

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 01/05/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968810	(X3) DATE SURVEY COMPLETED R 12/22/2016
NAME OF PROVIDER OR SUPPLIER OPEN ARMS ALF, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13453 SW 289 TERR HOMESTEAD, FL 33033	

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

0000 - Initial Comments

A Complaint (CCR #2016010596) revisit survey was conducted on 22, 2016. Open Arms ALF, Inc. with a Limited mental Health component, License # 12674 had the following uncorrected deficiency identified at the time of the survey:

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure to have proof in record of the annual 2 hours continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living for one (Caregiver B) out of three sampled staff members.

Findings included:

Review of Caregiver B's personnel file revealed medication management assist with self-medication training- 4 hours dated 7/1/16. The facility did not have any other training documentation for Caregiver B.

In an interview on 12/22/16 at 10:47 AM the Administrator revealed that Administrator assisted residents with self-administration of medications.

Class III

Uncorrected



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

Administrator
Open Arms Alf, Inc
13453 Sw 289 Terr
Homestead, FL 33033

Dear Administrator:

This letter reports the findings of a Complaint revisit survey conducted on 2016 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), 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 , 2017.**

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 (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

BBT7



STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11968810	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
NAME OF FACILITY OPEN ARMS ALF, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13453 SW 289 TERR HOMESTEAD, FL 33033	

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0078 Reg. # 58A-5.019(2) FAC LSC	Correction Completed	ID Prefix A0079 Reg. # 58A-5.019(3) FAC LSC	Correction Completed	ID Prefix A0081 Reg. # 58A-5.019(2) FAC LSC	Correction Completed
ID Prefix A0082 Reg. # 58A-5.019(3) FAC LSC	Correction Completed	ID Prefix A0083 Reg. # 58A-5.019(4) FAC LSC	Correction Completed	ID Prefix A0080 Reg. # 58A-5.019(11) FAC LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>02/11/17</i>	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 10/24/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO