

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11911829	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 1/9/2013
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Name of Facility CENTRAL PALACE RESIDENTIAL	Street Address, City, State, Zip Code 4491 SW 8 STREET MIAMI, FL 33134
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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 <u>A0025</u> Reg. # <u>58A-5.0182(1) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0030</u> Reg. # <u>58A-5.0182(6) FAC: 429.28</u> LSC _____	Correction Completed	ID Prefix <u>A0081</u> Reg. # <u>58A-5.0191(2) FAC</u> LSC _____	Correction Completed
ID Prefix <u>A0090</u> Reg. # <u>58A-5.0191(11) FAC</u> LSC _____	Correction Completed	ID Prefix <u>AL243</u> Reg. # <u>58A-5.0191(8) FAC</u> LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: <i>Isabel Juanton</i>	Date: 02/11/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Central Palace Residential,
4491 Sw 8 Street
Miami, FL 33134

CCR#2012009405 & 9645 f/u

Dear Administrator:

This letter reports the findings of a revisit survey to two complaints conducted on , 2013 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references the uncorrected deficiencies and/or new deficiencies, identified during the revisit.

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

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

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

Sincerely,

 Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

BBT7



Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911829	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER CENTRAL PALACE RESIDENTIAL,			STREET ADDRESS, CITY, STATE, ZIP CODE 4491 SW 8 STREET MIAMI, FL 33134		
(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 Follow up survey of a Complaint Survey (CCR # 2012009645 and 2012009405) was conducted on at Central Palace Assisted Living Facility with Limited Mental Health and Limited Nursing Services components. Two deficiencies were found STILL uncorrected A0078, A0152.	{A 000}			
{A 078} SS=D	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Newly hired staff shall have 30 days to submit a statement from a health care provider, based on a examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable including Freedom from must be documented on an annual basis. A person with a positive test must submit a health care provider ' s statement that the person does not constitute a risk of communicating Newly hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in service. If any staff member is later found to have, or is suspected of having, a communicable, he/she shall be removed from duties until the administrator determines that such condition no longer exists. (b) All staff shall be assigned duties consistent with his/her level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff shall exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s health care provider in	{A 078}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6509

C07D12

If continuation sheet 1 of 4

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911829	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/09/2013
NAME OF PROVIDER OR SUPPLIER CENTRAL PALACE RESIDENTIAL,			STREET ADDRESS, CITY, STATE, ZIP CODE 4491 SW 8 STREET MIAMI, FL 33134		
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{A 078}	Continued From page 1 accordance with this rule chapter. (c) All staff must comply with the training requirements of Rule 58A-5.0191, F.A.C. (d) Staff provided by a staffing agency or employed by a business entity contracting to provide direct or indirect services to residents must be qualified for the position in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor shall specifically describe the services the staffing agency or contractor will be providing to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility shall: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and 2. Maintain time sheets for all staff. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a statement from a health care provider that Staff #6 did not have any signs or symptoms of a communicable including _____ and failed to keep on file an updated documentation of freedom from _____ for 1 out of 13 staff records reviewed (Staff #13). The findings included: Personnel record review was conducted on _____ at about 10:30 a.m. Staff #6 did not have documentation from a health care provider that she did not have any signs or symptoms of a communicable including _____. Staff #13 did not have annually documented proof of freedom from _____. The last statement on file was done on 2011. On _____ at about 1:00 p.m. the facility	{A 078}			

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{A 078}	Continued From page 2 administrator stated that Staff #6 will be seeing a physician for an examination as soon as possible and the facility did not have the updated documentation of freedom from for Staff #13. Class III This is an uncorrected deficiency.		{A 078}		
{A 152} SS=D	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and 2. Must be maintained free of hazards; and 3. Must ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents shall be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress a comfortable height to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, chest or other furniture designed for storage of personal effects; 4. A table, bedside lamp or floor lamp, and waste basket; and 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate		{A 152}		

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{A 152}	Continued From page 3 keys to resident to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility shall be free of tears, stains and not be This Statute or Rule is not met as evidenced by: Based on observation and interview facility failed to obtain a safe environment. Findings include: Observation during tour conducted on at 9:20 a.m. revealed the following: 1- Peeling paint on the in # and #15. 2- Missing one piece of wood floor in # Administrator acknowledged the finding during interview conducted on at 3:00 pm. Class III This is an uncorrected deficiency.	{A 152}			