

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967459	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 5/6/2013
Name of Facility LILITA HOME II INC.	Street Address, City, State, Zip Code 2451 SW 103 WAY MIRAMAR, FL 33025	

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 A0026 Reg. # 58A-5.0182(2) FAC LSC	Correction Completed	ID Prefix A0032 Reg. # 58A-5.0182(8) FAC LSC	Correction Completed	ID Prefix A0056 Reg. # 58A-5.0185(7) FAC LSC	Correction Completed
ID Prefix A0057 Reg. # 58A-5.0185(8) FAC LSC	Correction Completed	ID Prefix A0079 Reg. # 58A-5.019(4) FAC LSC	Correction Completed	ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	Correction Completed
ID Prefix A0093 Reg. # 58A-5.020(2) FAC LSC	Correction Completed	ID Prefix A0160 Reg. # 58A-5.024(1) FAC LSC	Correction Completed	ID Prefix AZ815 Reg. # 408.809, 435.02(2), 435.06 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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	5/30/13			5/30/13
Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
CMS RO				

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER LILITA HOME II INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2451 SW 103 WAY MIRAMAR, FL 33025		
(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 This reports the status of the citations originally issued as a result of the biennial licensure survey conducted on _____ at Lilita Home II, Inc. Assisted Living Facility. During the revisit survey conducted the following citations were corrected: A0026, A0032, A0056, A0057, A0079, A0081, A0093, A160 and Z815. The following citations remain uncorrected: A0008 and A0078.	(A 000)			
(A 008) SS=D	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual's admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or therapy services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable disease which is _____ to be	(A 008)			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

5599

5S4K12

If continuation sheet 1 of 7

Agency for Health Care Administration

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{A 008}	Continued From page 1 transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual ' s needs can be met in an assisted living facility; and 8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state. (b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf . The form must be completed as follows: 1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment. a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion. b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider. c. Omitted information received verbally must be documented in the resident ' s record, including	{A 008}			

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{A 008}	Continued From page 2 the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided. 2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the elements in Section 3. This requirement does not apply for residents receiving: a. Extended congregate care (ECC) services in facilities holding an ECC license; b. Services under community living support plans in facilities holding limited mental health licenses; c. Medicaid assistive care services; and d. Medicaid waiver services. (c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual's admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823. (d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule. (f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care	{A 008}			

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{A 008}	Continued From page 3 provider may attach a _____ order for residents who do not wish _____ to be administered in the case of _____ or (g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility's admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to properly complete the Resident Health Assessment Form (form 1823), for 2 out of 4 sampled residents (Residents #1 and #2). The findings include: a) Record review of the medical record for Resident #1, revealed the 1823 Health Assessment Form was not properly completed. Page 4 of the Health Assessment form, which includes the examining physician signature and date of the exam, was missing from the record. b) Record review of Resident #2 medical record revealed there was no date on the 1823 Health Assessment form. The resident had been	{A 008}			

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{A 008}	Continued From page 4 admitted on _____ to the facility. On _____ at approximately 1:30 PM during an interview with the Administrator, she reviewed the records and confirmed she did not have a complete 1823 Assessment Form for the residents. This is an uncorrected deficiency from survey conducted on _____ Class III	{A 008}			
{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	{A 078}			

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{A 078}	Continued From page 5 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 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 ensure that the employee files had documentation of current freedom from communicable for 2 out of 4 sampled employee records (Employee #1 and #4). The findings are: During a review of the personnel records, it was noted that Employee #1 and Employee #4 did not have documentation of current freedom from communicable, including The Administrator was interviewed on at 1:30 PM and no additional information was provided.		{A 078}		

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{A 078}	Continued From page 6 This is an uncorrected deficiency from survey conducted Class III	{A 078}			



Better Health Care for all Floridians

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Lilila Home II Inc.
2451 SW 103 Way
Miramar, FL 33025

Dear Administrator:

This letter reports the findings of a state licensure survey revisit that was conducted on . 2013 by a representative of this office. Attached is the provider's copy of the State Revisit Report, which indicates the previously cited deficiencies that were found corrected. Also attached is the provider's copy of the State (3020) Form, which references the uncorrected deficiencies that were identified on the day of the revisit.

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 . 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,


Arlene Mayo-Davis
Field Office Manager

AMD/ls
Enclosure

