

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966853</b>            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JORGE'S HOME INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15172 SW 13TH TERRACE<br/>MIAMI, FL 33194</b> |                                                                                                                          |                               |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE      |
| A 000                                                       | Initial Comments<br><br>A Standard Biennial survey was conducted on<br>. Jorge's Home Assisted Living Facility<br>had deficiencies found at the time of the visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A 000                                                                                     |                                                                                                                          |                               |
| AL243<br>SS=D                                               | 58A-5.0191(8) FAC LMH - Training<br><br>(8) LIMITED MENTAL HEALTH TRAINING.<br>(a) Pursuant to Section 429.075, F.S., the<br>administrator, managers and staff, who have<br>direct contact with mental health residents in a<br>licensed limited mental health facility, must<br>receive the following training:<br>1. A minimum of 6 hours of specialized training in<br>working with individuals with mental health<br>diagnoses.<br>a. The training must be provided or approved by<br>the Department of Children and Families and<br>must be taken within 6 months of the facility's<br>receiving a limited mental health license or within<br>6 months of employment in a limited mental<br>health facility.<br>b. Staff in "direct contact" means direct care<br>staff and staff whose duties take them into<br>resident living areas and require them to interact<br>with mental health residents on a daily basis. The<br>term does not include maintenance, food service<br>or administrative staff, if such staff have only<br>incidental contact with mental health residents.<br>c. Training received under this subparagraph may<br>count once for 6 of the 12 hours of continuing<br>education required for administrators and<br>managers pursuant to Section 429.52(4), F.S.,<br>and subsection (1) of this rule.<br>2. A minimum of 3 hours of continuing education,<br>which may be provided by the ALF administrator<br>or through distance learning, biennially thereafter<br>in subjects dealing with one or more of the<br>following topics:<br>a. Mental health diagnoses; and | AL243                                                                                     |                                                                                                                          |                               |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

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If continuation sheet 1 of 3

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>JORGE'S HOME INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15172 SW 13TH TERRACE<br/>MIAMI, FL 33194</b>                                |                          |                               |
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| AL243                                                       | <p>Continued From page 1</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain documentation of having completed at least 3 hours training of Limited Mental Health continuing education for 3 out of 3 facility staff (Staff #1, #2 #3).</p> <p>The findings include:</p> | AL243                                                                          |                                                                                                                          |                          |                               |

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| AL243                                                       | <p>Continued From page 2</p> <p>Record review for Staff #1, #2 and #3 had no documentation of a minimum of having completed at least 3 hours training of Limited Mental Health continuing education.</p> <p>On _____ at about 2:30 p.m. the administrator stated that Staff #1, #2 and #3 had not taken a minimum of 3 hours training of Limited Mental Health continuing education.</p> <p>Class: III</p> | AL243                                                                          |                                                                                                                          |                          |                               |



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

, 2013

Administrator  
Jorge's Home Inc  
15172 Sw 13th Terrace  
Miami, FL 33194

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2013 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

