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
	AL11966809	A. BUILDING: _____ B. WING _____	R 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALF VILLA FRANCISCO HOME CARE CORP	16832 SW 110 COURT MIAMI, FL 33157

(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 A revisit survey was conducted at ALF Villa Francisco Home Care from through . The provider had deficiencies at the time of the survey.	{A 000}		
{A 025} SS=D	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 supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	{A 025}		

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{A 025}	Continued From page 1 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 record review and interview, the facility failed to maintain a written record, updated as needed, of any significant illness that resulted in medical attention, or other changes that resulted in the provision of additional services for one (Resident #2) out of six sampled residents. The facility failed to notify the primary care physician (PCP) and psychiatrist of Resident #2's hospitalization. Findings: A review of Resident #2's hospital records dated revealed that the patient suffered for three weeks.	{A 025}		

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{A 025}	Continued From page 2 A review of Resident #2's progress notes showed no documentation that Resident #2 was experiencing for the past three weeks prior to hospitalization on , including notifying the primary care physician and psychiatrist. Interviewed on at 10:08 AM the Administrator stated that she did not notify the doctor. The Administrator stated, "It was her personal decision for her (Resident #2) to go to the hospital. It was mental and not physical. I am going to repeat myself; it was mental and not a physical issue." Interviewed on at 10:00 AM Resident #2's Psychiatrist stated that he does not recall the facility contacting him that Resident #1 was prior to her hospitalization on . Class III	{A 025}		
A 027 SS=G	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation.	A 027		

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A 027	Continued From page 3 (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to make arrangements for health care immediately for one out of six sampled residents who suffered from , for 27 days and was hospitalized for more than four days. Findings: A review of Resident #2's hospital records dated showed the following: "Presenting complaint. Patient states: , who arrived via [ambulance] from [assisted living facility] with complaints od , , patient reports endorsing , for approximately three weeks. The patient has not recently seen a physician." A review of the nurse's notes dated from the hospital showed when Resident #2 was asked in the past two weeks if she (Resident #2) wished she (Resident #2) was , Resident #2 replied, "Yes." Interviewed on at 9:55 AM when asked why she was hospitalized, Resident #2 stated that she was . Resident #2 stated that she (Resident #2) I told the Administrator that she was going to the [hospital]. Interviewed on at 10:08 AM the Administrator stated that she did not notify the doctor. The Administrator stated further, "It was her (Resident #2) personal decision to go to the hospital. It was mental and not physical. I am	A 027		

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A 027	Continued From page 4 going to repeat myself it was mental and not a physical issue." Interviewed on at 10:45 AM when informed during the exit conference that for three weeks Resident #2 was while in the facility and was hospitalized, the Administrator stated that Resident #2 was for 27 years. Interviewed on at 10:00 AM Resident #1's Psychiatrist stated that the first time he evaluated Resident #2 was , and it was an initial visit and that he (psychiatrist) does not recall the facility informing him of any previous behavior of for the past three weeks, which led to her (Resident #2) hospitalization on . The Psychiatrist stated that he had been Resident #2's psychiatrist since 2023. Interviewed on at 2:01 PM the Service Team Coordinator for Resident #2's primary care physician stated that the last visit for Resident #2 was a video call on and before that was . When asked if there were any reports made to the PCP about Resident #2's before her hospitalization on , the Service Team Coordinator stated that she does not know and that she would have to check. Interviewed on at 12:14 PM Resident #2 Social Worker stated that Resident #2 was hospitalized because she (Resident #2) had an acute episode of . When asked how long she was going through , the Social Worker stated that he did not have that information. The Social Worker stated, "She was not feeling well, and she went to the hospital."	A 027		

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A 027	Continued From page 5 A review of resident #2's health assessment dated showed diagnoses of , , , , , , . The physical status showed . The status showed . The activities of daily living showed independent with ambulation, bathing, , eating, self-care, toileting, and transferring. The resident needed assistance with self-administration of medications. The Cleveland Clinic states that an is a false perception of objects or events involving your senses: sight, sound, smell, touch and taste. seem real, but they are not. Chemical reactions and/or abnormalities in your causes happen when you hear voices or noises that don't really exist in reality. In some cases, they are temporary and harmless, while others, they may be a sign of a more serious mental health or condition. have many possible causes. It is important for people experiencing to talk about them with their family and health care team. are manageable with treatment and can become disturbing or dangerous if they are not treated. It is important to seek medical treatment for the issue. Class II	A 027		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container;	A 054		

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A 054	Continued From page 6 or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ␣ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a medication observation record (MOR) of any known ␣ , including the name of the primary care provider for one (Resident #2) out of six sampled residents. Findings: A review of Resident #2's medication observation record found a handwritten MOR without any	A 054		

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A 054	Continued From page 7 known ⌄ listed and two names recorded. However, the names did not have any titles listed. Photographic evidence obtained. A review of Resident #2's health assessment dated showed resident was ⌄ to sulfur and . . . Interviewed on . . . . at 10:45 AM the Administrator acknowledged during the exit conference that the MOR was handwritten and that the ⌄ were not listed. Class III	A 054		
{A 056} SS=G	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be	{A 056}		

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{A 056}	Continued From page 8 contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or	{A 056}		

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{A 056}	Continued From page 9 complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow a medication order from the emergency room physician after discharge from the hospital for treatment of , and , one of six sampled residents (Resident #2). The resident did not receive the medications as prescribed for three weeks. Findings: A review of Resident #2's hospital discharge records dated revealed the resident was admitted to the hospital for , and , and was	{A 056}		

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{A 056}	Continued From page 10 discharged with the following medications: 20 MG, 20 MG, 40 MG, 1 MG, 20 MG, 137 MG, , 20 MG, , 1 MG (twice a day), 10 MG, 500 MG, , 50 MG, 10 MG, , 40 MG, , 1 MG (morning), , 2 MG (bedtime), and 2 MG. In addition to the medication changes, the discharge instructions included: follow-up with a psychiatrist within seven days of discharge, follow-up with primary care physician within days of discharge for medical follow-up. Thirty day prescription of , , medications and other medications provided. Patient has been advised to seek urgent , care and/or return to the emergency department if presenting , symptoms recur. Interviewed on at 9:55 AM when asked why she was hospitalized, Resident #2 stated that she was . Resident #2 stated, "I was missing my medications. I told the Administrator, I was going to the [hospital]. I missed my , and ." A review of Resident #2's medication observation record (MOR) for the month of , showed , 1 MG (Morning) and , 2 MG (Bedtime) were not given after discharge from the hospital on , , , and and , was only given once per day after discharge. A review of Resident #2's MOR for the month of , showed , 1 MG and , 1 MG were given each only once per day instead of twice per day as amended by the hospital discharge instructions.	{A 056}		

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{A 056}	Continued From page 11 Interviewed on at 10:45 AM during the exit conference, when informed that the order from the hospital after Resident #2 was discharged, the Administrator stated that Resident #2 was discharged from the hospital in the afternoon and the medications were picked up the next day. The Administrator stated further that Resident #2 changes insurance, doctors and pharmacies every two weeks and that she had a right to do so. Interviewed on at 10:00 AM Resident #1's Psychiatrist stated at the Psychiatrist stated that he (Psychiatrist) had been her psychiatrist since 2023. The psychiatrist stated that Resident #2 had a very , case which has to be managed. The Psychiatrist stated that she (Resident #2) was receiving 1 MG of , and 1 MG and , 1 MG and that Resident #2's medications needed to be managed. The Psychiatrist stated further that this was a case that deserves professional experience. Interviewed on at 1:15 PM the Pharmacist stated that Resident #2 had an active order of , 0.5 MG at bedtime. The Pharmacist stated that the insurance company rejected , 2 MG on , , and . The Pharmacist stated that the hospital ordered 15 days of supply for , 2 MG. The Pharmacist stated that there was a discharge for , 2 MG on . He stated that the only active order was 0.5 MG at bedtime. He stated that the insurance would not cover two of the same medications. However, a review of Resident #2's progress notes showed no documentation that there were medications issues.	{A 056}		

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{A 056}	Continued From page 12 A review of data from the Mayo Clinic showed that is used to treat , , , or irritability associated with and treats . A review of Resident #2's health assessment dated showed diagnoses of , , , , , , , , . The physical status showed . The status showed . The activities of daily living showed independent with ambulation, bathing, , eating, self-care, toileting, and transferring. The resident needed assistance with self-administration of medications. Class II	{A 056}		
A 058 SS=D	429.42( ) FS; 59A-36.023(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the	A 058		

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A 058	Continued From page 13 agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 59A-36.023(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 59A-36.008, F.A.C., is documented by agency personnel pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of a class I or class II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written	A 058		

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A 058	Continued From page 14 notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to correct one Class II deficiency cited under a complaint investigation regarding medication labeling orders. The facility failed to list know _ on the medication observation record and follow orders from an emergency room physician after one out of six residents was discharged from the hospital. Therefore, the facility is required to contract the services of a licensed pharmacist or registered nurse who will provide at least quarterly consultation until the Agency for Health Care Administration determines that these services are no longer needed. Findings: A record review showed the facility was cited during a complaint investigation on for not following a change of direction for use of medication for Resident #1. A review of Resident #2's hospital records dated showed the resident (Resident #2) was prescribed , 1 MG twice daily and , 1 MG (Morning) and , 2 MG (Bedtime) at discharge. However, a review of the medication observation records showed the order was not followed.	A 058		

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A 058	Continued From page 15 A review of Resident #2's handwritten medication observation records showed no listed although the resident's health assessment listed that Resident #2 was to sulfur and . Interviewed on at 10:45 AM during the exit conference the Administrator acknowledged. Class III	A 058		
{A 162} SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or	{A 162}		

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{A 162}	Continued From page 16	{A 162}		

other services to be provided, supervised, or implemented by the facility that require a health care provider's order.
(d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable.
(e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C.
(f) A ␣ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ␣ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ␣ not be taken.
(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.
(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C.
(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C.
(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S.
(k) For any facility that maintains a separate trust fund to receive funds or other property belonging

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{A 162}	Continued From page 17	{A 162}		

to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S.
(l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families.
(m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.
(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C.
(o) The resident's , DH Form 1896, if applicable.
(p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement.
(q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period

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{A 162}	Continued From page 18 of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain accurate and complete health assessments for three (#2, #5, #6) out of six sampled residents. Findings: A review of Resident #2's health assessment dated showed section of the nursing treatment, , , service requirements and special precautions were not filled out. A reviewed of Resident #5's health assessment dated showed the ⌄ of the resident was not recorded. A review of Resident #6's health assessment dated showed section one of the nursing treatment, , , service requirements, was not filled out. Interviewed on at 10:21 AM during the exit conference, the Administrator wanted to know the health assessments that were missing information. Class III	{A 162}		

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{AL241}	Continued From page 19	{AL241}		
{AL241} SS=D	429.075( ); 59A-36.020(2) FAC LMH - Records 429.075 (3) A facility that has a limited mental health license must: (a) Have a copy of each mental health resident's community living support plan and the , agreement with the mental health care services provider or provide written evidence that a request for the community living support plan and the , agreement was sent to the Medicaid managed care plan or managing entity under contract with the Department of Children and Families within 72 hours after admission. The support plan and the agreement may be combined. (b) Have documentation provided by the department that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that has a limited mental health license or provide written evidence that a request for documentation was sent to the department within 72 hours after admission. (c) Make the community living support plan available for inspection by the resident, the resident's legal guardian or health care surrogate, and other individuals who have a lawful basis for reviewing this document. (d) Assist the mental health resident in carrying out the activities identified in the resident's community living support plan. (4) A facility that has a limited mental health license may enter into a , agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager.	{AL241}		

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{AL241}	Continued From page 20 59A-36.020 (2) RECORDS. (a) A facility with a limited mental health license must 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 in rule 59A-36.015, F.A.C., satisfies this condition provided that all mental health residents are clearly identified. (b) Staff records must contain documentation that designated staff have completed limited mental health training as required by rule 59A-36.011, F.A.C. (c) Resident records must include: 1. Documentation, provided by a mental health care provider within 30 days of the resident's admission to the facility, that the resident is a mental health resident as defined in section 394.4574, F.S., and that the resident is receiving social security , or supplemental security income and , as follows: a. An affirmative statement on the Alternate Care Certification for , , ( ) form, CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-03988, that the resident is receiving SSI or SSDI due to a mental , b. Written verification provided by the Social Security Administration that the resident is receiving SSI or SSDI for a mental . Such 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, or c. A written statement from the resident's case	{AL241}		

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{AL241}	Continued From page 21 manager or other mental health care provider that the resident is an adult with severe and persistent mental . The case manager or other mental health care provider must consider the following minimum criteria in making that determination: (I) The resident is eligible for, is receiving, or has received mental health services within the last 5 years, or (II) The resident has been diagnosed as having a severe or persistent 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 must be conducted by a psychiatrist, clinical psychologist, clinical social worker, , , nurse, or an individual supervised by one of these professionals. a. Any of the following documentation that contains the name of the resident and the name, signature, date, and license number, if applicable, of the person making the assessment, meets this requirement: (I) Completed Alternate Care Certification for , , ( ) form, , , CF-ES Form 1006, (II) Discharge Statement from a state mental hospital completed no more than 90 days before admission to the assisted living facility 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 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 will not be considered a new admission and	{AL241}		

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{AL241}	Continued From page 22 will not require a new assessment. However, a break in a resident's residency that 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. Each mental health resident and the resident's mental health case manager must, 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 in paragraph (2)(c), whichever is later, that: a. Includes the specific needs of the resident that must be met in order to enable the resident to live in the assisted living facility and the community, b. 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, c. 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, d. Includes the of the facility to facilitate and assist the resident in attending and arranging transportation to for the services and activities identified in the plan that have been provided or arranged for by the resident's mental health care provider or case manager, e. Includes a description of other services to be provided or arranged by the facility, f. 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	{AL241}		

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{AL241}	Continued From page 23 immediate need for professional mental health services, g. Is in writing and signed by the mental health resident, the resident's mental health case manager, and the assisted living facility 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 must add a statement that the resident was asked but refused to sign the plan, h. Is updated at least annually or if there is a significant change in the resident's behavioral health, i. , include the , Agreement described in subparagraph (2)(c)4. If included, the mental health care provider must also sign the plan; and, j. Must be available for inspection to those who have legal authority to review the document. 4. , Agreement. The mental health care provider for each mental health resident and the facility administrator or designee must prepare a written statement, within 30 days of the resident's admission to the facility or receipt of the resident's appropriate placement assessment, whichever is later. The statement: 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 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 in section 409.912, F.S.; c. , cover all mental health residents of the	{AL241}		

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{AL241}	Continued From page 24	{AL241}		

facility who are clients of the same provider; and,
d. , be included in the Community Living Support Plan described in subparagraph (2)(c)3.
5. Missing documentation will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the appropriate party. A documented request for such missing documentation made by the facility administrator within 72 hours of the resident's admission will be considered a good faith effort. The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to maintain an updated community living support plan and the , agreement annually for two (Residents #1 & #2) out of six sampled residents.

Findings:

A review of the admissions and discharge log revealed Residents #2 and #3 were listed as a mental health resident. Photographic information obtained.

A review of Resident #2's records found a community living support plan and , agreement dated was not signed by the Administrator. However, the Administrator signed the document.

A review of Resident #1's records found a community living support plan and , agreement dated was not updated

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{AL241}	Continued From page 25 annually as required. Interviewed on at 9:23 AM the Administrator stated that she (Administrator) was waiting for the legal guardian's signature. The Administrator stated, "It is at the doctor's office." Class III	{AL241}		