

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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 Standard Biennial Licensure survey was conducted on _____ at Vicky's Assisted Living Facility with a Limited Mental Health (LMH) component. At the time of the survey, the following deficiencies were identified: A007, A0078, A0079, A0162, and L241. Census: 5	A 000			
A 007 SS=D	58A-5.0181(1) FAC Admissions - Criteria Admission Procedures, Appropriateness of Placement and Continued Residency Criteria. (1) ADMISSION CRITERIA. An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing or limited mental health license: (a) Be at least _____ (b) Be free from signs and symptoms of any communicable _____ which is likely to be transmitted to other residents or staff; however, a person who has _____ () _____ may be admitted to a facility, provided that he would otherwise be eligible for admission according to this rule. (c) Be able to perform the activities of daily living, with supervision or assistance if necessary. (d) Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. (e) Be capable of taking his/her own medication with assistance from staff if necessary. 1. If the individual needs assistance with self-administration the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance, and if unlicensed staff will be providing such assistance, obtain the resident ' s or the resident ' s surrogate, guardian, or attorney-in-fact ' s	A 007			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6800

L3ML11

If continuation sheet 1 of 18

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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 007	Continued From page 1 written informed consent to provide such assistance as required under Section 429.256, F.S. 2. The facility may accept a resident who requires the administration of medication, if the facility has a nurse to provide this service, or the resident or the resident ' s legal representative, designee, surrogate, guardian, or attorney-in-fact contracts with a licensed third party to provide this service to the resident. (f) Any special dietary needs can be met by the facility. (g) Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under Chapters 490 or 491, F.S. (h) Not require licensed professional mental health treatment on a 24-hour a day basis. (i) Not be bedridden. (j) Not have any _____ or 4 pressure sores. A resident requiring care of a _____ pressure may be admitted provided that: 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a physician, or the resident contracts directly with a licensed home health agency or a nurse to provide care; 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 licensed nurse or physician, the resident shall be discharged from the facility. (k) Not require any of the following nursing services: 1. Oral, _____, or _____ suctioning; 2. Assistance with tube feeding; 3. Monitoring of _____ gases; 4. Intermittent positive pressure breathing	A 007			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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 007	Continued From page 2 or 5. Treatment of surgical or wounds, unless the surgical or and the condition which caused it have been stabilized and a plan of care developed. (l) Not require 24-hour nursing supervision. (m) Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C. (n) Have been determined by the facility administrator to be appropriate for admission to the facility. The administrator shall base the decision on: 1. An assessment of the strengths, needs, and preferences of the individual, and the medical examination report required by Section 429.26, F.S., and subsection (2) of this rule; 2. The facility's admission policy, and the services the facility is prepared to provide or arrange for to meet resident needs; and 3. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established under Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C. (o) Resident admission 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 and interview, the facility failed to ensure that 1 out of 5 (resident #4) residents meet minimum criteria in order to be admitted to a facility. Findings Include: Observations on - at approximately 9:09 AM found a hoier lift located in # hanging	A 007		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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 007	Continued From page 3 over the bed. In an interview with there administrator on at approximately 11:04 AM, she stated resident #4 had an aneurysm five years ago and has been using it since he has been at the facility. She stated he uses it to pick himself up when he is lying down. She stated she is not sure what it is called and calls it the triangle. In an interview with the facility's physician on at approximately 1:57 PM, he stated that the device located in # is a hoier lift. Class III	A 007			
A 078 SS=D	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Newly hired staff shall have 30 days to submit a statement from a health care provider, based on a examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable including . Freedom from must be documented on an annual basis. A person with a positive test must submit a health care provider's statement that the person does not constitute a risk of communicating . Newly hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in service. If any staff member is later found to have, or is suspected of having, a communicable , he/she shall be removed from duties until the administrator determines that such condition no longer exists. (b) All staff shall be assigned duties consistent with his/her level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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 4 shall 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) Staff provided by a staffing agency or employed by a business entity contracting to provide direct or indirect services to residents must be qualified for the position in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor shall specifically describe the services the staffing agency or contractor will be providing to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility shall: 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. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 out of 3 (administrator) sampled staff members have freedom from _____ () documented on an annual basis. Findings Include: Personnel record review of the administrator, whose application was dated _____, found a free from communicable _____ statement dated _____ with no reference to having a test completed. Record review also revealed that a free from communicable _____ statement dated _____ which included a test.	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED																						
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032																								
(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 5 In an interview with the administrator on at approximately 10:36 AM, she stated she will fax the results because she stated she had a chest X-ray done. She stated she does not know why it was not included with the free from communicable statement because she goes to the same doctor every year. Class III	A 078																								
A 079 SS=D	58A-5.019(4) FAC Staffing Standards - Levels (4) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities shall maintain the following minimum staff hours per week: <table border="0"> <tr> <td>Number of Residents</td> <td>Staff Hours/Week</td> </tr> <tr><td>0-5</td><td>168</td></tr> <tr><td>6-15</td><td>212</td></tr> <tr><td>16-25</td><td>253</td></tr> <tr><td>26-35</td><td>294</td></tr> <tr><td>36-45</td><td>335</td></tr> <tr><td>46-55</td><td>375</td></tr> <tr><td>56-65</td><td>416</td></tr> <tr><td>66-75</td><td>457</td></tr> <tr><td>76-85</td><td>498</td></tr> <tr><td>86-95</td><td>539</td></tr> </table> For every 20 residents over 95 add 42 staff hours per week. 2. At least one staff member who has access to facility and resident records in case of an emergency shall be within the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 3. In facilities with 17 or more residents, there shall be at least one staff member awake at all	Number of Residents	Staff Hours/Week	0-5	168	6-15	212	16-25	253	26-35	294	36-45	335	46-55	375	56-65	416	66-75	457	76-85	498	86-95	539	A 079		
Number of Residents	Staff Hours/Week																									
0-5	168																									
6-15	212																									
16-25	253																									
26-35	294																									
36-45	335																									
46-55	375																									
56-65	416																									
66-75	457																									
76-85	498																									
86-95	539																									

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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 079	Continued From page 6 hours of the day and night. 4. At least one staff member who is trained in First Aid and _____, as provided under Rule 58A-5.0191, F.A.C., shall be within the facility at all times when residents are in the facility. 5. During periods of temporary absence of the administrator or manager when residents are on the premises, a staff member who is at least _____, must be designated in writing to be in charge of the facility. 6. Staff whose duties are exclusively building maintenance, clerical, or food preparation shall not be counted toward meeting the minimum staffing hours requirement. 7. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 8. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, shall have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 58A-5.0182, F.A.C. (c) The facility must maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules for direct care staff available to residents or	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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 079	Continued From page 7 representatives, specific to the resident ' s care. (d) The facility shall be required to provide staff immediately when the Agency determines that the requirements of paragraph (a) are not met. The facility shall also be required to immediately increase staff above the minimum levels established in paragraph (a) if the Agency determines that adequate supervision and care are not being provided to residents, resident care standards described in Rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents ' contracts. The Agency shall consult with the facility administrator and residents regarding any determination that additional staff is required. 1. When additional staff is required above the minimum, the agency shall require the submission, within the time specified in the notification, of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met. The plan shall be reviewed by the agency to determine if the plan will increase the staff to needed levels and meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, modifications may be made in staffing requirements for the facility and the facility shall no longer be required to maintain a plan with the agency. 3. Based on the recommendations of the local fire safety authority, the Agency may require additional staff when the facility fails to meet the fire safety standards described in Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the Agency that fire safety requirements are being met. (e) Facilities that are co-located with a nursing	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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 079	Continued From page 8 home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of Rule 58A-5.029, 58A-5.030, or 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview the assisted living facility failed to maintain a written work schedule which reflected 24 hour staffing pattern. Findings Include: Observations on : at approximately 8:58 AM found only staff #2 and her husband present at the facility. Record review of the facility staffing schedule for : 2012 revealed staff #1 was scheduled to be at the facility on : from 7:00 AM to 7:00 PM. In an interview with the administrator on : at approximately 9:58 AM, she stated staff #2 is currently sick and she has been out since Sunday (:). Class III 58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records shall be maintained on the premises and include:	A 079		
A 162 SS=D		A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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 162	Continued From page 9 (a) Resident demographic data as follows: 1. Name; 2. ...; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance ...; 8. Name, address, and telephone number of next of kin, responsible party, or other person the resident would like to have notified in case of an emergency, and relationship to resident; and 9. Name, address, and phone number of health care provider, and case manager if applicable. (b) A copy of the medical examination described in Rule 58A-5.0181, F.A.C. (c) Any health care provider's orders for medications, nursing services, therapeutic diets, ... or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) A signed statement from a resident refusing a therapeutic diet pursuant to Rule 58A-5.020, F.A.C. (e) The resident record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A weight record which is initiated on admission. Information may be taken from the resident's health assessment. Residents receiving assistance with the activities of daily living shall have their weight recorded semi-annually. (g) For facilities which will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract.	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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 162	Continued From page 10 (h) For facilities which manage a pill organizer, assist with self-administration of medications or administer medications for a resident, the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract, as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, or staff, or representative thereof serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required under Section 429.27, F.S. (k) For any facility which maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required under Section 429.27, F.S. (l) A copy of Alternate Care Certification for () Form, CF-ES 1006, 1998, if the resident is an recipient. The absence of this form 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. (m) Documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required under Rule 58A-5.0181, F.A.C. (o) For apartments, duplexes, quadruplexes, or single family homes that are designated for independent living but which are licensed as assisted living facilities solely for the purpose of delivering personal services to residents in their	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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 162	Continued From page 11 homes, when and if such services are needed, record keeping on residents who may receive meals but who do not receive any personal, limited nursing, or extended congregate care service shall be limited to the following: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required under this subsection; 3. The medical examination described in Rule 58A-5.0181, F.A.C.; 4. The resident 's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider 's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (p) Except for resident contracts which must be retained for 5 years, all resident records shall be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents shall be provided a copy of their resident records upon departure from the facility. (q) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 2 out of 2 (resident #4, #5) sampled resident record reviews included documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney.	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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 162	Continued From page 12 Findings Include: Record review of resident #4's file revealed resident #4's cousin was signing his paperwork which included the facility contract dated - and the informed consent to for unlicensed staff to assist with medications dated . Record review of resident #4's file also revealed the lack of documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney. Record review of resident #5's file revealed resident #5's son was signing her paperwork which included the facility contract dated . Record review of resident #5's file also revealed the lack of documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney. In an interview with the administrator on at approximately 11:15 AM, she stated resident #4's cousin is his guardian and he is the only family resident #4 has. She stated she does not have paperwork for guardianship for resident #4. In an interview with the administrator on at approximately 11:42 AM, she stated there is no paperwork for guardianship in resident #5's file because her son is having a hard time getting the paperwork and is currently working with his lawyers. Class III	A 162		
AL241 SS=0	58A-5.029(2) FAC LMH - Records (2) RECORDS.	AL241		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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
AL241	Continued From page 13 (a) A facility with a limited mental health license shall maintain an up-to-date admission and 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	AL241			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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
AL241	Continued From page 14 making that determination. (i) The resident is eligible for, is receiving, or has 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	AL241		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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	
AL241	Continued From page 15 will be considered a new admission and the resident ' s mental health care provider must 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;	AL241			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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
AL241	Continued From page 16 (vii) Is in writing and signed by the mental health resident, the resident's mental health case 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) include the 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. 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. cover all mental health residents of the facility who are clients of the same provider.	AL241		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VICKY'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 12438 S W 266 LANE HOMESTEAD, FL 33032		
(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
AL241	Continued From page 17 d. be included in the Community Living Support Plan described in subparagraph 3. 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 facility failed to clearly identify 1 out of 1 (resident #1) sampled mental health residents as a mental health resident on an admission and discharge log. Findings Include: Record review of the facility's admission and discharge log revealed resident #1, who was admitted to the facility on , was not clearly identified as a mental health resident. In an interview with the admission on : at approximately 10:04 AM, she stated resident #1 was the only mental health resident currently residing at the facility. She stated the facility does not have a separate admission and discharge log for mental health residents and acknowledged that resident #1 was not clearly identified on the facility's admission and discharge log as a mental health resident. Class III	AL241			



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Vicky's Alf
12438 S W 266 Lane
Homestead, FL 33032

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