIM STREET COCOA, FL 32926		
(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 3 and resident #3 resided in Resident #9 was sleeping in When she is not at the facility this is a staff At the time of the tour resident #9 is not at home she goes to a day program every day from 8AM-4PM. Medications for resident #9 are observed in the medication closet. There is a current Medication Observation Record (MOR) for resident #9 Review of Facility Admission Discharge Log on at approximately noon. The log revealed resident #9 was not listed on the Admission Discharge Log. The last resident admitted to the facility was on Review of resident #9's record revealed a face sheet, which indicated her legal contact as an Adult Protective Service (APS) case worker. Further review of the record revealed there was no facility health assessment (1823). However, there was a MOR and the resident's medications were being kept in the medication closet. Resident #9 arrived home from the day program at approximately 3:40 PM. She was observed sitting cross legged on the living by herself. She has severe and is non-verbal and sat rocking and flapping her hands. She did not respond to verbal greetings. When her name was called she would look in that direction. Interview with resident #2 on at approximately 2:00 PM who stated that resident #9 has resided at the home for several months. He indicated that on many nights she sleeps on the sofa. However her things are in Interview with resident #4 on at approximately 2:15 P M who revealed resident #9	A 004		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966564	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER CAROLINA CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2460 KATHI-KIM STREET COCOA, FL 32926		
(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 4 is living in the home. She goes to a program every day and returns before dinner. She sleeps in Interview by telephone on _____ at approximately 3PM with APS Case Worker, who stated that resident #9 was removed from her family home and placed at another residence owned by Mio Georges in _____. She was moved to this residence sometime after _____. An 1823 was obtained by the physician and provided to the facility. Interview by telephone on _____ at approximately 3:30 PM with the APS supervisor and APS case worker revealed that they were not aware the facility is over capacity. The resident was placed at the facility on an emergency basis. They are awaiting a court Hearing where a guardian will be appointed and make permanent decisions for the resident. Interview with the Administrator/Owner at approximately 4:00 PM stated that she admitted resident # 9 to another facility where she had a bed open but another resident who was more appropriate for that home moved in. She moved resident #9 to Carolina Care when another resident went to the hospital. It was her understanding the resident was not coming back. But the hospital discharged her back to Carolina Care. Class III	A 004			



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Carolina Care
2460 Kathi-Kim Street
Cocoa, FL 32926

Dear Administrator:

Re: CCR #2012009413

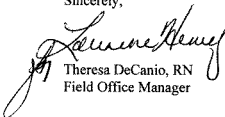
This letter reports the findings of a state licensure survey that was conducted on . 2012 by representative(s) of this office.

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 . 2013, 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 Lorraine Henry at

Sincerely,



Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
<http://ahca.myflorida.com>



Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone (407) 420-2502; Fax (407) 245-0998