

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 12/01/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966232	(X3) DATE SURVEY COMPLETED R / /
NAME OF PROVIDER OR SUPPLIER M & R PERSONAL CARE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1289 SOUTH HILLSBOROUGH AVENUE ARCADIA, FL 34266	

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

0000 Initial Comments

An unannounced follow-up survey was completed on 11/1/15 at M & R Personal Care, Inc., an assisted living facility in Arcadia, Florida. The original survey was completed on 10/1/15.

Five deficiencies were corrected. The following is description of the remaining deficiency:

L241 LMH - Records

Based on record review and interview, the facility failed to ensure 7 (Residents #1, #10, #12, #13, #14, #15, and #16) of 9 in-house Limited Mental Health residents reviewed had community support plans and agreements.

The findings include:

On 11/1/15, the Administrator was not able to provide documentation that 7 residents (Residents #1, #10, #12, #13, #14, #15 or #16) had appropriate community support plans and Agreements.

On 11/1/15 at 10:30 a.m., the Administrator said there were currently 9 in house residents in the facility that are mental health residents. Two of the residents have community support plans and agreements in place. Four of the residents (Residents #1, #12, #13 and #14) had been accepted to mental health services and are in the process of having community support plans and agreements put in place. There are three residents (Resident #10, #15 and #16) the Administrator is still working to have accepted into a mental health service.

Class III

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11966232	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 11/19/2015
Name of Facility M & R PERSONAL CARE, INC		Street Address, City, State, Zip Code 1289 SOUTH HILLSBOROUGH AVENUE ARCADIA, FL 34266

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>A0008</u> Reg. # <u>429.26(4-6) FS; 58A-5.0181</u> LSC _____	Correction Completed	ID Prefix <u>A0052</u> Reg. # <u>58A-5.0185 (3)</u> LSC _____	Correction Completed	ID Prefix <u>A0077</u> Reg. # <u>429.176 FS; 58A-5.019(1) F</u> LSC _____	Correction Completed
ID Prefix <u>A0078</u> Reg. # <u>58A-5.019(2) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0083</u> Reg. # <u>58A-5.019(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

Reviewed By _____	Reviewed By <u>[Signature]</u>	Date: <u>12/1/2015</u>	Signature of Surveyor: <u>[Signature]</u>	Date: <u>12.1.15</u>
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By _____	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



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

-----, 2015

Administrator
M & R Personal Care, Inc
1289 South Hillsborough Avenue
Arcadia, FL 34266

Dear Administrator:

This letter reports the findings of a State Licensure Revisit Survey conducted on _____, 2015 by representative(s) of this office.

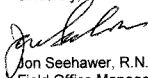
Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

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 _____, 2015.**

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 this office at (239) 335-1315.

Sincerely,


Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form and Revisit Report

YOSF

