

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER OUR DREAM RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1630-1640 PALM AVENUE 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)	
A 000	Initial Comments A Complaint (CCR #2013004109) Investigation Survey was conducted on _____, 2013. Our Dream Retirement Home had a deficiency found at the time of the survey.		A 000		
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 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		AL241		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

5599

X71611

If continuation sheet 1 of 6

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AL241	Continued From page 1 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 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 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	AL241			

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AL241	Continued From page 2 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. 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	AL241			

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AL241	Continued From page 3 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 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	AL241			

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AL241	Continued From page 4 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 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 1 out of 7 (#2) sampled residents had a completed Annual Community Living Support Plan. Findings include: Record review found that resident #2 who received () and diagnosed with () type () on health assessment dated () did not have a completed annual community living support plan. Record review found that resident #2's last living support plan was dated () Interview with the administrator on () at ()	AL241	

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AL241	Continued From page 5 12:53 p.m. with the administrator and her daughter confirmed that resident #2's last living support plan was dated _____. Class III		AL241		



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Our Dream Retirement Home
1630-1640 Palm Avenue
Hialeah, FL 33010

Re: CCR #2013004109

Dear Administrator:

This letter reports the findings of a state complaint 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,

Kristal Branton
Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
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