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 |
|---|---|---|---|
| | AL11965123 | A. BUILDING: _____ B. WING _____ | R |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAURELWOOD ASSISTED LIVING FACILITY, I | 1851 WEST TEN MILE ROAD CANTONMENT, FL 32533 |

| (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<br><br>A follow-up to a standard biennial survey was completed at Laurelwood Retirement Residence on , 2013. Deficient practice was cited at the time of the survey. | {A 000} | | |
| {A 078} SS=D | 58A-5.019(2) FAC Staffing Standards - Staff<br><br>(2) STAFF.<br>(a) Newly hired staff shall have 30 days to submit a statement from a health care provider, based on a examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable including . Freedom from must be documented on an annual basis. A person with a positive test must submit a health care provider ' s statement that the person does not constitute a risk of communicating . Newly hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in service. If any staff member is later found to have, or is suspected of having, a communicable , he/she shall be removed from duties until the administrator determines that such condition no longer exists.<br>(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.<br>(c) All staff must comply with the training | {A 078} | | |

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|---|---|---|---|
| | AL11965123 | A. BUILDING: _____ B. WING _____ | R |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAURELWOOD ASSISTED LIVING FACILITY, IN | 1851 WEST TEN MILE ROAD CANTONMENT, FL 32533 |

| (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 | {A 078} | | |

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 interview and record review the facility failed to have a statement for freedom from communicable for 2 of 7 employees reviewed (# 3 and #7).

The findings are:
A review of Employee file #3 and #7 failed to reveal a statement they were free of communicable . An interview was conducted with the Administrator about 11:35 am on . She searched the employee files and stated, "No it is not in here for Employee #3, and she is going to the doctor". She then stated Employee #7 gave me her form let me look on my desk for it. She confirmed the information was not in either file.
At the time of Exit on no additional information was provided for Employee #7.

Class III

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 |
|---|---|---|---|
| | AL11965123 | A. BUILDING: _____ B. WING _____ | R |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAURELWOOD ASSISTED LIVING FACILITY, I | 1851 WEST TEN MILE ROAD CANTONMENT, FL 32533 |

| (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 167} | Continued From page 2 | {A 167} | | |
| {A 167} SS=D | 58A-5.025(1) FAC Resident Contracts | {A 167} | | |

Resident Contracts.
(1) Pursuant to Section 429.24, F.S., prior to or at the time of admission, each resident or legal representative shall execute a contract with the facility which contains the following provisions:
(a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services if the facility is licensed to provide such services.
(b) The daily, weekly, or monthly rate.
(c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule which shall be attached to the contract.
(d) A provision giving at least 30 days written notice prior to any rate increase.
(e) Any rights, duties, or of residents, other than those specified in Section 429.28, F.S.
(f) The purpose of any advance payments or deposit payments and the refund policy for such advance or deposit payments.
(g) A refund policy which shall conform to Section 429.24(3), F.S.
(h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or facility. The resident or responsible party shall notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident ' s medical condition, such as the resident ' s being comatose, prevents the resident from giving written notification and

Agency for Health Care Administration

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|---|---|---|---|
| | AL11965123 | A. BUILDING: _____ B. WING _____ | R |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAURELWOOD ASSISTED LIVING FACILITY, I | 1851 WEST TEN MILE ROAD CANTONMENT, FL 32533 |

| (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 167} | Continued From page 3 | {A 167} | | |

the resident does not have a responsible party to act in the resident ' s behalf.
(i) A provision stating whether the organization is affiliated with any religious organization, and, if so, which organization and its relationship to the facility.
(j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those the facility is licensed to provide, the resident or the resident ' s representative, or agency acting on the resident ' s behalf, shall be notified in writing that the resident must make arrangements for transfer to a care setting that has services needed by the resident. In the event the resident has no person to represent him, the facility shall refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions as outlined in Section 429.26(8), F.S., shall take effect.
(k) A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule.
(l) The facility ' s policies and procedures for self-administration, assistance with self-administration and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule.
(m) The facility ' s policies and procedures related to a properly executed

This Statute or Rule is not met as evidenced by:
Based on interview and record review, the facility

Agency for Health Care Administration

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|---|---|---|---|
| | AL11965123 | A. BUILDING: _____ B. WING _____ | R |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAURELWOOD ASSISTED LIVING FACILITY, I** | **1851 WEST TEN MILE ROAD CANTONMENT, FL 32533** |

| (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 167} | Continued From page 4 | {A 167} | | |

failed to have 30 day notice of rate increase and 45 day notice before discharge of the resident for all residents in the facility.
The findings are:
An interview was conducted with the administrator on about 12:50 pm. The Administrator showed the new contract she has prepared for all residents and families to sign. The above provisions are in the new contract.

She confirmed that the new contract has not been signed by any of the residents or the families of residents who had signed the old contract . She stated, "All the residents or family will need to sign the new contract . No it has not been done yet but I have the new contract ready to be signed".

Class III

## State Form: Revisit Report

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| AL11965123 | A. Building<br>B. Wing | 3/8/2013 |

**Name of Facility**

LAURELWOOD ASSISTED LIVING FACILITY, INC

**Street Address, City, State, Zip Code**

1851 WEST TEN MILE ROAD
CANTONMENT, FL 32533

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 Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix **A0028**<br>Reg. # **58A-5.0182(4) FAC**<br>LSC | | ID Prefix **A0029**<br>Reg. # **58A-5.0182(5) FAC**<br>LSC | | ID Prefix **A0052**<br>Reg. # **58A-5.0185(3) FAC**<br>LSC | |
| ID Prefix **A0077**<br>Reg. # **58A-5.019(1) FAC**<br>LSC | | ID Prefix **A0079**<br>Reg. # **58A-5.019(4) FAC**<br>LSC | | ID Prefix **A0081**<br>Reg. # **58A-5.0191(2) FAC**<br>LSC | |
| ID Prefix **A0082**<br>Reg. # **58A-5.0191(3) FAC**<br>LSC | | ID Prefix **A0085**<br>Reg. # **58A-5.0191(6) FAC**<br>LSC | | ID Prefix **A0090**<br>Reg. # **58A-5.0191(11) FAC**<br>LSC | |
| ID Prefix **A0093**<br>Reg. # **58A-5.020(2) FAC**<br>LSC | | ID Prefix **A0161**<br>Reg. # **58A-5.024(2) FAC**<br>LSC | | ID Prefix **A0162**<br>Reg. # **58A-5.024(3) FAC**<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| | | | | | |
|---|---|---|---|---|---|
| **Reviewed By** **State Agency** | **Reviewed By** | **Date:** 3/15/13 | **Signature of Surveyor:** for Lynne Walker / KDO | **Date:** 3/15/13 | |
| **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

[redacted], 2013

Administrator
Laurelwood Assisted Living Facility, Inc
1851 West Ten Mile Road
Cantonment, FL 32533

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2013 by a representative 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 850-412-4540.

Sincerely,

for Donah Heiberg, M.S.W.
Field Office Manager

DH/kb
Enclosure

BB17

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Tallahassee, FL 32308
http://ahca.myflorida.com

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