STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965358	11/06/2015
NAME OF PROVIDER OR SUPPLIER **MOLINA'S ADULT CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **9830 SW 12 TERRACE** **MIAMI, FL 33174**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

A Limited Mental Health licensure expansion survey was conducted on / . Molina's Adult Care had the following deficiencies found at time of the survey:

0007 Admissions - Criteria

Based on record review and interview the facility failed to ensure that individuals' need can be met at the assisted living facility for 1 out of 5 (#3) sampled residents.
Findings included:
Record review on / showed Resident #3 (admitted on /)'s health assessment (form 1823) dated documented the resident's needs be can not be met in an assisted living facility. The question (section C) "in your professional opinion can this individual's needs be met in Assisted Living Facility (ALF), which is not a medical nursing or facility" was answered "no."
During an interview on / at 11:49 AM the Administrator acknowledged that the health assessment for Resident #3 stated that resident needs cannot be met at the ALF. She stated I will contact the physician.
Class III

0160 Records - Facility

Based on record review and interview the facility failed to have proof of a satisfactory health department inspection.
Findings included:
Review facility record on / showed a health department inspection report dated on . The facility did not have a current inspection report..
During an interview on / at 11:00 AM, the facility's Administrator stated that the facility has a satisfactory health department inspection but the documents were not in the facility at the time of the survey. Facility administrator searched at the facility board and new sanitation inspection report was not found.
Class III

L240 LMH - Licensing

Based on observation, record review, and interview the facility failed to have a Limited Mental Health(LMH) component on the license before admitting 1 out of 5 (#2) sampled residents.
Findings included:
Observation on / at 9:00 AM found Resident #2 in the facility's terrace.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965358	**11/06/2015**
NAME OF PROVIDER OR SUPPLIER **MOLINA'S ADULT CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **9830 SW 12 TERRACE** **MIAMI, FL 33174**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Record review found Resident #2 (admitted on)'s health assessment dated had the following diagnoses: . Another health assessment dated had the following diagnoses: and . Resident #2 also received optional stated supplementation ( ).
During an interview on // at 11:45 AM Resident #2 stated I'm receiving my for a year.
Record review found the facility admitted a mental health resident prior to have the LMH licensure component.
During an interview on // at 11:49 AM the Administrator acknowledged the facility admitted a limited mental health resident without the license component.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Molina's Adult Care
9830 Sw 12 Terrace
Miami, FL 33174

Dear Administrator:

This letter reports the findings of a limited mental health expansion licensure survey that was conducted on , 2015 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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