STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911570	02/26/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Our Dream Retirement Home	1630-1640 Palm Avenue Hialeah, FL 33010	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D

Specific Tag Findings:

0000-Initial Comments

A Complaint Investigation Survey (CCR#2015000199) was conducted on . Our Dream Retirement Home had the following deficiency found at the time of the survey:

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC

Based on record review and interview the assisted living facility failed to follow the facility's elopement policy and procedure.

Findings included:

On . at 10:00 AM during record review found that Resident #1 left the facility on and the police were called to report him missing on . Record review found the facility did not complete the one day adverse incident to report Resident #1 missing till .

Record review found that the facility's elopement policy and procedure stated "Within the first 24 hours: 1. Upon notification that a resident is in fact missing, Administrative staff will contact all local hospitals, all jails, and any possible leads of where the resident may be. 2. All appropriate parties will be notified".

An interview with the Administrator on at 1:20 PM, acknowledged that the facility did not follow the policies and procedures as they are established in the facility.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March ', .

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

RE: CCR #2015000199

Dear Administrator:

This letter reports the findings of a Complaint Investigation survey that was conducted on February ', by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) 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 04/ 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure
XG90

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