State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11965516	A. Building B. Wing	

Name of Facility	Street Address, City, State, Zip Code
HOMEWOOD RESIDENCE AT DELRAY B	8020 W. ATLANTIC AVENUE DELRAY BEACH, FL 33446

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 A0008 Reg. # 58A-5.0181(2) FAC LSC	Correction Completed	ID Prefix A0055 Reg. # 58A-5.0185(6) FAC LSC	Correction Completed	ID Prefix A0056 Reg. # 58A-5.0185(7) FAC LSC	Correction Completed
ID Prefix A0078 Reg. # 58A-5.019(2) FAC LSC	Correction Completed	ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	Correction Completed	ID Prefix A0082 Reg. # 58A-5.0191(3) FAC LSC	Correction Completed
ID Prefix A0152 Reg. # 58A-5.023(3) FAC LSC	Correction Completed	ID Prefix AZ815 Reg. # 408.809, 435.02(2), 435.06 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	Date:	Signature of Surveyor:	Date:
State Agency			Monica Thomas-Smith HFETD	9/10/12
Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
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

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965516	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE AT DELRAY B	8020 W. ATLANTIC AVENUE DELRAY BEACH, FL 33446

(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 Biennial Licensure revisit survey conducted at Homewood Residence At Delray Beach Assisted Living Facility on . The following deficiencies were found to be corrected: A 0008, A 0055. A 0056, A 0078, A 0081, A 0082, A 0089, A 0152 and Z815 The following deficiencies remained uncorrected: A 0084, A 0089 and A 0092.	{A 000}		
{A 084} SS=D	58A-5.0191(5) FAC Training - Assis Self-Admin Meds & Med Mgmt (5) ASSISTANCE WITH SELF-ADMINISTERED MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with self-administered medications as described in Rule 58A-5.0185, F.A.C., must meet the training requirements pursuant to Section 429.52(5), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall	{A 084}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965516	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE AT DELRAY B	8020 W. ATLANTIC AVENUE DELRAY BEACH, FL 33446

(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 084}	Continued From page 1	{A 084}		

include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises.
(b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates an ability to:
1. Read and understand a prescription label;
2. Provide assistance with self-administration in accordance with Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., including:
a. Assist with oral dosage forms, dosage forms, and and nasal dosage forms;
b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions;
c. Recognize the need to obtain clarification of an " as needed " prescription order;
d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident ' s health care provider or facility employer of inability to assist in the administration of such orders;
e. Complete a medication observation record;
f. Retrieve and store medication; and
g. Recognize the general signs of adverse reactions to medications and report such reactions.
(c) Unlicensed persons, as defined in Section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 4 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training shall only be provided by a licensed registered nurse, or a licensed pharmacist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965516	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE AT DELRAY B	8020 W. ATLANTIC AVENUE DELRAY BEACH, FL 33446

(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 084}	Continued From page 2	{A 084}		

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that 1 of 4 sampled employees obtained the training requirements for assisting residents with self-administered medications, as required (Employee #2).

The findings include:

Interview with the Director of Nursing and Business Office Manager on [redacted] at approximately 10:00 AM revealed Employee #2 assists residents with self-administered medications on a routine basis. Review of Employee #2's personnel record revealed that the Employee's file lacked evidence of documentation that the employee received a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an Assisted Living Facility on an annual basis for 2012, as required.

Class III
UNCORRECTED

{A 089} SS=D — 429.178 FS [redacted] - Special Care {A 089}

Special care for persons with [redacted]'s [redacted] or other related [redacted]
(1) A facility which advertises that it provides special care for persons with [redacted] or other related [redacted] must meet the following standards of operation:
(a)1. If the facility has 17 or more residents, have an awake staff member on duty at all hours of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965516	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE AT DELRAY B	8020 W. ATLANTIC AVENUE DELRAY BEACH, FL 33446

(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 089}	Continued From page 3 day and night; or 2. If the facility has fewer than 17 residents, have an awake staff member on duty at all hours of the day and night or have mechanisms in place to monitor and ensure the safety of the facility ' s residents. (b) Offer activities specifically designed for persons who are cognitively Have a physical environment that provides for the safety and welfare of the facility ' s residents. (d) Employ staff who have completed the training and continuing education required in subsection (2). (2)(a) An individual who is employed by a facility that provides special care for residents with Alzheimer ' disease other related disorders, who has regular contact with such residents, must complete up to 4 hours of initial dementia training developed or approved by the department. The training shall be completed within 3 months after beginning employment and shall satisfy the core training requirements of s. 429.52(2)(g). (b) A direct caregiver who is employed by a facility that provides special care for residents with Alzheimer ' disease other related disorders, who provides direct care to such residents, must complete the required initial training and 4 additional hours of training developed or approved by the department. The training shall be completed within 9 months after beginning employment and shall satisfy the core training requirements of s. 429.52(2)(g). (c) An individual who is employed by a facility that provides special care for residents with Alzheimer ' disease other related disorders, who only has incidental contact with such residents, must be given, at a minimum, general information on interacting with individuals with Alzheimer ' disease other related disorders, 3	{A 089}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965516	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE AT DELRAY B	8020 W. ATLANTIC AVENUE DELRAY BEACH, FL 33446

(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 089}	Continued From page 4	{A 089}		

months after beginning employment.
(3) In addition to the training required under subsection (2), a direct caregiver must participate in a minimum of 4 contact hours of continuing education each calendar year. The continuing education must include one or more topics included in the [illegible]-specific training developed or approved by the department, in which the caregiver has not received previous training.
(4) Upon completing any training listed in subsection (2), the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different facility. The employee or direct caregiver must comply with other applicable continuing education requirements.
(5) The department, or its designee, shall approve the initial and continuing education courses and providers.
(6) The department shall keep a current list of providers who are approved to provide initial and continuing education for staff of facilities that provide special care for persons with [illegible] or other related [illegible].
(7) Any facility more than 90 percent of whose residents receive monthly optional supplementation payments is not required to pay for the training and education programs required under this section. A facility that has one or more such residents shall pay a reduced fee that is proportional to the percentage of such residents in the facility. A facility that does not have any residents who receive monthly optional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965516	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE AT DELRAY B	8020 W. ATLANTIC AVENUE DELRAY BEACH, FL 33446

(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 089}	Continued From page 5 supplementation payments must pay a reasonable fee, as established by the department, for such training and education programs. (8) The department shall adopt rules to establish standards for trainers and training and to implement this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Employee's records contained evidence of documentation of compliance with [redacted] and other related [redacted] training requirements for 3 of 4 sampled Employee's records (Employee #1, #3 and #4). The findings are: Interview with the Director of Nursing and Business Office Manager on [redacted] at approximately 10:00 AM revealed that Employee #1, #3 and #4 all provide direct care for residents residing in the facility's secured unit. Further record review revealed that the Employees' file lacked evidence of documentation of 4 hours of continuing education on an annual basis in regards to [redacted] and other related [redacted] as required. Class III UNCORRECTED	{A 089}		
{A 092} SS=D	58A-5.020(1) FAC Food Service - General Responsibilities Food Service Standards. (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the	{A 092}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965516	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE AT DELRAY B	8020 W. ATLANTIC AVENUE DELRAY BEACH, FL 33446

(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 092}	Continued From page 6 administrator or a person designated in writing by the administrator shall: (a) Be responsible for total food services and the day to day supervision of food services staff. (b) Perform his/her duties in a safe and sanitary manner. (c) Provide regular meals which meet the nutritional needs of residents, and therapeutic diets as ordered by the resident ' s health care provider for resident ' s who require special diets. (d) Maintain the in-service and continuing education requirements specified in Rule 58A-5.0191, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an accurate and up-to-date list of residents who were ordered therapeutic diets by their health care providers and failure to provide therapeutic diets for 2 of 4 sampled residents (Resident #1 and #4). The findings are: 1) Upon request on [redacted] at approximately 11:15 AM, The Director of Nursing provided documentation of a diet list of all residents residing in the facility and stated that the kitchen staff utilizes this roster when preparing meals to serve to the residents. Record review revealed that Resident #1'ss Health Assessment, dated [redacted] documented that the resident requires a "no added salt" diet however the facility's diet roster documented that the resident required a "regular" diet.	{A 092}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965516	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE AT DELRAY B	8020 W. ATLANTIC AVENUE DELRAY BEACH, FL 33446

(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 092}	Continued From page 7 2). Review of Resident #4' s Health Assessment, dated . . . . . revealed the resident requires a "no added salt/low fat/low . . . . . diet, however the facility's diet roster documented that the resident requires a . controlled" diet. Class III UNCORRECTED	{A 092}		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

. 2012

Administrator
Homewood Residence At Delray Beach
8020 W. Atlantic Avenue
Delray Beach, FL 33446

Dear Administrator:

This letter reports the findings of a revisit survey conducted on . 2012 by a representative from this office. Enclosed is the provider's copy of the State Form: Revisit Report and Statement of Deficiencies and Plan of Correction (State Form 3020), which references the corrected and uncorrected deficiencies identified during the revisit. **All deficiencies shall be corrected no later than 10, 2012. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure State Form 3020/State Form: Revisit Report

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924