

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 An unannounced relicensure survey was conducted on _____ at Irving's Places of Loving Care, License #11007. The facility had had deficiencies at the time of the visit.	A 000			
A 010 SS=D	429.26(1&9) FS; 58A-5.0181(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (9) A _____, ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of	A 010			

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 010	Continued From page 1 the resident are being met. 58A-5.0181 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. (a) The resident may be bedridden for up to 7 consecutive days. (b) A resident requiring care of a _____ pressure _____ may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider; 2. The condition is documented in the resident ' s record; and 3. If the resident ' s condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A _____ ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 010	Continued From page 2 consents to the services of a licensed hospice that coordinates and ensures the provision of any additional care and services that may be needed; 2. Continued residency is agreeable to the resident and the facility; 3. An interdisciplinary care plan, which specifies the services being provided by hospice and those being provided by the facility, is developed and implemented by a licensed hospice in consultation with the facility; and 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, the facility failed to monitor the appropriateness of continued residency, for 1 of 1 residents (Resident #4) reviewed for care. The findings include:	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

IRVING'S PLACE OF LOVING CARE

**4561 SW 36TH STREET
WEST PARK, FL 33023**

(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 010	Continued From page 3 During an interview on _____ at 10:00 am with Resident #4, he stated he had a _____ to his left ankle for a few weeks and that a nurse comes in to change the dressings. He is unable to express the type or stage of the _____. During an interview on _____ at 3:00 pm with Staff A, she confirmed that a third party nurse comes in daily to change the dressings but the resident often removes the dressings himself. She stated that there is one on is left ankle and his left great toe but she does not know the type of _____ it is but thinks its a _____ and stated she thinks she informed the doctor about it in _____. Review of records for Resident #4, found no progress notes or other documentation of the _____ to the left foot and great toe. There was no documentation that the physician was called or orders for _____ treatment. Another folder was presented by Staff A from a local Home Health Agency, which also did not contain any information regarding physician orders, _____ care, type of _____, measurements or staging. A call was placed to the Home Health Agency by Staff A and requested the above information. Review of the information received from the Home Health Agency consisted only of admission assessment completed on _____ which indicate that Resident #4 was initially being seen for left outer ankle _____ (unstageable), left great toe nail _____, right foot _____ between great toe and second toe. During an interview on _____ at 3:15 pm with the Home Health Nurse who arrived at the facility, she confirmed that she comes to the facility daily to change the dressing to Resident #4 left ankle	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 010	Continued From page 4 and great toe and there is no further treatment to the right ankle. She confirmed that she did not have any documentation of measurements or staging of the wound by a qualified nurse or medical practitioner. She stated that she would usually measure the but she did not have the measuring tape with her today. She confirms that is a little smaller than dime sized and the center of the contains eschar (a piece of tissue). According to the Nation Advisory Panel (NPUAP), an unstageable pressure injury is full thickness and tissue loss which the extent of the tissue damage of the cannot be confirmed because it is obscured by or eschar, which if removed, a or will be revealed. During an interview at 4:00 pm with the Administrator via telephone, no further information was offered in regards to Resident #4 residency or documentation. She says that she will contact the doctor and have the assessed and go from there. Class III	A 010		
A 025 SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 025	Continued From page 5 acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 (1) An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by:	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 025	Continued From page 6 Based on observation, interview and record review, the facility failed to maintain a written record, updated as needed, of significant changes that resulted in the provision of additional services for 1 of 2 (Resident #4) residents reviewed. The findings include: During an interview on _____ at 10:00 am with Resident #4, he stated he had a _____ to his left ankle for a few weeks and that a nurse comes in to change the dressings. He is unable to express the type or stage of the _____. During an interview on _____ at 3:00 pm with Staff A, she confirms that a third party nurse comes in daily to change the dressings but the resident often removes the dressings himself. She stated that there is one on is left ankle and his left great toe but she does not know the type of _____ it is but thinks its a _____ and says she thinks she informed the doctor about it in _____. Review of records for Resident #4, found no progress notes or other documentation of the _____ to the left foot and great toe. There was no documentation that the physician was called or orders for _____ treatment. Another folder was presented by Staff A from a local Home Health Agency, which also did not contain any information regarding physician orders, _____ care, type of _____, measurements or staging. A call was placed to the Home Health Agency by Staff A and requested the above information. Review of the information received from the Home Health Agency consisted only of admission assessment completed on _____ which indicate that Resident #4 was initially being seen for left	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 025	Continued From page 7 outer ankle, _____ (unstageable), left great toe nail _____, right foot between great toe and second toe. During an interview on _____ at 3:15 pm with the Home Health Nurse who arrived at the facility, she confirms that she comes to the facility daily to change the dressing to Resident #4 left ankle and great toe and there is no further treatment to the right ankle. She confirms that she did not have any documentation of measurements or staging of the wound by a qualified nurse or medical practitioner. She said that she would usually measure the _____ but she did not have the measuring tape with her today. She confirms that _____ is a little smaller than dime sized and the center of the _____ contains eschar (a piece of tissue). According to the Nation _____ Advisory Panel (NPUAP), an unstageable pressure injury is full thickness and tissue loss which the extent of the tissue damage of the _____ cannot be confirmed because it is obscured by _____ or eschar, which if removed, a _____ or _____ _____ will be revealed. During an interview at 4:00 pm with the Administrator via telephone, no further information was offered in regards to Resident #4 residency or documentation. She says that she will contact the doctor and have the assessed and go from there. Class III	A 025			
A 026 SS=D	58A-5.0182(2) FAC Resident Care - Social & Leisure Activities	A 026			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 026	Continued From page 8 (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident ' s needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents ' participation through one or more of the following methods: resident meetings, committees, a resident council, suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility	A 026		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 026	Continued From page 9 failed to consult with residents in selecting, planning and scheduling activities, and failed to provide individual and group activities adapted to resident needs, abilities and preferences 6 days a week. The findings include: Observation of residents upon entrance to the facility on _____ at 8:30 am, found 5 residents sitting in the living _____ front of the television. One resident was sitting in the back yard sitting area. There was one staff member, Staff A, present in charge of the resident care. During a tour of the facility, the activity calendar was found posted in the bulletin board in the dining _____. The calendar is dated _____ - _____. The calendar list Monday through Friday and 2 activities scheduled per day which is to be repeated for the entire month. The calendar listed the days of survey (Thursday) activities as: am exercise and 2-4 pm reading club. Other activities included community meeting, board games reading club. During an interview on _____ at 9:10 am with Resident #6, he says that they don't do anything together and it would be nice to have some planned activities they can enjoy. During an interview on _____ at 9:30 am, Resident # 5 said " There is nothing to do here. It's very boring. I would definitely like something to do. He denies being asked his opinion on activities. Attempted interview with Resident #1 found he has an altered thought process and may have difficulty participating in board games listed on the activities calendar for Tuesday mornings. During an interview with the family of Resident #3, when asked about activities, she says there	A 026			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023			
(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 026	Continued From page 10 are none. She denies observing activities during visits. Observation at 10:15 am found 4 residents sitting in the living ... front of the television, two of them sleeping, 2 residents were sitting on the front porch and 1 resident in the back sitting area. Staff A was noted to be cleaning the resident ... Observation at 2:15 pm, there were no activities noted taking place. The residents were noted to be in the living ... out on the front porch. During an interview on ... at 3:00 pm with Staff A, the direct care aide, she says that for activities, the residents usually just listen to music and dance and Resident #1 usually does exercises with them in the morning but was not feeling well today. She says she sometimes plays games or cards with them but it's hard to get the to participate. She confirms that no activities took place today as scheduled and there have been no community meetings with the residents or meetings regarding activities they would like to participate in and there is no documentation of the residents refusing the planned activities. Class III	A 026			
A 054 SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023			
(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 054	Continued From page 11 and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must include the name of the resident and any known _____ the resident may have; the name of the resident's health care provider, the health care provider's telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The medication observation record must be immediately updated each time the medication is offered or administered. (c) For medications that serve as chemical _____, the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain an accurate Medication Observation record (MOR), for 3 of 3 residents reviewed. The findings include: 1. During a confidential interview on _____ at 4:30 pm, concerns were voiced regarding the lack of communication from the staff and, in _____, dealing with medications. Review of the MOR at this time showed that _____ Solution 0.0005% 1 drop in both eyes daily at bedtime is ordered and signed off as	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 054	Continued From page 12 given from through Further review and interview revealed the documentation is wrong on the MOR because the medication had run out and the family member had just brought in a new bottle today. During an interview on at 4:35 pm with Staff A, when asked to see the medication that she had on hand, she stated that she just threw out the empty bottle the other day but could not remember what day. When asked why the medication was signed off as given by her when she was not at work, she said that it was a mistake and no other information was offered. 2. Review of the record on for Resident #5 found the MOR dated for through revealed no documentation that the following medications were given in the month of This includes: 0.5 mg every 12 hours, used to treat, polyethylene 3350 daily, used to treat, and Gel Drops 0.4-0.3% 1 drop in both eyes three times a day used to treat dry eyes. Further review found that there were two MORs dated for with the dates through and the other dated through Both MORs have the 0.5 mg and Polyethylene 3350 listed on the MORs but the medication was not given or signed off by staff. There was no reason written in the appropriate areas on back of the more. 3. Review of record for Resident #6 found that there were also two MORs dated for dated through and the other dated through The MOR dated for through show 120 mg CD daily listed as a current medication but no documentation that the medication was given in	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023			
(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 054	Continued From page 13 the months of _____, _____ and _____ of 2017. During an interview with staff A at 3:30 pm, she stated that the dates on the MORs are wrong and confirmed the MORs dated _____ was used for the month of _____ 2017. Staff A stated that she contacted the pharmacy when they did not send the medications, and was told that the medications were not renewed by the physicians. She confirmed there is no documentation or progress notes written that she spoke with the pharmacy, the physician or the Administrator. She says the the Advanced Registered nurse Practitioner (ARNP) reviewed Resident #6 MOR yesterday and did not say anything. During an interview on _____ at approximately 3:30 pm with the Advanced Registered nurse Practitioner (ARNP) for resident #6 to clarify the medications. She was made aware that the resident had not received the _____ since the end of _____. She stated that although she did not have her paperwork in front of her, she did not discontinue the _____ for Resident #6 and does not know why he is not receiving the medications. She will review it and get back with the facility. Class III	A 054			
A 078 SS=D	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable _____. The examination performed by the health care provider must have	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

IRVING'S PLACE OF LOVING CARE

**4561 SW 36TH STREET
WEST PARK, FL 33023**

(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 078	Continued From page 14 been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials, shall satisfy the annual examination requirement. An individual with a positive test must submit a health care provider 's statement that the individual does not constitute a risk of communicating 2. If any staff member has, or is suspected of having, a communicable, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent 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) An assisted living facility contracting to	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 078	Continued From page 15 provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 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. (f) Level 2 background screening must be conducted for staff, including staff contracted by the facility to provide services to residents, pursuant to Sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 3 (Staff A) employees submitted a written statement from a health care provider upon hire and annually, which documents freedom of (). This could lead exposure to to a population. The findings include: Record review on for Staff A revealed a hire date of There was no statement of freedom of communicable or noted on file for Staff A prior to or within 30 days after her date of hire. Staff A's record contained only a statement of freedom of communicable dated The section for screening was not filled out.	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 078	Continued From page 16 During an interview with Staff A on at 11:30 am, she says she does not know where to locate the documentation. During a telephone interview on at 4:00 pm, the Administrator, she said she is unsure where the documentation is and will review the facility's paperwork. There was no other information offered. Class III	A 078			
A 093 SS=B	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.frules.org/Gateway/reference.asp?No=Ref-04003 , and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf . Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents,	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 093	Continued From page 17 standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 093	Continued From page 18 provider ' s order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident ' s refusal to comply with a therapeutic diet and provide notification to the resident ' s health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of ... the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on hand. (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has contracted with residents to serve, must be on hand at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 093	Continued From page 19 This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure menus were dated and planned at least 1 week in advance and failed to ensure the correct menus were posted or readily available for the residents review. The findings include: During an interview with Staff A on _____ at 11:45 am, prior to lunch service, she stated that they were currently on cycle 3 of the menu. Observation on _____ at 12:00 pm, Staff A served lunch to the residents which consisted of: chicken with barbeque sauce, rice and peas, salad with dressing, papaya, and drink of choice. Review of the posted menu, which was posted on the dining _____ board, was dated through _____ stating cycle 4. This menu indicated Thursday's lunch menu was listed as Roast chicken, potatoes, peas, mixed salad with salad dressing, and gelatin. During a follow-up interview with Staff A an 1:30 pm, Staff A confirmed the menu posted was dated _____ through _____ and that they should be on cycle 2 of the 4 week cycle. A copy of the posted menu was requested, and upon removal from the bulletin board, it was noted that several weeks of menus were posted behind the current one. These menus were reviewed along with Staff A and she confirms that the posted menus for the last four weeks were all cycle 4. A copy of the original dietitian signed menu containing all cycles was requested.	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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 093	Continued From page 20 Review of a folder presented found the menus for the last 6 months, a copy of cycle 2 was found and Staff A confirmed there was no dated menu for this week posted elsewhere or readily available. Staff A says that they had not served the same things four weeks in a row but no other information was offered when asked how they determined what is prepared and served for the meals. Class	A 093			
CZ815 SS=C	408.809; 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses. - (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest if the agency has reason to believe that such person has been convicted of any offense prohibited by s. 435.04. For each controlling interest who has been convicted of any such offense, the licensee shall submit to the agency a description and explanation of the conviction at the time of license application. (e) Any person, as required by authorizing	CZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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
CZ815	Continued From page 21 statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, contracting with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All fingerprints must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud.	CZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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
CZ815	Continued From page 22 (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (h) Section 817.234, relating to false and fraudulent insurance claims. (i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider. (k) Section 817.505, relating to patient brokering. (l) Section 817.568, relating to criminal use of personal identification information. (m) Section 817.60, relating to obtaining a credit card through fraudulent means. (n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (o) Section 831.01, relating to forgery. (p) Section 831.02, relating to uttering forged instruments. (q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (s) Section 831.30, relating to fraud in obtaining medicinal drugs. (t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (u) Section 895.03, relating to racketeering and collection of unlawful debts.	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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
CZ815	Continued From page 23 (v) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or contracted with a licensee as of, 2014, and was screened and qualified under ss. 435.03 and 435.04, has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) A person who serves as a controlling interest of, is employed by, or contracts with a licensee on, 2010, who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by, 31, 2015, in compliance with the following schedule. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. The rescreening schedule shall be:	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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
CZ815	Continued From page 24 (a) Individuals for whom the last screening was conducted on or before _____, 2004, must be rescreened by _____, 2013. (b) Individuals for whom the last screening conducted was between _____, 2005, and _____, 2008, must be rescreened by _____, 2014. (c) Individuals for whom the last screening conducted was between _____, 2009, through _____, 2011, must be rescreened by _____, 2015. (6) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (7)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: - Does not have an active professional license or certification from the Department of Health; or - Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (8) The agency and the Department of Health	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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
CZ815	Continued From page 25 may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining fingerprints pursuant to s. 943.05(2). (9) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment. - (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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
CZ815	Continued From page 26 with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including fingerprints if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER IRVING'S PLACE OF LOVING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4561 SW 36TH STREET WEST PARK, FL 33023		
(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
CZ815	Continued From page 27 action for damages against, an employer that, upon notice of a conviction or _____ for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was _____, regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that background screenings (BGS) were completed for 1 of 3 (Staff B) staff records reviewed. The findings include: Record review on _____ for Staff B, a direct care staff, found no documentation that a BGS had been conducted prior to her hire date of _____. Further review of Staff B employment history found she was not employed by a qualified entity within 90-days of beginning employment by the facility and would need another Level II background screening completed. During an interview on _____ at 2:00 PM with Staff A, she confirmed that Staff B had just began working at the facility _____ and has been alone and in charge of the residents during the prior weekend. Review of the Agency for Health Care Administration Background Screening website	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2017
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

IRVING'S PLACE OF LOVING CARE

**4561 SW 36TH STREET
WEST PARK, FL 33023**

(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
CZ815	Continued From page 28 found that Staff B last request for screening was and her fingerprints have not been retained in the clearinghouse indicating she would have to report in person to be fingerprinted. During an interview with the Administrator on _____ at 3:30 PM, she confirmed that she did not get an opportunity to pull the BGS for Staff B. She says she will have it completed as soon as possible. Unclassified	CZ815		