AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967623	**05/13/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
MAGNOLIA HOUSE	**103 YACHT HAVEN DRIVE COCOA BEACH, FL 32931**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

. . . . . MENDED - changed from FS to CHOW
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The Change of Ownership survey was conducted on . . Magnolia House had a deficiency found at the time of the survey.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on interview and record review the facility failed to ensure the Resident Health Assessment form (1823) was updated when a resident had a significant change and was placed on Hospice for 1 of 2 sampled residents (#1).
Findings
On . . a resident record review was completed for resident #1. The record revealed the resident was admitted on . . Further review revealed the 1823 was dated . . Continued review revealed the resident was placed under the care of Vitas Hospice services on . . . . . There was no updated 1823 to reflect the resident had a significant change and was placed on hospice.
On . . . at approximately 12:30pm in an interview with the administrator she stated that she has no other 1823 for this resident
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015 (amended, change from FS to CHOW)
, 2015

Administrator
Magnolia House
103 Yacht Haven Drive
Cocoa Beach, FL 32931

RE: Change of Ownership

Dear Administrator:

This letter reports the findings of a state licensure CHOW survey that was conducted on 13, 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) 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 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 Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

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