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
	AL11911395	A. BUILDING: _____ B. WING _____	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL PLAZA AT BLUE LAGOON	5617 NW 7 STREET MIAMI, FL 33126

(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 AMENDED: A biennial re-licensure and a complaint investigation (complaint numbers 2021006591, 2021017431, 2022000678, and 2022002806) was conducted at Residential Plaza at Blue Lagoon on to . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=H	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal	A 025		

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A 025	Continued From page 1 supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide personal supervision as appropriate for each resident and maintain a general awareness of the resident's whereabouts for two out of three sampled residents (Resident #1 and #2). Resident #1 eloped from the Memory Care Unit 14th floor and was located at a nearby fast-food restaurant gasping for air and rescue was called. Resident #2 eloped from the 8th floor and was found by law enforcement about 2.5 miles from the facility.	A 025		

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A 025	Continued From page 2 Findings include: 1} A review of the incident report filed by the facility on [redacted], showed that Resident #1 eloped on [redacted] at 5:30 PM. The incident report further showed that Resident #1 eloped from the 14th floor of the Memory Care Unit (MCU) a "secured environment" through the emergency exit. A Review of Resident #1's 1823 AHCA health assessment completed [redacted] showed that the resident was identified as at risk for elopement and [redacted]. The resident was diagnosed with [redacted] (HLD), [redacted]. Physical or Sensory Limitation: Unsteady Gait, Mild Hearing Loss. [redacted] or Behavioral Status: [redacted], Intermittent Episode of Agitation, and aggression. The resident need assistance with self -administration of medications. The resident ambulates with a cane and need supervision. Resident need supervision and one person assist with bathing and [redacted], and assistance with toileting. Observation on [redacted] at 10:00 AM showed the memory care unit; 14th floor with three emergency exits, front entrance leading in and out of the MCU, North exit and South Exit. Observation also showed to enter and exit the MCU from the front entrance, a key is required, and the North and South Entrances are alarmed and if exited, the alarm will be triggered. Observation also showed there were video cameras.	A 025		

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A 025	Continued From page 3 Interviewed on at 11:29 AM, Staff H stated, "There is no video of [Resident #1] elopement. Videos are stored up to 30 days, and then erased." Interviewed on at 11:32 AM Staff H stated, the facility did not have documentation/case number from rescue or police concerning Resident #1 elopement. Staff H stated, "As far as a police report or case number, we don't have one because she [Resident #1] left the facility only for an hour or more, and she was brought right by fire rescue and the police." Interviewed on at 2:44 PM, Staff N stated, "We have no maintenance record or log for the alarms on the door on the Memory Care Unit. We check the alarms every week. The alarms on the Memory Care Unit were working during the Month of . Staff I texted me the night the lady [Resident #1] left the facility." Interviewed on at 2:50 PM, Staff O stated, "I conduct air conditioning repairs, and I heard about someone [Resident #1] leaving the facility [ ], but I did not hear the alarm. But after she left, I tested the door and the alarms, and they worked." Interviewed on at 3:25 PM, Staff J stated, on , "My shift started from 2:00 PM-10:30 PM. I did not hear the alarm because I was taking care of another resident. The [Resident #1] was in the living room and in a couple of minutes she disappeared. There are four staff on the floor, two on each wing. We check on the residents every two hours. The [Resident #1] is always by the doors. After the	A 025		

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A 025	Continued From page 4	A 025		

elopement, the alarms were changed, and we discussed [Resident #1] case. I received some training. If the resident is sitting down, we would keep an _ on her and if she moved, we would watch her, but the other staff was taking care of another resident at the time she left."

Interviewed on at 11:29 AM, Staff P stated, "I worked on the 14th floor. I was working that day [ ]. Resident #1 asked to use the bathroom and went out the exit door."

Interviewed on . . . . . at 11:50 AM, the Administrator stated, Resident #1 exited the facility from the Memory Care Unit at 5:30 PM. The Administrator stated the staff reported the elopement to the team leader. The Administrator stated, on ," The staff called me, and I reviewed the cameras. She exited on the south side. The alarm went off at 5:42 PM. The staff did a floor check and identified the resident was not inside the facility. She [Resident #1] was brought . . . by fire rescue/police. We have an elopement risk list. The resident is identified as an elopement risk. All memory care residents are on the elopement risk list. All my staff conduct rounds on the general residents and elopement risks residents every two hours and additional rounds for elopement risks residents. The alarms are only on the 13th and 14th floors. Residents are educated to sign-in and out. When we search the building, we search the stairs too. We don't have any videos because it erases every 30 days but there are cameras on the exits. The Memory Care Unit Staff have a key to turn off the alarm. I don't know who turned off the alarm."

Interviewed on at 12:31 PM, Staff I (Director of Memory Care Program) stated, "I was on the floor to put out the schedules after 5:00

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A 025	Continued From page 5 PM. The staff asked me to watch the floor. It was about two to three minutes. The [Resident #1] asked to use the bathroom in her room. When she did not return, we initiated the search. She left out the emergency exit. She ambulates well. The team leader was notified. The team leader had staff from other floors conduct the search. The memory care staff don't leave their floors. I don't recall hearing the alarm. Every time there is a shift change, we check the alarms. " Review of the fire rescue report (received on [illegible]) dated [illegible] at 18:04:59 showed, "Rescue was dispatched for a lady [Resident #1] that was gasping for air at a [fast food restaurant]. Upon arrival the [patient] was QRU and seemed to have and lost. was lost and had no ID [Identification]. Rescue waved down PD [police department] and asked about a missing person. While talking to PD, PD was notified for a missing person that left [a facility] x 1 hour ago. Missing person was the and she was taken to her residence. No [Emergency Medical Services] were required." 2} A review of the incident report filed by the facility on showed that Resident #2 eloped on . The incident report showed that Staff E identified him (Resident #2) as missing from his unit at 6:30 AM, and the entire building was checked because the camera footage could not confirm if the resident had left the building. The incident report filed by the facility stated that the Administrator reviewed the camera and reported Resident #2 to law enforcement as missing.	A 025		

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A 025	Continued From page 6 A review of the Resident#2's demographic sheet showed he was admitted on . . . . . A review of Resident #2 facility admission assessment completed on . . . . . showed a diagnosis of type II, , Depressed, Essential , , ... , and . . . . of the Type. The resident was not identified as an elopement risk. The resident was prescribed a cane and rolling walker. The resident needed assistance in ambulation, , and transferring. The resident needed supervision in bathing, grooming and toileting, but independent in eating. The resident needed assistance with self-administration of medication. Resident #2's Medication Observation Record (MOR) showed that the resident was prescribed and missed taken the following medications (due to the elopement on . . . . .): . . . . . 20 mg (used for and triglyceride levels) bedtime, ... 10 mg (memory loss) 8:00 AM, . . . SOD 10 mg (prevent and treat . . . .) 8:00 AM, ... 45 mg ( )v8:00 AM, ... 50 mg (. . . . .) 8:00 AM New Order . . . . . 2 mg (, ,) 8:00 PM. On at 12:01 PM Resident #2 stated, "I have been here[at facility] for two months. I wanted to go to my house because I have nothing to do here but watch television. I left the facility[unable to recall date] around 12:00 AM-1:00 AM. I walked down the hallway and I did not know whether the staff was asleep. I got on the elevator and went down to the first floor and then went to the second floor and to the first	A 025		

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A 025	Continued From page 7 floor. I walked down the hall to the exit door and walked outside. Nobody [the staff] saw me when I was leaving. I walked and then I saw and talked to a police officer, and they[police officer] brought me . . . ." Interviewed on . . . . . at 9:58 AM, Staff Q (Case Manager) stated, "I was assigned to him [Resident #2] about 2 months ago. When the camera was reviewed, they saw him on the first floor, then he went . . . to the second floor. We believe he left the building through the sides, and he was not showing any signs that he was an elopement risk. He took the elevator to the 2nd floor from the 8th floor the morning of his elopement, climbed the tree and jumped the fence. Then he went down to the first floor, but he saw the staff and went to the 2nd floor. His granddaughter said that he has these episodes at the end of the month because of his wife. The day of the elopement [. . . . .] family came with flyers and the police found the resident down the street. When he returned to the facility, he was placed on the Memory Care Unit. He tried to leave from the Memory Care Unit again, but it has an alarm. He is considered an elopement risk." Interviewed on . . . . . at 12:47 PM, Staff L stated on Resident #2, "was not in his, room on the 8th floor. When I arrived, I did not see the staff that was working on the 8th floor. My shift is 5:30 AM-2:00 PM. When I was conducting my rounds, I found out that the resident was not in his room at 5:47 AM. When I noticed he was missing, I called the team leader and went looking for the resident. I don't remember if training was done for this elopement. I take care of 11 residents on the 8th floor. He was on the Memory Care Unit for two weeks."	A 025		

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A 025	Continued From page 8 Interviewed on at 11:50 AM, the Administrator stated, "he [Resident #2] told the staff he jumped the fence when he eloped. I called the City of Miami Police. They did not want to take a report. They sent a service aide. The family was here with the resident. The granddaughter has the police case number. He (Resident #2) jumped the fence. The resident is ", it is possible. He ambulates with a cane. He was found downtown. When he returned, he was placed on the Memory Care Unit. The granddaughter purchased an Apple Watch to monitor him, and it is only accessible to the family. This elopement occurred because the family took his cellular phone. We don't have it. Resident #2 was placed on the elopement list." The Administrator stated all staff conducts rounds on the elopement risk residents every two hours. Review of the police report (received), dated showed, "Missing person [Resident #2] was seen on video surveillance at a gas station at around 6:14 AM, approximately 2.5 miles from the facility. Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support	A 032		

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A 032	Continued From page 9 and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises,	A 032		

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A 032	Continued From page 10 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow the elopement standards and include as part of its resident elopement response policies and procedures, at a minimum, a daily effort to determine that at risks residents have identification on their persons that includes their name and facility's name, address, and telephone number. Resident#1 eloped from the 14th floor memory care unit of the facility and was found at a fast-food restaurant, rescue arrived and found resident to have no identification. The facility identified Resident #1 as elopement risk and resident did not have her name, facility's name, address, and telephone number on her person. Findings Included : A review of the incident report filed by the facility on [redacted], showed that Resident #1 eloped on [redacted] at 5:30 PM. The incident report further showed that Resident #1 eloped from the 14th floor of the Memory Care Unit (MCU) a	A 032		

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A 032	Continued From page 11 "secured environment" through the emergency exit. A Review of Resident #1's Health Assessment Completed [redacted] showed that the resident was identified as at risk for elopement and [redacted]. The resident was diagnosed with [redacted]'s [redacted], HLD, [redacted], [redacted]. Physical or Sensory Limitation: Unsteady Gait, Mild Hearing Loss. [redacted] or Behavioral Status: [redacted], Intermittent Episode of Agitation, and aggression. The resident need assistance with self -administration of medications. The resident ambulates with a cane and need supervision. Resident need supervision and one person assist with bathing and [redacted], and assistance with toileting. Review of the fire rescue report (received on [redacted]), dated [redacted] at 18:04:59 showed, "Rescue was dispatched for a lady [Resident #1] that was gasping for air at a [fast food restaurant]. Upon arrival the [patient] was QRU and seemed to have [redacted] and lost. [redacted] was lost and had no ID [Identification]. Rescue waved down PD [police department] and asked about a missing person. While talking to PD, PD was notified for a missing person that left [a facility] x 1 hour ago. Missing person was the and she was taken [redacted] to her residence. No [Emergency Medical Services] were required." Interviewed on [redacted] at 11:50 AM, the Administrator stated, Resident #1 exited the facility from the Memory Care Unit at 5:30 PM. The Administrator stated the staff reported the elopement to the team leader. The Administrator stated, on [redacted]," The staff called me, and I	A 032		

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A 032	Continued From page 12 reviewed the cameras. She exited on the south side. The alarm went off at 5:42 PM. The staff did a floor check and identified the resident was not inside the facility. She [Resident #1] was brought . . . by fire rescue/police. We have an elopement risk list. The resident is identified as an elopement risk. All memory care residents are on the elopement risk list. All my staff conduct rounds on the general residents and elopement risks residents every two hours and additional rounds for elopement risks residents. The alarms are only on the 13th and 14th floors. Residents are educated to sign-in and out. When we search the building, we search the stairs too. We don't have any videos because it erases every 30 days but there are cameras on the exits. The Memory Care Unit Staff have a key to turn off the alarm. I don't know who turned off the alarm." Review of the facility records and elopement response polices & procedures showed no documentation that the facility would ensure at a minimum, a daily effort to determine that at risks residents have identification on their persons that includes their name and facility's name, address, and telephone number. Class III	A 032		
A 033 SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . . . . . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use;	A 033		

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	AL11911395	A. BUILDING: ______ B. WING ______	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL PLAZA AT BLUE LAGOON	**5617 NW 7 STREET MIAMI, FL 33126**

(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 033	Continued From page 13	A 033		

2. The maximum amount of time the resident is to have the applied each day; and,
3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed

(b) Facility staff must ensure that the device is applied appropriately and safely.
(c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to have a written care plan for the use of the physical for two out of 30 sample residents (Resident #11 and Resident #12).

Finding include:

A)

A review of Resident #11 1823 AHCA health assessment dated , showed that the resident has a medical history and diagnosis of , , and . The resident is under hospice care.

A review of Resident #11 medical order dated , showed that the resident has an order for full side rails.

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A 033	Continued From page 14 A review of Resident #11 medical record showed that the resident representative signed the consent for full bed rails on . Further review of Resident #11 medical record showed there was no documentation of a written care plan. B) A review of Resident #12 1823 AHCA health assessment dated showed that the resident has a medical history and diagnosis of , , , , , , and . The resident is under hospice care. A review of Resident #12 Hospice record dated , showed that the resident has a medical order for full bed rails. Further review of Resident #12 record showed that the resident representative signed the consent for full bed rails on Further review of Resident #12 medical record showed there was no documentation of a written care plan. C) In an interview with Staff G on at 12:25 PM, Staff G acknowledged that Resident #11 and Resident #12 did not have written care plans in their files. Class III	A 033		

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A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of	A 093		

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A 093	Continued From page 16 the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal.	A 093		

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A 093	Continued From page 17 Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation and interviews, the facility failed to offer snacks for all residents at least once per day. Findings included: Observation on at 9:30 AM showed the residents did not have access to the dining area and kitchen. The dining area was locked due to renovations. On at 11:12 AM, Resident #16 stated	A 093		

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A 093	Continued From page 18 she does not receive snacks. On [redacted] at 11:16 AM, Resident #17 stated, "They don't give snacks." On [redacted] at 12:05 PM, Staff U stated, "The residents receive breakfast, lunch, and dinner. We do not have enough staff to serve snacks to the residents." Class III	A 093		
AL243 SS=D	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a	AL243		

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AL243	Continued From page 19 licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) 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. 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(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact	AL243		

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AL243	Continued From page 20 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. (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. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility with limited mental health component failed to ensure staff receive a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses within six months of employment for one out of 7 sampled staff (Staff D). Findings included: Review of the facility license showed the facility hold a limited mental health component. Review of Staff D's record showed a hired date on . . . . . There was no documentation having completed a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses within six months of employment in file. On . . . . . at 3:25 p.m. Staff H stated the LMH training has been schedule for Staff "D" for the date of	AL243		

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AL243	Continued From page 21 Class III	AL243		