

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964707	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER INDIGO PALMS			STREET ADDRESS, CITY, STATE, ZIP CODE 570 NATIONAL HEALTHCARE BLVD DAYTONA BEACH, FL 32114		
(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 000}			
{A 167}	58A-5.025(1) FAC Resident Contracts 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	{A 167}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0899

XLVP12

If continuation sheet 1 of 3

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{A 167}	Continued From page 1 facility unless the resident ' s medical condition, such as the resident ' s being comatose, prevents the resident from giving written notification and 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	{A 167}			

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{A 167}	Continued From page 2 This Statute or Rule is not met as evidenced by: Based on resident record review and an interview with the administrator, the facility failed to provide documentation that a refund has been made to Resident #6. The findings include: An interview with the administrator on 18, 2013 at 4:00pm, confirmed that the facility did not pay a refund to Resident #6 , within the required 45 days. He further stated that he had sent a refund to the resident on 2012. A review of the resident record revealed that the refund should have been paid prior to or by , 2012 . The administrator was unable to provide documentation of the refund being made using a registered letter, certified mail or other means. In addition he has not provided a cancelled check to assist in determining the check has been received by the resident. This citation was previously cited on , 2012. Class	{A 167}			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11964707	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
Name of Facility INDIGO PALMS		Street Address, City, State, Zip Code 570 NATIONAL HEALTHCARE BLVD DAYTONA BEACH, FL 32114

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0053</u> Reg. # <u>58A-5.0185(4) FAC</u> LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	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 <u>KH</u>		Reviewed By <u>KH</u>		Date: <u>5.1.13</u>	Signature of Surveyor: _____
State Agency _____		Reviewed By _____		Date: _____	Signature of Surveyor: _____
Reviewed By _____		Reviewed By _____		Date: _____	Signature of Surveyor: _____
CMS RO _____		Reviewed By _____		Date: _____	Signature of Surveyor: _____
Followup to Survey Completed on: _____		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO			



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Indigo Palms
570 National Healthcare Blvd.
Daytona Beach, FL 32114

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 deficiency, identified during the revisit.

The deficiency should have been corrected no later than _____, 2013. A recommendation for sanction has been forwarded to the Central Office in Tallahassee for the uncorrected Class III deficiency. This action, if taken, will be a matter of separate correspondence from the Central Office in Tallahassee.

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 (904) 798-4201.

Sincerely,

A handwritten signature in black ink, appearing to read "Keisha Woods", is written over a horizontal line.

Keisha Woods, MPH
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JPL/KW/sm
Enclosure

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



Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone (904) 798-4201; Fax (904) 359-6054