

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/19/2013
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 investigation (CCR# 2013000090) was conducted on Mother's Years inc. Assisted Living Facility had the following deficiencies at time of survey.	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 an 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 accordance with this rule chapter. (c) All staff must comply with the training	A 078			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0099

4V/1111

If continuation sheet 1 of 17

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 078	Continued From page 1 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 have documentation of freedom from _____ on annual basis for 2 of 3 (#1 and #2) facility staff. Findings as follow: Record review documented 2 of 3 (#1,#2) facility staff had no documentation of freedom from communicable _____ including _____ on annual basis as follow: Staff #1 freedom from communicable _____ including _____ statement was dated _____ Staff #2 freedom from communicable _____ including _____ statement was dated _____ On _____ at about 11:30 a.m. The facility caretaker/owner (#2) stated the facility failed to have freedom from communicable _____ statement including _____ on annual basis for 2 of 3 (#1, and #2) facility staff.		A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 078	Continued From page 2 Class III	A 078		
A 083 SS=D	58A-5.0191(4) FAC Training - First Aid and (4) FIRST AID AND (). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation of attendance at First Aid or course offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American Association, or National Safety Council; or a provider approved by the Department of Health, shall satisfy this requirement. (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 observation, record review and interview the facility failed to have at least 1 staff present at all times with First Aid and trainings. Findings as follow: On at about 9:00 a.m. it was observed staff #3 (caretaker) working in facility alone with a census of 6 residents. On at about 11:30 a.m. staff #2 (caretaker, owner) stated the facility failed to have 3 of 3 facility staff	A 083		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 3 trained in _____ and First Aid training as follow. Staff #2 also stated staff #3 was working in facility alone with 6 residents with a First Aid training expired on _____ Record review documented staff #3 first aid training was expired on _____ Record review also documented: Staff #1 First aid and _____ trainings were expired on _____ Staff #2 First aid and _____ trainings were expired on _____ Class III		A 083		
A 093 SS=D	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition Board - National Research Council, adjusted for age, _____ and activity, shall be the nutritional standard used to evaluate meals. Therapeutic diets shall meet these nutritional standards to the extent possible. A summary of the Tenth Edition Recommended Dietary Allowances, interpreted by a daily food guide, is available from the DOEA Assisted Living Program. (b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the recommended dietary allowances to be made available to each resident daily by the facility are as follows: 1. Protein: 6 ounces or 2 or more servings;		A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 093	Continued From page 4 2. Vegetables: 3 5 servings; 3. Fruit: 2 4 or more servings; 4. Bread and starches: 6 11 or more servings; 5. Milk or milk equivalent: 2 servings; 6. Fats, oils, and sweets: use sparingly; and 7. Water. (c) All regular and therapeutic menus to be used by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, to ensure the meals are commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date reviewed. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months. (e) Therapeutic diets shall be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining or family style dining are not required to document what is eaten unless a health care	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 093	Continued From page 5 provider ' s order indicates that such monitoring is necessary. However, the food items which enable residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility. 2. The facility shall document a resident ' s refusal to comply with a therapeutic diet and notification to the resident ' s health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the resident ' s responsible party refusing the diet is acceptable documentation of a resident ' s preferences. In such instances daily documentation is not necessary. (f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly distributed throughout the day with not less than two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food shall be served attractively at safe and palatable temperatures. All residents shall be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, shall be on hand. (h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity. The supply shall consist of dry or canned foods that do not require refrigeration and	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 093	Continued From page 6 shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to have a menu reviewed annually. Findings as follow: On at about 9:00 a.m. it was observed the menu posted omn the board in the dining to facility residents was expired on Record review documented the facility last menu available for review was dated On at about 12:00 noon staff #1 (caretaker/owner) stated the facility failed to review the menu on annual basis. Also stated had no other newest menu than the menu posted (expiration date) Class III	A 093			
A 160 SS=D	58A-5.024(1) FAC Records - Facility Records. The facility shall maintain the following written records in a form, place and system ordinarily	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 160	Continued From page 7 employed in good business practice and accessible to Department of Elder Affairs and Agency staff. (1) FACILITY RECORDS. Facility records shall include: (a) The facility 's license which shall be displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident 's: 1. Date of admission, the place from which the resident was admitted, and if applicable, a notation the resident was admitted with a pressure ; and 2. Date of discharge, the reason for discharge, and the identification of the facility to which the resident is discharged or home address, or if the person is , the date of . Readmission of a resident to the facility after discharge requires a new entry. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intends to return pursuant to Rule 58A-5.025, F.A.C. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) An up-to-date record of major incidents occurring within the last 2 years. Such record shall contain a clear description of each incident; the time, place, names of individuals involved; witnesses; nature of injuries; cause if known; action taken; a description of medical or other services provided; by whom such services were provided; and any steps taken to prevent recurrence. These reports shall be made by the individuals having first hand knowledge of the incidents, including paid staff, volunteer staff,		A 160		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 160	Continued From page 8 emergency and temporary staff, and student interns. (e) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described under Rule 58A-5.026, F.A.C., which shall be located where immediate access by facility staff is assured. (f) Documentation of radon testing conducted pursuant to Rule 58A-5.023, F.A.C.; (g) The facility's liability insurance policy required under Rule 58A-5.021, F.A.C.; (h) For facilities which have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C. (i) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 58A-5.0182, F.A.C. (j) If the facility advertises that it provides special care for persons with _____'s _____ or related _____, a copy of all such facility advertisements as required by Section 429.177, F.S. (k) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C. (l) All food service records required under Rule 58A-5.020, F.A.C., including menus planned and served; county health department inspection reports; and for facilities which contract for catered food services, a copy of the contract for catered services and the caterer's license or certificate to operate. (m) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last two (2) years. (n) All sanitation inspection reports issued by the	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 160	Continued From page 9 county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (o) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (p) Additional facility records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. (q) The facility's resident elopement response policies and procedures. (r) The facility's documented resident elopement response drills. This Statute or Rule is not met as evidenced by: Based on observation record review and interview the facility failed to have an up to date admission and discharge log. Findings as follow: On at about 9:00 a.m. there were observed 6 residents in facility . Record review the facility had demographic information for 6 residents. On at about 9:00 a.m. facility caretaker staff #3 stated the facility had 6 residents. On at about 11:30 a.m. staff #2 (owner/caretaker) stated the facility had 6 residents also stated the facility failed to add resident #6 to the admission and discharge log. Class III.		A 160		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 SS=D	58A-5.024(2) FAC Records - Staff (2) STAFF RECORDS. (a) Personnel records for each staff member shall contain, at a minimum, a copy of the original employment application with references furnished and verification of freedom from communicable including . In addition, records shall contain the following, as applicable: 1. Documentation of compliance with all staff training required by Rule 58A-5.0191, F.A.C.; 2. Copies of all licenses or certifications for all staff providing services which require licensing or certification; 3. Documentation of compliance with level 1 background screening for all staff subject to screening requirements as required under Rule 58A-5.019, F.A.C.; 4. A copy of the job description given to each staff member pursuant to Rule 58A-5.019, F.A.C., for facilities with a licensed capacity of seventeen (17) or more residents; and 5. Documentation of facility direct care staff and administrator participation in resident elopement drills pursuant to paragraph 58A-5.0182(8)(c), F.A.C. (b) The facility shall not be required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by a business entity contracting to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 58A-5.019, F.A.C. (c) The facility shall maintain the facility 's written work schedules and staff time sheets as required under Rule 58A-5.019, F.A.C., for the last 6 months.		A 161		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 11 This Statute or Rule is not met as evidenced by: Based on record review an interview the facility failed to have an employment application with references for 1 of 3 (#1, facility administrator) facility staff. Findings as follow: Record review documented the facility failed to have an employment application with references for staff #1 (administrator) available for review. On at about 11:30 a.m. staff #2 (caretaker/owner) stated the facility failed to have an employment application with references for staff #1 (administrator) Class III.	A 161			
A 162 SS=D	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records shall be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2. ; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance ; 8. Name, address, and telephone number of next of kin, responsible party, or other person the resident would like to have notified in case of an emergency, and relationship to resident; and 9. Name, address, and phone number of health care provider, and case manager if applicable. (b) A copy of the medical examination described	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 162	Continued From page 12 in Rule 58A-5.0181, F.A.C. (c) Any health care provider's orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) A signed statement from a resident refusing a therapeutic diet pursuant to Rule 58A-5.020, F.A.C. (e) The resident record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A weight record which is initiated on admission. Information may be taken from the resident's health assessment. Residents receiving assistance with the activities of daily living shall have their weight recorded semi-annually. (g) For facilities which will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract. (h) For facilities which manage a pill organizer, assist with self-administration of medications or administer medications for a resident, the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract, as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, or staff, or representative thereof serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required under Section 429.27, F.S. (k) For any facility which maintains a separate trust fund to receive funds or other property	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 162	Continued From page 13 belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required under Section 429.27, F.S. (l) A copy of Alternate Care Certification for () Form, CF-ES 1006, 1998, if the resident is an recipient. The absence of this form shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Family Services. (m) Documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required under Rule 58A-5.0181, F.A.C. (o) For apartments, duplexes, quadruplexes, or single family homes that are designated for independent living but which are licensed as assisted living facilities solely for the purpose of delivering personal services to residents in their homes, when and if such services are needed, record keeping on residents who may receive meals but who do not receive any personal, limited nursing, or extended congregate care service shall be limited to the following: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required under this subsection; 3. The medical examination described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by		A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 162	Continued From page 14 the facility. (p) Except for resident contracts which must be retained for 5 years, all resident records shall be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents shall be provided a copy of their resident records upon departure from the facility. (q) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to have health assessments for 1 of 6 (#3) facility residents. Findings as follow. Record review documented the facility failed to have a health assessment for Resident #3 (admitted on _____). On _____ at about 11:00 a.m. facility owner/caretaker (staff #2) stated the facility failed to have health assessments for resident #3. Class III	A 162			
A 181 SS=D	58A-5.026(2) FAC Emergency Mgmt - Plan Approval (2) EMERGENCY PLAN APPROVAL. The plan shall be submitted for review and approval to the county emergency management agency.	A 181			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 181	Continued From page 15 (a) The county emergency management agency has 60 days in which to review and approve the plan or advise the facility of necessary revisions. Any revisions must be made and the plan resubmitted to the county office of emergency management within 30 days of receiving notification from the county agency that the plan must be revised. (b) Newly-licensed facility and facilities whose ownership has been transferred, must submit an emergency management plan within 30 days after obtaining a license. (c) The facility shall review its emergency management plan on an annual basis. Any substantive changes must be submitted to the county emergency agency for review and approval. 1. Changes in the name, address, telephone number, or position of staff listed in the plan are not considered substantive revisions for the purposes of this rule. 2. Changes in the identification of specific staff must be submitted to the county emergency management agency annually as a signed and dated addendum that is not subject to review and approval. (d) The county emergency management agency shall be the final administrative authority for emergency management plans prepared by assisted living facilities. (e) Any plan approved by the county emergency management agency shall be considered to have met all the criteria and conditions established in this rule. This Statute or Rule is not met as evidenced by:		A 181		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MOTHER'S YEARS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 SW 145 AVENUE MIAMI, FL 33175		
(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 181	Continued From page 16 Based on record review and interview the facility failed to submit for approval on annual basis the emergency management plan. Findings as follow: Record review documented the facility's last emergency management plan approved was dated _____ On _____ at about 12:00 noon staff #2 (caretaker/owner) stated the facility last emergency management plan was approved on _____ Also stated the facility failed to submit for approval the emergency management plan on annual basis. Class III	A 181			



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Mother's Years Inc
5454 Sw 145 Avenue
Miami, FL 33175

Dear Administrator:

Re: CCR #2013000090

This letter reports the findings of a state complaint survey that was conducted on , 2013 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe.

Staff from this office will conduct a review after 4/18/2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Ar Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
XG90

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