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
	AL11910967	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAS MANOR	645 NORTHEAST 131ST STREET NORTH MIAMI, FL 33161

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A 000	Initial Comments A Biennial Standard Survey was completed at Jas Manor with Limited Mental Health (LMH) component on . There was a census of 8 residents. There were deficiencies identified at the time of survey. A Monitoring Survey was also completed on at Jas Manor.	A 000		
A 025 SS=G	58A-5.0182(1) FAC Resident Care An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor 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 individual. (c) 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) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents,	A 025		

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A 025	Continued From page 1	A 025		

changes in the method of medication administration, or other changes which resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on observation, record review, and interview the assisted living facility failed to provide care and services to meet the needs of the 2 out of 2 (#1 and #5) sampled residents who were admitted to the facility. The facility failed to provide personal supervision and have the general awareness of 3 out of 3 (#1, #2, and #5) sampled residents. The facility failed to have a written record, updated as needed, of any significant changes for 3 out of 3 (#1, #2, and #5) sampled residents.

Findings include:

Arrived to the facility on : at 8:45 a.m. found staff member #2; staff #2 stated that resident #1 has not returned to the facility since last night ( ). Facility tour found that resident #2 was not at the facility but at the hospital based on conversations with staff #2. Observations found that resident #5 was not at the facility.

Record review found that resident #1's progress notes were not updated regarding the resident leaving the facility on : and not returning. Record review found that resident #'1 progress notes did not have any written documentation as to the resident's where about's or if the police were called to report the resident missing. Record review found that the facility's resident service logs showed that resident #1 has a history of leaving the facility.

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A 025	Continued From page 2	A 025		

Record review found that on , 2012 at 5:30 p.m. a certificate of professional initiating involuntary examination was completed for resident #1 because he was refusing to take medications, threatening passers by, screaming for no reason, and not sleeping at night. Record review found that the facility did not have any written documentation regarding resident #1 and these incidents.

Record review found that for the month of resident #1 was not listed on the facility's service log. The facility writes on that resident #1 "did not sleep here , , or ". Record review found that the service log for the month of has that resident #1 was not there from 1-5, 11-12, 15-16, 20-22, and 29. Record review found that resident #1 was at the facility for a total of 16 days for the month of . Record review found that the service log for the month of has that resident #1 was not there on , , 18-19, and , 22-23. Record review found that resident #1 was at the facility for a total of 25 days for the month of . Record review found that the service log for the month of has that resident #1 was not there on 21-23, , and 29-30. Record review found that resident #1 was at the facility for a total of 25 days for the month of . Record review found that the service log for the month of has that resident #1 was not there on , 5-6, resident #1 was in the hospital from 7-17, and was discharge from the hospital to the facility on .

Record review found that resident #2's last written note by the facility was dated . Record review found that the facility's service log reflected that resident #2 was not at the facility on

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A 025	Continued From page 3	A 025		

and was transferred to the hospital on 15. Record review found that the facility did not have any written notes regarding resident #2's where about's on and documentation of his hospitalization documented.

Record review found that the facility's resident service logs showed that resident #5 has a history of leaving the facility. Record review found that the service log for the month of has that resident #5 was not there from 3-5, 16-19, 24-27, and 29-31. Resident #5 was only at the facility for 13 days for the month of . Record review found that the service log for the month of has that resident #5 was not there from 5-7, 14-15, 17-20, 22-25, 27-28. Resident #5 was only at the facility for 12 days for the month of . Record review found that the service log for the month of has that resident #5 was not there from 1-4, 8-9, 11-13, 15-23, and 27-31. Resident #5 was only at the facility for 7 days for the month of . Record review revealed that resident #5 was not at the facility for the whole month of . Record review found that resident #5 was only at the facility for 3 days in the month of 14-15 and 23. Record review found that resident #5 has been for only two days in ; June 11-12.

Record review found that the facility failed to document and keep track of resident #5's where about's in the six months. The facility reflected on the service log that resident #5 was not in the facility for the month of but the facility does not have any written documentation

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A 025	Continued From page 4	A 025		

regarding resident #5's absence.

Interview with resident #1's sister on : at 12:17 p.m. revealed that she was not aware that resident #1 was not at the facility. She stated I'm his sister and not his guardian. She said that resident #1 was an and this was his "M O". He was at another facility and he would do the same thing. He leaves when he wants to.

The assistant administrator stated on at 10:01 a.m. that resident #1 left the facility last night around 9 p.m. Interview with the assistant administrator on : at 2:06 p.m. revealed that resident #1 had not returned to the facility since last night. She stated she called his guardian but did not call the police. She stated that resident #1 would leave the facility and not come back. Resident notes were reviewed with her and she confirmed that the facility did not document each time that resident #1 left and that steps that were taken to find him were also not documented at the facility.

The assistant administrator confirmed on : at 2:13 p.m. that resident #5 left the facility and has not returned. She stated that her guardian was called because resident #5 sometimes goes to her boyfriends house. She stated that the facility did not have the boyfriend's phone number or address. She stated that resident #5 leaves the facility often and does not return.

The assistant administrator confirmed during the exit that the facility did not have written documentation regarding resident #1, #2 and #5.

On : at 4:43 p.m. the assistant administrator contacted the surveyor by email

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A 025	Continued From page 5 and stated that resident #1 was located. Resident #1 was picked up last night by the police for "vagrancy" and she had not heard from #5 yet. On ., the assistant administrator was contacted by email and stated that resident #5 had still not be located by the facility. On at 1:02 p.m. the facility filed a missing person police report for resident #5 who had not been in the facility since based on the facility's resident service log. Resident #5 was located by the police at her boyfriend's house on at 1:27 p.m. Class II	A 025		
A 032 SS=G	58A-5.0182(8) FAC Resident Care - Elopement Standards (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement shall be identified so staff can be alerted to their needs for support and supervision. 1. As part of its resident elopement response policies and procedures, the facility shall make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility ' s name, address, and telephone number. Staff attention shall be directed towards residents assessed at high risk for elopement, with special attention given to those with ' s and related assessed at high risk. 2. At a minimum, the facility shall have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The photo identification shall be made available for the file within 10 calendar	A 032		

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A 032	Continued From page 6	A 032		

days of admission. In the event a resident is assessed at risk for elopement subsequent to admission, photo identification shall be made available for the file within 10 calendar days after a determination is made that the resident is at risk for elopement. The photo identification may be taken by the facility or provided by the resident or resident ' s family/caregiver.
(b) Facility Resident Elopement Response Policies and Procedures. The facility shall develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures shall include:
1. An immediate staff search of the facility and premises;
2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities;
3. The identification of staff responsible for contacting law enforcement, the resident ' s family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and
4. The continued care of all residents within the facility in the event of an elopement.
(c) Facility Resident Elopement Drills. The facility shall conduct resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S.

This Statute or Rule is not met as evidenced by:
Based on observations, record review, and interview the facility failed to ensure that 2 out of 2 (#1 and #5) sampled residents who had a history of elopement where identified so staff can be alerted to their needs for support and supervision. The facility failed to have a photo identification for 2 out of 2 (#1 and #5) sampled

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A 032	Continued From page 7	A 032		

residents who had a history of eloping. The facility failed to follow it's elopement policy. The facility failed to conduct two elopement drills annually.

Findings include:

Arrived to the facility on at 8:45 a.m. found staff member #2; staff #2 stated that resident #1 has not returned to the facility since last night ( ). Facility tour found that resident #2 was not at the facility but at the hospital based on conversations with staff #2. Observations found that resident #5 was not at the facility.

Record review found that resident #1's progress notes were not updated regarding the resident leaving the facility on and not returning. Record review found that resident #1 progress notes did not have any written documentation as to the resident's where about's or if the police were called to report the resident missing. Record review found that the facility's resident service logs showed that resident #1 has a history of leaving the facility. Record review found that for the month of resident #1 was not listed on the facility's service log. Record review found that resident #1 was at the facility for a total of 16 days for the month of . Record review found that resident #1 was at the facility for a total of 25 days for the month of , . Record review found that resident #1 was at the facility for a total of 25 days for the month of . Record review found that the service log for the month of has that resident #1 was not there on , 5-6, resident #1 was in the hospital from 7-17, and was discharge from the hospital to the facility on .

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A 032	Continued From page 8 Record review found that the facility's resident service logs showed that resident #5 has a history of leaving the facility. Resident #5 was only at the facility for 13 days for the month of . Resident #5 was only at the facility for 12 days for the month of . Resident #5 was only at the facility for 7 days for the month of . Record review revealed that resident #5 was not at the facility for the whole month of . Record review found that resident #5 was only at the facility for 3 days in the month of : 14-15 and 23. Record review found that resident #5 has been for only two days in ; June 11-12. Record review found that the facility did not have a complete elopement assessment or photographic identification for resident #1 and #5 at the facility. Record review found that the facility had an elopement policy and procedures. After reviewing the elopement policy it was revealed that the facility was not following the policy. The facility failed to identify to call the police when residents #1 and #5 were found missing, the facility failed to document that a search was conducted, and family, guardian, and doctors were contacted for residents #1 and #5. Record review found that the facility's who has a history of residents eloping only had one elopement drill documented on : for the last year. Interview with resident #1's sister on : at 12:17 p.m. revealed that she was not aware that resident #1 was not at the facility. She stated I'm his sister and not his guardian. She said that resident #1 was an : and this was his "M O". He was at another facility and he would do the same thing. He leaves when he wants to.	A 032		

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A 032	Continued From page 9 The assistant administrator stated on [redacted] at 10:01 a.m. that resident #1 left the facility last night around 9 p.m. Interview with the assistant administrator on [redacted] at 2:06 p.m. revealed that resident #1 had not returned to the facility since last night. She stated she called his guardian but did not call the police. She stated that resident #1 would leave the facility and not come back. Resident notes were reviewed with her and she confirmed that the facility did not document each time that resident #1 left and that steps that were taken to find him were also not documented at the facility. The assistant administrator confirmed on [redacted] at 2:13 p.m. that resident #5 left the facility and has not returned. She stated that her guardian was called because resident #5 sometimes goes to her boyfriends house. She stated that the facility did not have the boyfriend's phone number or address. She stated that resident #5 leaves the facility often and does not return. The assistant administrator confirmed during the exit that the facility did not have written documentation regarding resident #1 and #5. She confirmed that both residents did not have elopement assessments completed or photo id at the facility. The only elopement drill provided was dated [redacted]. On [redacted] at 4:43 p.m. the assistant administrator contacted the surveyor by email and stated that resident #1 was located. Resident #1 was picked up last night by the police for "vagrancy" and she had not heard from #5 yet. On [redacted], the assistant administrator was contacted by email and stated that resident #5 had still not be located by the facility.	A 032		

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A 032	Continued From page 10	A 032		

On at 1:02 p.m. the facility filed a missing person police report for resident #5 who had not been in the facility since based on the facility's resident service log. Resident #5 was located by the police at her boyfriend's house on at 1:27 p.m.

Class II

A 054 SS=D	58A-5.0185(5) FAC Medication - Records	A 054		

(5) MEDICATION RECORDS.
(a) For residents who use a pill organizer managed under subsection (2), the facility shall 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 and strength of the drug, and the directions for use.
(b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR 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 MOR must be immediately updated each time the medication is offered or administered.
(c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing

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A 054	Continued From page 11 physician ' s annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview the assisted living facility failed to maintain medication observation records (MORs) for 1 out of 3 (#2) sampled residents. Findings include: Record review found the medication observation record for resident #2 was not maintained by the facility. The following were found during the review of the medication observation record and medication reconciliation for resident #2: , , 300 milligrams (mg), , 10 mg, and 10 mg all three afternoon medications were initialed on 6/8 with "r" for refused medication but medication was not in bingo card and on MORs were initialed "n" (not there) but medication were not in bingo. 300 mg, 1 mg, 10 mg, and 10 mg were night time medication which were still in bingo card and facility did not initial the MOR. The findings were reviewed with the assistant administrator on at 1:03 p.m. who confirmed that resident #2's MORs were not maintained. Class III	A 054		
A 077 SS=D	58A-5.013(1) FAC Staffing Standards - Administrators Staffing Standards.	A 077		

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A 077	Continued From page 12	A 077		

(1) ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429, F.S., and this rule chapter.
(a) The administrators shall:
1. Be at least , ;
2. If employed on or after , 1990, have a high school diploma or general equivalency diploma (G.E.D.), or have been an operator or administrator of a licensed assisted living facility in the State of Florida for at least one of the past 3 years in which the facility has met minimum standards. Administrators employed on or after , 1995, must have a high school diploma or G.E.D.;
3. Be in compliance with Level 2 background screening standards pursuant to Section 429.174, F.S.; and
4. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C.
(b) Administrators may supervise a maximum of either three assisted living facilities or a combination of housing and health care facilities or agencies on a single campus. However, administrators who supervise more than one facility shall appoint in writing a separate " manager " for each facility who must:
1. Be at least , ; and
2. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C.
(c) Pursuant to Section 429.176, F.S., facility owners shall notify both the Agency Field Office and Agency Central Office within ten (10) days of a change in a facility administrator on the Notification of Change of Administrator, AHCA Form 3180-1006, 2006, which is incorporated by reference and may be obtained

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A 077	Continued From page 13 from the Agency Central Office. The Agency Central Office shall conduct a background screening on the new administrator in accordance with Section 429.174, F.S., and Rule 58A-5.014, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview the assisted living facility failed to have evidence of the administrator's high school diploma or GED. Findings include: Personnel record review found that the facility's administrator (hired) did not have evidence of having a high school diploma or it's equivalent. Record review found that the administrator did not have any evidence of meeting the education requirement. Interview with the assistant administrator on at 1:53 p.m. confirmed that the administrator listed did not have evidence of completing high school or GED at the facility. Class II	A 077		
A 080 SS=D	58A-5.0191(1) FAC Training - Core & Competency Test Staff Training Requirements and Competency Test. (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training	A 080		

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	AL11910967	A. BUILDING _____ B. WING _____	

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JAS MANOR	645 NORTHEAST 131ST STREET NORTH MIAMI, FL 33161

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A 080	Continued From page 14	A 080		

requirements established by the department pursuant to Section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test.
(b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to , 1997, and managers who attended the core training program prior to , 1998, shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with Part II of Chapter 468, F.S., are exempt from this requirement.
(c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years as provided under Section 429.52, F.S.
(d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must:
1. Retake the assisted living facility core training; and
2. Retake and pass the competency test.
(e) The fees for the competency test shall not exceed $200. The payment for the competency test fee shall be remitted to the entity

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A 080	Continued From page 15 administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by: Based on record review and interview the assisted living facility failed to ensure that facility's listed administrator passed the competency test within 3 months of employment. Findings include: Personnel record review found that the facility's listed administrator (hired) completed 26 hours of CORE training from 6-8, 2012. Record review found that the administrator did not passed the competency test within 3 months of employment. Interview with the assistant administrator on at 1:53 p.m. revealed that since she completed CORE training and passed the competency test; she would complete a change of administrator for the facility. Class III	A 080		
A 082 SS=D	58A-5.0191(3) FAC Training - /. ... . (3) / (/). Pursuant to Section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of Section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the Section 381.0035, F.S. New facility staff must	A 082		

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A 082	Continued From page 16 obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12) of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview the assisted living facility failed to ensure that 1 out of 3 (#1) sampled staff members received / training within 30 days of employment. Findings include: Record review revealed that staff #1 (caretaker; application date) did not have any documentation of having / training at the facility. Interview with the assistant administrator on at 1:53 p.m. revealed that staff #1 completed training and she thought everything was there. Class III	A 082		
A 090 SS=D	58A-5.0191(11) FAC Training - Do Not Orders (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding within 60 days after the effective date of this rule. (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident	A 090		

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A 090	Continued From page 17 admissions must receive at least one hour of training in the facility ' s policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in Rule 58A-5.0186, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record review and staff interview the assisted living facility failed to ensure that 3 out of 3 (#1, #2, and #3) sampled staff members received ( ) training. Findings include: Record review revealed that staff #1 (caretaker; application date), staff #2 (assistant administrator; application date) and staff #3 (administrator; application date) did not have any documentation of having ( ) training within 30 days of employment or 60 days of the effective. Interview with the assistant administrator on at 1:53 p.m. confirmed that staff members did not have ( ) training. Class III	A 090		
AL241 SS=D	58A-5.029(2) FAC LMH - Records (2) RECORDS. (a) A facility with a limited mental health license shall maintain an up-to-date admission and	AL241		

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discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required under Rule 58A-5.024, F.A.C., shall be sufficient provided that all mental health residents are clearly identified.
(b) Staff records shall contain documentation that designated staff have completed limited mental health training as required by Rule 58A-5.0191, F.A.C.
(c) Resident records for mental health residents in a facility with a limited mental health license must include the following:
1. Documentation, provided by the Department of Children and Family Services within 30 days of the resident ' s admission to the facility, that the resident is a mental health resident. Documentation that the resident is receiving social security or supplemental security income, , and any of the following shall meet this requirement.
a. An affirmative statement on the Alternate Care Certification for ( ) Form, CF-ES 1006, 1998, that the resident is receiving SSI/SSDI due to a
b. Written verification provided by the Social Security Administration that the resident is receiving SSI or SSDI for a mental Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information to the Department of Children and Family Services.
c. A written statement from the resident ' s case manager that the resident is an adult with severe and persistent mental illness. The case manager shall consider the following minimum criteria in making that determination.
(i) The resident is eligible for, is receiving, or has

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received state funded services from the Department of Children and Family Services ' and Mental Health program office within the last 5 years; or
(ii) The resident has been diagnosed as having a mental
2. An appropriate placement assessment provided by the resident ' s mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment shall be conducted by a psychiatrist, clinical psychologist, clinical social worker, or nurse, or person supervised by one of these professionals.
a. Any of the following documentation which contains the name of the resident and the name, signature, date, and license number, if applicable, of the person making the assessment, shall meet this requirement
(i) Completed Alternate Care Certification for ( ) Form, CF-ES Form 1006, 1998;
(ii) Discharge Statement from a state mental hospital completed within 90 days prior to admission to the ALF provided it contains a statement that the individual is appropriate to live in an assisted living facility; or
(iii) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility.
b. A mental health resident returning to a facility from treatment in a hospital or crisis stabilization unit (CSU) will not be considered a new admission and not require a new assessment. However, a break in a resident ' s continued residency which requires the facility to execute a new resident contract or admission agreement will be considered a new admission and the resident ' s mental health care provider must

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provide a new assessment.
3. A Community Living Support Plan.
a. Each mental health resident and the resident ' s mental health case manager shall, in consultation with the facility administrator, prepare a plan within 30 days of the resident ' s admission to the facility or within 30 days after receiving the appropriate placement assessment under paragraph (c), whichever is later, which:
(i) Includes the specific needs of the resident which must be met in order to enable the resident to live in the assisted living facility and the community;
(ii) Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident ' s needs, and the frequency and duration of such services;
(iii) Includes any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident ' s needs, and the frequency and duration of such services and activities;
( ) Includes the of the facility to facilitate and assist the resident in attending appointments and arranging transportation to appointments for the services and activities identified in the plan which have been provided or arranged for by the resident ' s mental health care provider or case manager;
(v) Includes a description of other services to be provided or arranged by the facility;
(vi) Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms , to the resident that indicate the immediate need for professional mental health services;
(vii) Is in writing and signed by the mental health resident, the resident ' s mental health case

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manager, and the ALF administrator or manager and a copy placed in the resident ' s file. If the resident refuses to sign the plan, the resident ' s mental health case manager shall add a statement that the resident was asked but refused to sign the plan;
(viii) Is updated at least annually;
(ix) [illegible] include the [illegible] Agreement described in subparagraph 4. If included, the mental health care provider must also sign the plan; and
(x) Must be available for inspection to those who have a lawful basis for reviewing the document.
b. Those portions of a service or treatment plan prepared pursuant to Rule 65E-4.014, F.A.C., which address all the elements listed in sub-subparagraph a. above may be substituted.
4. [illegible] Agreement. The mental health care provider for each mental health resident and the facility administrator or designee shall, within 30 days of the resident ' s admission to facility or receipt of the resident ' s appropriate placement assessment, whichever is later, prepare a written statement which:
a. Provides procedures and directions for accessing emergency and after-hours care for the mental health resident. The provider must furnish the resident and the facility with the provider ' s 24-hour emergency crisis telephone number.
b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services under Section 409.912, F.S.
c. [illegible] cover all mental health residents of the facility who are clients of the same provider.
d. [illegible] be included in the Community Living Support Plan described in subparagraph 3.

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Missing documentation shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Family Services, or the mental health care provider under contract to provide mental health services to clients of the department.

This Statute or Rule is not met as evidenced by:
Based on record review and interview the assisted living facility failed to have a signed annual living support plan for 4 out of 4 (#1, #2, #3, and #5) sampled residents.

Findings include:

Record review found that resident #1 who was admitted to the facility on / did not sign his annual community living support plan within 30 days of admission.

Record review found that resident #2 who was admitted to the facility on did not sign his annual community living support plan within 30 days of admission.

Record review found that resident #3 who was admitted to the facility on did not sign her annual community living support plan within 30 days of admission.

Record review found that resident #5 who was admitted to the facility on did not sign her annual community living support plan within 30 days of admission.

Interview with the assistant administrator on

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AL241	Continued From page 23 at 2:06 p.m. confirmed that residents #1, #2, #3, and #5 did not sign there annual living support plans. Class III	AL241		
AL243 SS=D	58A-5.0191(8) FAC LMH - Training (8) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to Section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility ' s receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Staff in " direct contact " means direct care staff and staff whose duties take them into resident living areas and require them to interact with mental health residents on a daily basis. The term does not include maintenance, food service or administrative staff, if such staff have only incidental contact with mental health residents. c. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to Section 429.52(4), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics:	AL243		

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a. Mental health diagnoses; and
b. Mental health treatment such as mental health needs, services, behaviors and appropriate interventions; resident progress in achieving treatment goals; how to recognize changes in the resident ' s status or condition that may affect other services received or may require intervention; and crisis services and the procedures.
3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to Section 429.52(4), F.S., and subsection (1) of this rule.
4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement.
(b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility ' s personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files.

This Statute or Rule is not met as evidenced by:
Based on personnel record review and interview the assisted living facility failed to ensure that 1 out of 3 (#1) sampled staff members received limited mental health training within six months of employment provided by or approved by the Department of Children and Family Services.

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Findings include:

Record review found that staff #1 (caretaker; application date) who provided direct care to residents did not have any documentation of having a minimum of 6 hours training in limited mental health training within 6 months of employment.

Interview with the assistant administrator on at 1:53 p.m. confirmed that staff #1 did not have the training. She stated that she contacted DCF and was waiting for a respond.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Jas Manor
645 Northeast 131st Street
North Miami, FL 33161

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2012 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe.

Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
XG90

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

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone (305) 593-3100; Fax (305) 593-3121