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
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 (2012012019) Follow-up Survey was completed at De'Blanca Home with Limited Mental Health on . There were multiple Uncorrected Deficiencies identified at the time of survey.	{A 000}		
{A 025} SS=G	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}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 025}	Continued From page 1	{A 025}		

This Statute or Rule is not met as evidenced by:
Based on Observation, Interview, and Record review, the assisted living facility STILL failed to provide care and services to meet the needs of 1 out of 3 (#3) sampled residents who has a history of falling. The facility STILL failed to provide hospice doctor's orders and have a written records for 1 out of 3 (#1) sampled residents. The facility STILL failed to have written records for 2 out of 3 (#2 and #3) residents who were hospitalized.

Findings Include:

Nursing observations on at 8:40 a.m. found resident #1 resting in her hospital bed with half (1/2) side rails up. She was receiving via nasal canal at 2 liters. Her hospice nurse, was charting at bedside.

The hospice nurse reported on at 8:40 a.m. that the patient is taking in very little food and a small amount of fluids. She states that she sometimes opens her eyes but rarely. The nurse denied that the resident had any open . She reports just redness at her . The nurse stated she is on crisis care which started and they are there around the clock. Interview with the hospice nurse on at 11:15 a.m. revealed that the facility staff members who are unlicensed were giving medications to resident #1.

Interview with staff #3 on at 12:14 p.m. revealed that the staff of the assisted living facility (ALF) was giving medications to resident #1 until the doctor put the medications on hold on . No order to hold medications was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 025}	Continued From page 2 found in resident record. The medication observation record (MOR) for resident #1 showed medications initialed on : and by the facility staff. Staff #3 stated that the facility gave resident #1 a puree diet and she confirmed that the facility did not have a doctor's order to change resident #1's diet. Record review found that the MOR for resident #1 was initialed on and . Record review found that at the time of survey the facility was unable to provide a doctor's order to hold resident #1's medications. There was no documentation from the facility regarding resident #1 to her back area. The facility did not have any documentation from hospice regarding resident #1's current care plan or hospice orders. On the agency received a fax from resident #1's hospice company. The hospice company provided a diet order for pure for resident #1 although at the time of survey the facility did not have the diet order. Nursing observations on at 11:40 a.m. found that resident #2 had under both eyes. Interview with resident #2 on at 11:40 a.m. revealed that he but he didn't know when. While the interview with resident #2 was being conducted on the patio staff #5 was in the area. Staff #5 reported that resident #2 on Thursday night and went to Kendall Regional Hospital for treatment. Record review found the last written note that the facility had for resident #2 was dated	{A 025}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 025}	Continued From page 3	{A 025}		

Record review found that the facility did not have any documentation that resident #2 . The facility did not have any documentation that his family was notified or that he was taken to the hospital. The facility did not have any documentation regarding resident #2's hospitalization or hospital discharge orders.

Interview with staff #3 on at 12:14 p.m. She reports that the resident had on ', at 6:00AM and was taken to Kendall Regional Hospital by 9-1-1. He had a and was released after 48 Hrs. She confirmed that the facility did not have any documentation regarding resident #2's . Interviews with staff #3 and staff # 5 give different accounts of how and when resident #2 and was treated for his .

Record review found that resident #3 on and sustained a head injury. Resident #3 was transferred to the hospital and received four stitches. Record review found that the facility did not have any documentation of resident #3's head injury after she was discharge from the hospital and did not have discharge order for resident #3. Record review found that facility wrote on that "resident #3 has several times, she is very fragile, her balance is very poor". Record review found that the facility did not have any documentation that an assessment was completed for resident #3 who has several times. The facility did not have a care plan which was identified how the facility could meet resident #3's needs who is constantly falling and sustaining injuries.

Interview with staff #3 on at 12:14 p.m. revealed that resident #3 did and has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 025}	Continued From page 4 before. The last time she on she received four staples. She confirmed that the facility did not have any written notes for resident #3 after . She also stated that the facility did not have any care plans or assessment completed for resident #3 who has a history of falling. Uncorrected Deficiency. Class II	{A 025}		
{A 079} SS=D	58A-5.019(4) FAC Staffing Standards - Levels (4) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities shall maintain the following minimum staff hours per week: Number of Residents — Staff Hours/Week 0-5 — 168 6-15 — 212 16-25 — 253 26-35 — 294 36-45 — 335 46-55 — 375 56-65 — 416 66-75 — 457 76-85 — 498 86-95 — 539 For every 20 residents over 95 add 42 staff hours per week. 2. At least one staff member who has access to facility and resident records in case of an emergency shall be within the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 3. In facilities with 17 or more residents, there	{A 079}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 079}	Continued From page 5	{A 079}		

shall be at least one staff member awake at all hours of the day and night.
4. At least one staff member who is trained in First Aid and , as provided under Rule 58A-5.0191, F.A.C., shall be within the facility at all times when residents are in the facility.
5. During periods of temporary absence of the administrator or manager when residents are on the premises, a staff member who is at least , must be designated in writing to be in charge of the facility.
6. Staff whose duties are exclusively building maintenance, clerical, or food preparation shall not be counted toward meeting the minimum staffing hours requirement.
7. The administrator or manager ' s time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility ' s staffing schedule.
8. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.
(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, shall have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 58A-5.0182, F.A.C.
(c) The facility must maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 079}	Continued From page 6	{A 079}		

direct care staff available to residents or representatives, specific to the resident ' s care.
(d) The facility shall be required to provide staff immediately when the Agency determines that the requirements of paragraph (a) are not met. The facility shall also be required to immediately increase staff above the minimum levels established in paragraph (a) if the Agency determines that adequate supervision and care are not being provided to residents, resident care standards described in Rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents ' contracts. The Agency shall consult with the facility administrator and residents regarding any determination that additional staff is required.
1. When additional staff is required above the minimum, the agency shall require the submission, within the time specified in the notification, of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met. The plan shall be reviewed by the agency to determine if the plan will increase the staff to needed levels and meet resident needs.
2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, modifications may be made in staffing requirements for the facility and the facility shall no longer be required to maintain a plan with the agency.
3. Based on the recommendations of the local fire safety authority, the Agency may require additional staff when the facility fails to meet the fire safety standards described in Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the Agency that fire safety requirements are being met.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 079}	Continued From page 7	{A 079}		

(e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios.
(f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of Rule 58A-5.029, 58A-5.030, or 58A-5.031, F.A.C., respectively.

This Statute or Rule is not met as evidenced by:
Based on record review and interview the assisted living facility STILL failed to ensure that they had a staffing pattern available. The facility STILL failed to have a written designation of authority during periods of absence of the administrator.

Findings include:

Record review found that the facility did not have a staffing pattern available for review. Record review found a posted designation of authority letter. Record review found that the listed staff member did not have a record at the facility.

Interview with staff #3 on at 8:22 a.m. revealed that she could not find the staff schedule for the facility. She stated that the staff member listed on the designation letter no longer worked for the facility, her last day was , 2012. Staff #3 stated on at 10:27 a.m. that she spoke to the facility's consultant, administrator on vacation Punta Cana, Domican Republic. She stated that consultant was faxing the schedule to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 079}	Continued From page 8 Interview with staff #3 on at 11:45 a.m. confirmed that the facility still did not have a staffing pattern. Staff #3 revealed that her and her mother worked at the facility. She stated that staff #1 works on the weekends. She stated that the administrator works at nights. Staff #3 stated that the facility's consultant told her that the administrator was in Dominican Republic. She then stated that the owner was working at night. Interview with the facility's owner on at 11:52 a.m. revealed that her sister was on vacation and that she was covering for her at nights. The owner and staff #3 confirmed that she did not have a record at the facility. Uncorrected Deficiency. Class III	{A 079}		
{A 081} SS=D	58A-5.0191(2) FAC Training - Staff In-Service (2) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions, and facility sanitation procedures before providing personal care to residents. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service	{A 081}		

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
	AL11965837	A. BUILDING _____ B. WING _____	12/3

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 081}	Continued From page 9	{A 081}		

training within 30 days of employment that covers the following subjects:
1. Reporting major incidents.
2. Reporting adverse incidents.
3. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.
(c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Resident rights in an assisted living facility.
2. Recognizing and reporting resident neglect, and [illegible].
(d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects:
1. Resident behavior and needs.
2. Providing assistance with the activities of daily living.
(e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices.
(f) All facility staff shall receive in-service training regarding the facility ' s resident elopement response policies and procedures within thirty (30) days of employment.
1. All facility staff shall be provided with a copy of the facility ' s resident elopement response policies and procedures.
2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 081}	Continued From page 10	{A 081}		

This Statute or Rule is not met as evidenced by:
Based on record review and interview the assisted living facility STILL failed to ensure that 1 out of 6 (#1) sampled staff member had 3 hours of Activity of Daily Living (ADLs) and Behavioral Needs Training.

Findings include:

Record review found that staff #1 did not have any evidence of having 3 hours of 3 hours of Activity of Daily Living (ADLs) and Behavioral Needs Training.

Interview with staff #3 on at 9:20 a.m. revealed that staff #1 works on the weekends which include Fridays, Saturdays, and Sundays.
Interview with staff #3 on at 11:55 a.m. confirmed that the facility did not have documentation that staff #1 completed 3 hours of Activity of Daily Living (ADLs) and Behavioral Needs Training.

Uncorrected Deficiency.

Class III

{A 083} SS=D 58A-5.0191(4) FAC Training - First Aid and {A 083}

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 11	{A 083}		

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.
(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 and interview the assisted living facility STILL failed to ensure that 1 out of 6 (#1) sampled staff members have First Aid and training.

Findings include:

Record review found that staff #1 did not have documentation that she completed and First Aid training at the facility.

Interview with staff #3 on at 9:20 a.m. revealed that staff #1 works on the weekends which include Fridays, Saturdays, and Sundays. Interview with staff #3 on at 11:55 a.m. confirmed that the facility did not have documentation that staff #1 completed First Aid and training.

Uncorrected Deficiency.

Class III

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 085}	Continued From page 12	{A 085}		
{A 085} SS=D	58A-5.0191(6) FAC Training - Nutrition & Food Service	{A 085}		

(6) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility ' s food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. A certified food manager, licensed dietician, registered dietary technician or health department sanitarians are qualified to train assisted living facility staff in nutrition and food service.

This Statute or Rule is not met as evidenced by:
Based on record review and interview the assisted living facility STILL failed to ensure 1 out of 6 (#1) sampled staff members have a minimum of 2 hours of nutrition training annually.

Findings include:

Record review found that staff #1's last nutrition training was dated . The facility did not have documentation that staff #2 had 2 hour nutrition training annually.

Interview with staff #3 on at 11:55 a.m. that staff #1 took the training with her and that it was at Blanca #1. She confirmed that the training documentation was not at the facility. Staff #3 stated she would call them to have it faxed to the facility. The documentation for the training was not faxed to the facility as of at 12:14 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 085}	Continued From page 13 Uncorrected Deficiency. Class III	{A 085}		
{A 090} SS=D	58A-5.0191(11) FAC Training - Do Not Orders (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility ' s policies and procedures regarding within 60 days after the effective date of this rule. (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility ' s policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in Rule 58A-5.0186, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and staff interview the assisted living facility STILL failed to ensure that 1 out of 6 (#1) sampled staff members received ( ) training. Findings include: Record review revealed that staff #1 did not have any documentation of having ( ) training. Interview with staff #3 on at 9:20 a.m.	{A 090}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 090}	Continued From page 14	{A 090}		

revealed that staff #1 works on the weekends which include Fridays, Saturdays, and Sundays. Interview with staff #3 on at 11:55 a.m. confirmed that the facility did not have documentation that staff #1 completed ( ) training.

Uncorrected Deficiency.

Class III

{A 161} SS=D 58A-5.024(2) FAC Records - Staff {A 161}

(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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 15	{A 161}		

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 observations, record review, and interview the assisted living facility STILL failed to ensure that 2 out of 6 (#5 and #6) sampled staff members had a personnel record. The facility STILL failed to ensure that 3 out of 6 (#1, #2, and #3) sampled staff members had accurate and completed applications.

Findings include:

Observations on at 8:05 a.m. found staff members #3 and #5 present caring for a census of 6 residents. During the tour staff #5 was observed in resident # dressing resident #3 who was on the bed nude.

Interview with staff #3 on at 8:22 a.m. revealed that the facility does not have a record for staff #5 because she is working today to cover for staff #2, her mother.

Record review found that the facility did not have a records for staff #5 and #6. The facility did not have a completed level 2 background screening, training, or any documentation for staff members

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 16 #5 and #6. Record record found that staff #1's application was not signed and dated. Record review found that applications for staff members #1 , #2, and #3 had the same education history, same references, and appeared to have the same hand writing for all three applications. Interview with staff #3 on [redacted] at 11:45 a.m. revealed that she and her mother worked at the facility. She stated that staff #1 works on the weekends. She stated that the administrator works at nights. Staff #3 stated that the facility's consultant told her that the administrator was in Dominican Republic. She then stated that the owner was working at night. Interview with the facility's owner on [redacted] at 11:52 a.m. revealed that her sister was on vacation and that she was covering for her at nights. The owner and staff #3 confirmed that she did not have a record at the facility. Uncorrected Deficiency. 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	{AZ815}		

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
	AL11965837	A. BUILDING _____ B. WING _____	R 12/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 17	{AZ815}		

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 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 a person are not retained by

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
	AL11965837	A. BUILDING _____ B. WING _____	R 12/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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 18	{AZ815}		

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 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

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
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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	{AZ815}		

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 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.

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
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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	{AZ815}		

(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, 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 Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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	{AZ815}		

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 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

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
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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	{AZ815}		

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 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

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
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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	{AZ815}		

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 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 observations, record review, and interview the assisted living facility STILL failed to ensure that 2 out of 6 (#2 and #5) sampled staff members had a completed level 2 background screening prior to providing care to residents.

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
	AL11965837	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

(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	{AZ815}		

Findings include:

Observations on at 8:05 a.m. found staff members #3 and #5 present caring for a census of 6 residents. During the tour staff #5 was observed in resident # dressing resident #3 who was on the bed nude.

Interview with staff #3 on at 8:22 a.m. revealed that the facility does not have a record for staff #5 because she is working today to cover for staff #2, her mother.

Record review found that the facility did not have a record for staff #5. The facility did not have a completed level 2 background screening, training, or any documentation for staff #5. Record review found that the facility also did not have a completed level 2 background screening for staff #2. The background screening sheet for staff #2 was printed on and stated that screening in process. Record review found that as of staff #2 and #5 did not have a completed level 2 background screening.

Interview with staff #3 on at 10:25 a.m. She stated she called last week, staff #2 needs to take finger print again, appointment next Monday, , 2013.

Uncorrected Deficiency.

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11965837	A. Building B. Wing	12/31/2012

Name of Facility	Street Address, City, State, Zip Code
DE' BLANCA HOME	125 SW 103 COURT MIAMI, FL 33174

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 A0011 Reg. # 58A-5.0181(5) FAC LSC	Correction Completed	ID Prefix A0030 Reg. # 58A-5.0182(6) FAC; 429.28 LSC	Correction Completed	ID Prefix A0084 Reg. # 58A-5.0191(5) 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 12/31/2012	ID Prefix AL243 Reg. # 58A-5.0191(8) FAC 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: Ronald Charles	Date: 03/08/2013
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		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
De' Blanca Home
125 Sw 103 Court
Miami, FL 33174

CCR#2012012019 f/u

Dear Administrator:

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

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

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

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

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

BBT7

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

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone (305) 593-3100; Fax (305) 593-3121