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
	AL11942940	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OAKS ASSISTED LIVING HOME, LLC	6141 SW 34TH STREET MIRAMAR, FL 33023

(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 An Assisted Living Facility complaint survey (CCR#2012011572) was conducted on South Oaks Assisted Living Home, had licensure deficiencies found at the time of the visit.	A 000		
A 025 SS=F	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 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure resident records accurately reflected their conditions for 3 out of 3 sampled residents, (R #1, R# 2 and R #3) as evidenced by failing to document the assessment and condition of wounds for Residents #1 and #2 and failing to document the development of a for Resident #1; and failed to document the reason for hospitalization for Resident #2 and #3. The findings include: 1) Resident #1 was admitted to the facility on with diagnoses to include left femur with a to the left leg, and Review of an initial admission note on the Resident Observation Log dated document the resident had a bed on the center of her bottom and she had a on her left leg. There is no evidence of the size or condition of the or the length of the on the left leg. Documentation on the Resident Observation Log dated documents the resident is "still complaining about her left leg. She complains about discomfort." There is no evidence of documentation the physician or family was notified of the resident's complaints. Review of Medication Observation Records (MORs) revealed an order for Hydrocodon tablets one tablet 4 times daily as needed for pain. Further review of the MOR revealed Resident #1 never received any pain medication for her complaints of discomfort. Further review of the Resident Observation Log dated documents "Resident has a	A 025		

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A 025	Continued From page 2	A 025		

doctors appointment 11 AM tomorrow morning". Review of the medical record revealed physician orders dated [illegible] for daily [illegible] care to the left ankle and to cleanse the [illegible] and apply [illegible] ointment daily. Review of the record revealed no evidence of documentation or assessment of the resident's skin condition that a [illegible] developed on her left ankle. Further record review revealed no evidence the home health agency was notified of the new [illegible] or if the [illegible] was available for use.

On [illegible] at 1:27 PMa telephone interview was conducted with the Director of Nurses (DON) and Case Manager (CM) presiding over resident #1's care. The CM stated they were seeing the resident every 3 days to do [illegible] care on a [illegible] to the sacral area and were not advised of the development of a [illegible] to the left ankle. Additionally, she stated it was not until the resident moved to another facility on [illegible] that they were advised of the order dated [illegible] for daily [illegible] care to the left ankle by the resident's physician. The CM stated the left ankle [illegible] was not a pressure [illegible] but a [illegible] that developed due to compression and friction from the [illegible] on the left leg. The CM stated they called the prior ALF on [illegible] to obtain the [illegible] However, the ALF never did order the ointment.

2) Resident #2 was admitted to the facility on [illegible] with diagnoses to include [illegible] and [illegible]. Review of the Resident Observation Log dated [illegible] documents the "resident developed [illegible] this evening. Her temperature is 105. Her [illegible] sugar was taken by the medics and she was transported to the hospital". The next entry in the Resident Observation Log is dated [illegible]

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A 025	Continued From page 3	A 025		

documenting the resident arrived back at the facility today from the hospital. There is no evidence of documentation in file the physician or responsible party was notified of the resident's condition on , that she returned to the facility on , and what her condition was on arrival back to the ALF.

Further review of the resident's record revealed documentation from the hospital records dated , documenting the resident has a to the right heel with no signs of or . Further review of the record revealed the resident was being seen by a home health agency for care to the right heel with a start of care date of .

On at 12:10 p.m. an interview was conducted with the Registered Nurse (RN) visiting Resident #2 to perform care. The RN stated they have been seeing the resident 3 times a week since to perform care and the is almost healed.

Further review of the Resident Observation Log dated documents 'resident is developing an on her left heel. Please inform nurse.' There is no further evidence of documentation in the record regarding an on the resident's left heel, notification to the physician and the resident's responsible party. During the interview with the home health agency RN on at 12:10 PM she stated there has never been an issue with the resident's left heel and she checks both heels on every visit.

3) Resident #3 was admitted to the facility on with diagnoses to include , and . Review of the record revealed documentation on the Resident

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A 025	Continued From page 4 Observation Log dated [redacted] 'Called to get prescription for resident for [redacted] and runny nose.' There was no evidence of documentation the resident's responsible party was notified of her condition. Further review of the Resident Observation Log, revealed no further documentation or follow up to the call to the physician. Review of the MOR for [redacted] and [redacted] 2012 revealed no new orders or prescriptions for a [redacted] and runny nose. Further review of the Resident Observation Log dated 12/0[redacted] the resident was 'taken to hospital, she was not responding, her sugar level was low.' There is no evidence of documentation the resident's physician and responsible party were notified of her condition. Documentation on 12/0[redacted] 'resident returned to facility. Doing much better.' There is no evidence of documentation the resident's physician or responsible party was advised. On 12/2[redacted] 9:30 a.m. upon entering the facility the Aide present stated she sent the resident out to the hospital at 8:45 AM this morning due to a low blood [redacted] of the Resident Observation Log revealed no evidence of documentation regarding the incident, notification of the resident's change in condition to the physician and responsible party. On 12/2[redacted] 2:00 PM, an interview was conducted with the Aide who stated when there is a change in resident condition she notifies the owner and he is the one who contacts the doctor and family. She stated she was not told she needed to document in the chart. Class II	A 025		

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A 030	Continued From page 5	A 030		
A 030 SS=G	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures	A 030		

(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 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,

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A 030	Continued From page 6	A 030		

as resident responsibilities, the facility ' s [illegible] 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 [illegible]

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

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A 030	Continued From page 7	A 030		

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 [illegible] 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 [illegible] his or her spouse if both are residents of the facility.
(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.

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A 030	Continued From page 8 (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 ... of a resident who has been adjudicated mentally , 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. This Statute or Rule is not met as evidenced by:	A 030		

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A 030	Continued From page 9 Based on observation, interview and record review, the facility failed to ensure a resident's right to live in an environment free from neglect. As evident by the facility not providing the care and services required for the assessment and monitoring of a ... for 1 of 3 sampled residents, Resident #1; and for not assessing and monitoring the use of anti-embolic stockings for 2 of 3 sampled residents, Residents #1 and #2 as evidenced by the facility accepting residents with needs that can only be met under a Limited Nursing Services license which the facility did not have. The findings include: 1) Resident #1 was admitted to the facility on 09/1_ ... diagnoses to include fractured ... femur with a cast ... the left leg, hypertension ... arthritis. ... of a physician progress note dated 09/1 ... the rehabilitation center, prior to admission to the facility documents 'Cast ... Strict non-weight bearing status left leg'. Review of an initial admission note on the Resident Observation Log dated 09/1 ... the resident has a cast ... her left leg. There is no evidence of the condition of the cast ... the resident's left leg and no evidence of documentation regarding the resident's mobility restrictions. Review of a physician progress note dated 09/2 ... the resident to be non-weight bearing to the left leg with toe touch only for balance only left leg. Additionally the physician documented thigh high anti-embolic stockings to left leg during the day, roll on, remove at bedtime and check skin. Review of the Resident Observation Log reveals no evidence of documentation of the condition of the left leg cast,	A 030		

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A 030	Continued From page 10 left leg, anti-embolic stocking use or skin checks.Further review of the Resident Observation Log dated . . . documents 'Resident has a doctors appointment 11 AM tomorrow morning.' Review of the clinical record revealed physician orders dated . . . . . for daily . . . care to the left ankle. Additionally the physician documents continued non-weight bearing status for the left leg. Review of the clinical record revealed no evidence of documentation or assessment of the resident's skin condition that a . . . developed on her left ankle. Further review of the clinical record revealed no evidence the home health agency was notified of the new . . . . and orders for daily . . . care to the left ankle. Further review of the clinical record revealed no evidence of documentation if the thigh high anti-embolic stockings were ever obtained and applied as prescribed by the Physician. On . . . . at 2:25 PM, a telephone interview was conducted with the Owner and Administrator of the ALF and when an inquiry was made as to why they accepted a resident who had a . . . and ordered anti-embolic stockings to a facility that had a standard license and was not licensed for Limited Nursing Services, they both had no comment. When an inquiry was made as to who was assessing and monitoring the status of the left leg . . . they both had no comment. When an inquiry was made as to how the resident developed a . . . to the left ankle they both had no comment. When an inquiry was made as to who applied the anti-embolic stockings in the morning and removed them in the evening the Administrator stated the home health nurse did that. On . . . . at 1:27 PM, a telephone interview	A 030		

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A 030	Continued From page 11 was conducted with the DON and CM of the home health agency presiding over resident #1's care. The CM stated they were seeing resident #1 every 3 days to do [illegible] care on a [illegible] to the sacral area and were not advised of the development of a [illegible] to the left ankle. Additionally she stated it was not until the resident moved to another facility on [illegible] that they were advised of the order dated [illegible] for daily [illegible] care to the left ankle by the resident's physician. Additionally, the CM stated the left ankle [illegible] was not a pressure [illegible] but a [illegible] that developed due to compression and friction from the [illegible] on the left leg. The CM was not aware of the order for the anti-embolic stockings to be applied on Resident #1. 2) Resident #2 was admitted to the facility on [illegible] with diagnoses to include [illegible] and [illegible] Review of the clinical record revealed a physician prescription dated [illegible] for 'Anti-embolic thigh high stockings, use when out of bed'. Review of the Resident Observation Log dated [illegible] documents the resident went to the physician. However, there is no documentation regarding the anti-embolic stockings. On [illegible] at 12:10 PM, observation was made of the home health Registered Nurse (RN) doing an assessment of Resident #2. An interview was conducted with the RN, who stated they visit the resident every 3 days to perform [illegible] care to the resident's right heel. The RN had no knowledge of the order and use of the anti-embolic stockings. Further observation of Resident #2 on [illegible] at 12:10 PM revealed she was wearing knee high anti-embolic stockings which were noted to be just below the knee joint, bunched up and tight around the calf and knee joint on both legs.	A 030		

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A 030	Continued From page 12 On [redacted] at 2:00 PM, an interview was conducted with the facility's Aide and an inquiry was made who applies the anti-embolic stockings for Resident #2. She stated she puts them on in the morning and takes them off in the evening and sometimes the home health nurse will do it. Further interview, revealed she is an unlicensed employee and had no prior training in implementing this service for the resident. Facility's failure to ensure physician orders and nursings services were provided as ordered, directly affected the well-being of the resident. Class II	A 030		
A 054 SS=F	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider ' s name, the resident ' s name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known [redacted] the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942940	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OAKS ASSISTED LIVING HOME, LLC	6141 SW 34TH STREET MIRAMAR, FL 33023

(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 054	Continued From page 13	A 054		

the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered.
(c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication.

This Statute or Rule is not met as evidenced by:
Based on observation, interview and record, review the facility failed to ensure the Medication Observation Records (MOR) were accurately completed for 7 out of 7 sampled residents for the administration of medications, (Resident #1, #2, #3, #4, #5, #6 and #7) as evidenced by medication not being documented as given on the MOR for residents #4 and #5; medication documented as being given when the medication was not available for residents #3 and #4; no documentation a supplement was being given for resident #2; medications substituted for residents #3 and #4; medications given without evidence of an order for residents #5 and #6; specific doses not documented for residents #4 and 6; and no evidence a l care medication was obtained for resident #1.
The findings include:
1) Review of resident #1's clinical record revealed a physician prescription order for the l care ointment l dated . Further review of the record revealed no evidence of documentation the ointment was obtained and l care was being rendered daily as ordered.
On at 1:27 PM a telephone interview was conducted with the Home Health Agency Director of Nurses and Case Manager who stated they were coming into the ALF to do l care

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for resident #1's sacral area and were not advised of the [redacted] to the left ankle. The Case Manager further stated they were not advised of the new order for [redacted] care to the left ankle until [redacted] when the resident was relocated to a different facility and they called the ALF and were told the ALF never obtained the [redacted].

2) Review of resident #2's record revealed she was being seen by a Home Health Agency for [redacted] care to her right foot. Further review of the clinical record revealed a physician order dated [redacted] for Body [redacted] Protein Powder one scoop daily, a protein supplement to aide in [redacted] healing. Review of the [redacted] 2012 and [redacted] 2012 MORs revealed no evidence of documentation it was added to the MOR on [redacted] and no evidence it was being given as ordered. On [redacted] at 2:00 p.m. an interview was conducted with the Aide Medication Tech who stated she is giving the supplement. However,it was revealed that she was never informed to document it anywhere.

3) On [redacted] at 1:30 PM, a medication reconciliation was completed for Resident #3. In comparing the MOR to the medications available revealed the medication [redacted] 81 mg daily and [redacted] one tablet daily were not available in the medication cabinet. Review of the [redacted] MOR revealed these medications were being signed off daily as given. On [redacted] at 1:35 PM, an interview was conducted with the Aide Medication Technician who stated she was not sure why the [redacted] was not available. She provided a bottle of [redacted] C 500 mg tablets with no resident identifying information on the bottle and stated this is what she gives instead of the [redacted]. She further stated this is what she is told to give and that takes the

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A 054	Continued From page 15	A 054		

place of the . She further stated the medications come in a prepackaged container and she gives what ever is provided by the pharmacy.

4) On at 1:45 PM, a medication reconciliation was completed for Resident #4. In comparing the MOR to the medications available revealed the medications 25 mg daily, Therems-M one tablet daily and 25 mg daily were not available in the medication cabinet. Review of the MOR revealed these medications were being signed off daily as given. Further review of the MOR and the prepackaged medications from the pharmacy revealed an order for half tab daily with no specific dosage documented. Additional review of the MOR revealed an order for Lotrisone Cream apply to affected area everyday with no indication of which body part it was to be applied to. Review of the medications in the medication cabinet revealed the Lotrisone Cream was being substituted with Voltaren 1% gel with a prescription label to apply to left knee twice daily and as needed for pain. On at 1:50 PM, an interview was conducted with the Aide / Medication Technician who stated she was not sure what body part the cream was to be applied to and after consulting with the resident, the resident stated she rubs it on her knees. On at 1:50 PM, the Aide Medication Technician provided a bottle of C 500 mg tablets with no resident identifying information on the bottle and stated this is what she gives instead of the . She further stated that is what she is told to give and that takes the place of the .

5) Review of the 2012 MOR for Resident #5 revealed an order for 100 mg

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A 054	Continued From page 16 twice daily. Further review of the [redacted] 2012 MOR revealed the medication was not signed off as given for the 8 AM dose on [redacted]. During the interview with the Aide Medication Technician on [redacted] at 1:35 PM regarding the bottle of [redacted] C 500 mg tablets, it was revealed she also gives Resident #5 a [redacted] C tablet every day also. Review of the [redacted] MOR revealed no order for [redacted] C 500 mg daily. 6) Reconciliation of Resident #6's medications with the medications supplied from pharmacy and the orders on the [redacted] 2012 MOR revealed an order for eye drops [redacted] instill one drop into affected eye(s) twice a day and [redacted] instill one drop into affected eye(s) at bedtime, with no indication of which eyes required the drops. On [redacted] at 1:40 PM, an interview was conducted with the Aide Medication Technician who was unable to state if the drops went into both eyes or just the left or right eye. Further review of the MOR revealed an order for Invega Sustenna 117 mg monthly by the home health agency. However, there was no date the last dose was given or the next one was due. During reconciliation of the medications with the Aide Medication Technician, it was revealed the medication was not available. DUring an interview on [redacted] at 1:45 PM, it was revealed that she was not sure where that medication might be. 7) During the interview with the Aide Medication Technician on [redacted] at 1:35 PM regarding the bottle of [redacted] C 500 mg tablets, it was revealed she also gives Resident #7 a [redacted] C tablet every day also. Review of the [redacted] 2012 MOR and Resident #7's file revealed no order for [redacted] C 500 mg daily.	A 054		

Agency for Health Care Administration

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A 054	Continued From page 17 Class III	A 054		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
South Oaks Assisted Living Home, LLC
6141 SW 34th Street
Miramar, FL 33023

Dear Administrator:

Re: CCR #2012011572

This letter reports the findings of a complaint survey that was conducted on , 2012 by a representative from 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 (30) 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMd/dso
Enclosure
XG90

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