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
	AL11963986	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM HOME INC	158 WEST 8TH STREET HIALEAH, FL 33010

(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 A Complaint (CCR # 2012010142) Follow-up Survey was completed at Adam Home Inc with Limited Mental Health (LMH) component on . The following deficiencies were found uncorrected at the time of survey: A 054 and L 241.	{A 000}		
{A 054} SS=D	58A-5.0185(5) FAC Medication - Records (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 physician ' s annual evaluation of the use of the medication.	{A 054}		

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{A 054}	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview the assisted living facility failed to ensure that 1 out of 6 (#3) sampled residents medication observation records were initialed only when the medication was given to the resident. Findings include: Medication review on [redacted] at 11:48 a.m. found that resident #3 had [redacted] which was stored by the facility. The [redacted] label stated [redacted] 55 units in the morning and 33 units at night. Record review found that the facility's medication observation records for resident #3 were initialed for [redacted] administration by staff in [redacted] and [redacted]. Record review found that the facility did not have any documentation that a nurse or home health agency was providing [redacted] administration to resident #3. Record review found that resident #3's doctor order [redacted] for her on [redacted]. Interview with the administrator on [redacted] at 2:48 p.m. confirmed that resident #3's medication observation record for the months of [redacted] and [redacted] were initialed by the facility for [redacted]. Uncorrected Deficiency Class III	{A 054}		
{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 discharge log containing the names and dates of	{AL241}		

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{AL241}	Continued From page 2	{AL241}		

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 received state funded services from the

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{AL241}	Continued From page 3 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 provide a new assessment.	{AL241}		

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{AL241}	Continued From page 4 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 manager, and the ALF administrator or manager	{AL241}		

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{AL241}	Continued From page 5	{AL241}		

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.
d. be included in the Community Living Support Plan described in subparagraph 3.
Missing documentation shall not be considered a

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{AL241}	Continued From page 6	{AL241}		

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 ensure that 2 out of 6 (#2 and #5) sampled residents had a completed annual Community Living Support Plan.

Findings include:

Record review found that resident #2 who received and diagnosed with Psych (health assessment dated did not have a signed annual community living support plan by the resident's doctor or case manager and the facility's administrator. Record review found that resident #5 who received and diagnosed with did not have an annual living support plan. Record review found that resident #5's last plan was completed and dated

Interview with the administrator and staff #2 on at 2:32 p.m. confirmed that the support plan was not signed by the provider and the administrator. She stated that resident #2's doctor needs to sign the plan. The administrator and staff #2 stated on 2:39 p.m. that resident #5's 'case manager is but they will call PACE to complete another plan for him.

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{AL241}	Continued From page 7 Uncorrected Deficiency Class III	{AL241}		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11963986	A. Building B. Wing	

Name of Facility	Street Address, City, State, Zip Code
ADAM HOME INC	158 WEST 8TH STREET HIALEAH, FL 33010

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 A0030 Reg. # 58A-5.0182(6) FAC; 429.28 LSC	Correction Completed	ID Prefix A0032 Reg. # 58A-5.0182(8) FAC LSC	Correction Completed 12/04/2012	ID Prefix A0077 Reg. # 58A-5.019(1) FAC LSC	Correction Completed
ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	Correction Completed 12/04/2012	ID Prefix A0161 Reg. # 58A-5.024(2) FAC LSC	Correction Completed 12/04/2012	ID Prefix A0165 Reg. # 429.23 FS; 58A-5.0241 FAC LSC	Correction Completed 12/04/2012
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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: Krystal Granter	Date: 12/12/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: _____

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Adam Home Inc
158 West 8th Street
Hialeah, FL 33010

CCR#2012010142 f/u

Dear Administrator:

This letter reports the findings of a revisit survey to a complaint conducted on , 2012by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references the uncorrected deficiencies and/or new deficiencies, identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2013.**

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

BBT7

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