

Agency for Health Care Administration

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|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965243</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>11/19/2018</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**FRIENDS AT HOME ASSISTED LIVING, INC**

**3680 CANAVERAL GROVES BLVD.  
COCOA, FL 32926**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| {A 000}                  | Initial Comments<br><br>A revisit to a monitoring visit was conducted on 11/19/2018. Friends at Home Assisted Living, had a deficiency at the time of the visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | {A 000}             |                                                                                                                          |                          |
| {A 181}<br>SS=D          | 58A-5.026(2) FAC Emergency Plan Approval<br><br>(2) EMERGENCY PLAN APPROVAL. The plan must be submitted for review and approval to the local emergency management agency.<br>(a) If the local emergency management agency requires revisions to the emergency management plan, such revisions must be made and the plan resubmitted to the local office within 30 days of receiving notification that the plan must be revised.<br>(b) A new facility as described in Rule 58A-5.023, F.A.C., and facilities whose ownership has been transferred, must submit an emergency management plan within 30 days after obtaining a license.<br>(c) The facility must review its emergency management plan on an annual basis. Any substantive changes must be submitted to the local emergency agency for review and approval.<br>1. Changes in the name, address, telephone number, or position of staff listed in the plan are not considered substantive revisions for the purposes of this rule.<br>2. Changes in the identification of specific staff must be submitted to the local emergency management agency annually as a signed and dated addendum that is not subject to review and approval.<br>(d) The local emergency management agency is the final administrative authority for emergency management plans prepared by assisted living facilities.<br>(e) Any plan approved by the local emergency management agency is considered to have met | {A 181}             |                                                                                                                          |                          |

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                                                                                 |                                                                                                                          |                                                              |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965243</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                          |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R<br/>11/19/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>FRIENDS AT HOME ASSISTED LIVING, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3680 CANAVERAL GROVES BLVD.<br/>COCOA, FL 32926</b> |                                                                                                                          |                                                              |
| (X4) ID<br>PREFIX<br>TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                     |
| {A 181}                                                                         | <p>Continued From page 1</p> <p>all the criteria and conditions established in this rule.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on interview, the facility did not have evidence that the comprehensive emergency management plan (CEMP) was approved by the local emergency management agency.</p> <p>Findings:</p> <p>On _____ at 11:00am, the House Manager confirmed the facility's CEMP was submitted on _____ and the facility had not received the approval letter from the emergency management agency.</p> <p>Class III</p> |                                                                                | {A 181}                                                                                         |                                                                                                                          |                                                              |