

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/14/2019
NAME OF PROVIDER OR SUPPLIER SHARON'S SENIOR SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2270 NW 64TH ST MIAMI, FL 33147		
(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
CZ809 SS=C	59A-35.062(3)(e)&(7);408.803(7) &.810(8) Proof of Financial Ability to Operate 59A-35.062 (3) Definitions. The following definitions apply to this section for proof of financial ability to operate. (e) "Financial instability" means the provider cannot meet its financial obligations. Evidence such as the issuance of bad checks, an accumulation of delinquent bills, or inability to meet current payroll needs shall constitute prima facie evidence that the ownership of the provider lacks the financial ability to operate. Evidence shall also include the Medicare or Medicaid program's indications or determination of financial instability or fraudulent handling of government funds by the provider. 408.803 Definitions.-As used in this part, the term: (7) "Controlling interest" means: (a) The applicant or licensee; (b) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or (c) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member. 408.810 FS (8) Upon application for initial licensure or change of ownership licensure, the applicant shall furnish satisfactory proof of the applicant's financial ability to operate in accordance with the requirements of this part, authorizing statutes,	CZ809			

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/14/2019
NAME OF PROVIDER OR SUPPLIER SHARON'S SENIOR SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2270 NW 64TH ST MIAMI, FL 33147		
(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	
CZ809	Continued From page 1 and applicable rules. The agency shall establish standards for this purpose, including information concerning the applicant's controlling interests. The agency shall also establish documentation requirements, to be completed by each applicant, that show provider revenues and expenditures, the basis for financing the cash-flow requirements of the provider, and an applicant's access to contingency financing. A current certificate of authority, pursuant to chapter 651, may be provided as proof of financial ability to operate. The agency may require a licensee to provide proof of financial ability to operate at any time if there is evidence of financial instability, including, but not limited to, unpaid expenses necessary for the basic operations of the provider. An applicant applying for change of ownership licensure is exempt from furnishing proof of financial ability to operate if the provider has been licensed for at least 5 years, and: (a) The ownership change is a result of a corporate reorganization under which the controlling interest is unchanged and the applicant submits organizational charts that represent the current and proposed structure of the reorganized corporation; or (b) The ownership change is due solely to the of a person holding a controlling interest, and the surviving controlling interests continue to hold at least 51 percent of ownership after the change of ownership. 59A-35.062 FS (7) An applicant for renewal of a license shall not be required to provide proof of financial ability to operate, unless the licensee or applicant has demonstrated financial instability. If an applicant or licensee has shown signs of financial	CZ809			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/14/2019
NAME OF PROVIDER OR SUPPLIER SHARON'S SENIOR SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2270 NW 64TH ST MIAMI, FL 33147		
(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	
CZ809	Continued From page 2 instability, as provided in section 408.810(9), F.S., at any time, the Agency may require the applicant or licensee to provide proof of financial ability to operate by submission of: (a) AHCA Form 3100-0009, Proof of Financial Ability Form, that includes a balance sheet and income and expense statement for the next 2 years of operation which provide evidence of having sufficient assets, credit, and projected revenues to cover liabilities and expenses; and, (b) Documentation of correction of the financial instability, including but not limited to, evidence of the payment of any bad checks, delinquent bills or liens. If complete payment cannot be made, evidence must be submitted of partial payment along with a plan for payment of any liens or delinquent bills. If the lien is with a government agency or repayment is ordered by a federal or state court, an accepted plan of repayment must be provided. This Statute or Rule is not met as evidenced by: Base on record interview and interview, the facility failed to provide proof of financial ability to operate, that included a balance sheet and income and expense statement for the last three months of operation. Findings included: A review of facility records showed that there was no documentation of the income and expense records for the prior three months. On at 3:42 PM, Administrator stated that she would not provide the income and expense records. She said "I am not feeling comfortable sending my account information. My account was not for debate at this point."	CZ809			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/14/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SHARON'S SENIOR SERVICES, INC

**2270 NW 64TH ST
MIAMI, FL 33147**

(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
CZ809	Continued From page 3 Unclassified	CZ809		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/14/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SHARON'S SENIOR SERVICES, INC

**2270 NW 64TH ST
MIAMI, FL 33147**

(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 complaint investigation (complaint number 2019010181) was conducted at Sharon's Senior Services Inc. on _____ & _____ Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must 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 shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 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 58A-5.020, 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	A 025		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/14/2019
NAME OF PROVIDER OR SUPPLIER SHARON'S SENIOR SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2270 NW 64TH ST MIAMI, FL 33147		
(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 025	Continued From page 1 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 offer personal supervision appropriate to needs of two out of six (Resident #1 and #4) sampled residents who eloped from the facility. The facility failed to contact the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager. Resident #1 eloped from the facility on _____ and Resident #4 eloped from the facility _____. The facility is not aware of Resident #1 whereabouts. Findings Included: Review of Resident #1 record showed she was admitted to the facility on _____, diagnoses included acute _____ and _____. Review of Resident #1 record showed she walked out of the facility on _____. The health care provider did not identify the resident as an elopement risk. No proof of documentation the facility informed resident family. No proof of documentation that the facility was aware of	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/14/2019
NAME OF PROVIDER OR SUPPLIER SHARON'S SENIOR SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2270 NW 64TH ST MIAMI, FL 33147		
(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 025	Continued From page 2 Resident #1 whereabouts. On at 10:25 AM, the Administrator stated Resident #1 expressed that she was not comfortable in the facility. She stated, "the next day, I tried to determine if she had family members, but the resident did not say anything." The Administrator stated, Resident #1 said to the staff she wanted to leave. Resident's #1 took her belongings and left the facility. The Administrator stated, "no contact was made after she left because she was not an elopement risk." Review of Resident #4 record showed she was admitted to the facility on and diagnosed with dependent, with right side and major with features. The health care provider did not identify the resident as an elopement risk. Review of Resident # 4 record dated showed a written note stating a staff member assumed Resident #4 was sitting on the front porch. When the staff member went to check on the resident she was not on the facility grounds. According to the written note a housemate stated to the staff member that Resident #4 was seen walking down the street. The Administrator stated Resident #4 walked out to the street and the staff member followed her. The Administrator stated, "I did not contact the police or her primary physician because she was not under my care." On at 12:18 PM, Resident #4 stated she went to her daughter- in- law house. She said "My daughter- in- law- called the police and took	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/14/2019
NAME OF PROVIDER OR SUPPLIER SHARON'S SENIOR SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2270 NW 64TH ST MIAMI, FL 33147			
(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 025	Continued From page 3 me to a mental health facility. "I was depressed." "I spent three days at the mental health facility." On at 10:46 AM, Resident # 4 daughter-in-law reported on a staff member from the facility notified her and informed her Resident #4 walked down the street. She stated the staff member followed Resident # 4 to a bus stop. She stated the staff member left Resident #4 at the bus stop and returned to the facility to call the police. She stated Resident # 4 later showed up at her house and stated she caught the bus to her house. She stated she had taken Resident #4 to the hospital and Resident # 4 remained at the hospital for 3 days and then she returned to the facility. She stated this was the second time Resident #4 eloped from the facility. Review of facility records showed no proof of documentation that the physician and law enforcement was notified of Resident #1 and #4 elopement. The facility records showed no proof of documentation the facility implemented preventive measures to prevent further elopement. Class III A 032 SS=G 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(i) Resident Care - Elopement Standards 58A-5.0182 (8) 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	A 025			
		A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/14/2019
NAME OF PROVIDER OR SUPPLIER SHARON'S SENIOR SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2270 NW 64TH ST MIAMI, FL 33147		
(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 032	Continued From page 4 so staff can be alerted to their needs for support 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 58A-5.0181(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 58A-5.0191(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	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/14/2019
NAME OF PROVIDER OR SUPPLIER SHARON'S SENIOR SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2270 NW 64TH ST MIAMI, FL 33147		
(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 032	Continued From page 5 premises, 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 sections 429.41(1)(a)3. and 429.41(1)(l), F.S. 429.41(1)(a)3 & 3(l),FS 3. Resident elopement requirements.-Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures. (l) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to identify and assess two out of six (Resident #1 and #4) sampled residents who	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/14/2019
NAME OF PROVIDER OR SUPPLIER SHARON'S SENIOR SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2270 NW 64TH ST MIAMI, FL 33147		
(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 032	Continued From page 6 were at risk for elopement. The facility failed to develop an elopement preventive plan for two out of six (Resident #2 and #4) sampled residents. Resident #1 eloped from the facility on _____ and no proof of documentation that the facility was aware of Resident #1 whereabouts. Resident #4 eloped from the facility on _____. No proof of documentation that the physician had been notified of Resident #2 and #4 elopement risk. No proof of documentation the facility implemented preventive measures to prevent further elopement. Findings Include: Review of Resident #1 record showed she was admitted to the facility on _____, diagnoses included Acute _____. The health assessment dated _____ showed the resident was independent with ambulation, _____, eating, toileting, transferring and required supervision with bathing and grooming. The health care provider did not identify the resident as an elopement risk. On _____ at 10:25 AM, the Administrator stated she went to the hospital to assess Resident #1 prior to accepting her at the facility. She stated the resident was alert and _____. The Administrator stated the Resident #1 told her she had no family locally. The Administrator stated she did not asked the hospital's case manager for information regarding resident's contact information. She said, Resident #1 expressed that she was not comfortable in the facility. She stated, "the next day, i tried to determine if she had family members, but the resident did not say anything." The Administrator stated, Resident #1 said to the staff she wanted to leave. Resident's #1 took her belonging's and	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/14/2019
NAME OF PROVIDER OR SUPPLIER SHARON'S SENIOR SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2270 NW 64TH ST MIAMI, FL 33147		
(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 032	Continued From page 7 left the facility. The Administrator stated, "no contact was made after she left because she was not an elopement risk." Review of the facility records showed no proof of documentation that the facility was aware of Resident #1 whereabouts as of _____. Review of Resident #4 record showed she was admitted to the facility on _____ and diagnosed with _____ (_____), status post _____ (_____), _____ dependent, _____ with right side _____, and major _____ with _____ features. The health assessment dated _____ showed Resident #4 needed medication administration, supervision with ambulation, bathing and grooming and independent with eating. The health care provider did not identify the resident as an elopement risk. Medication prescribed included aripiprazole 20 mg daily, _____ 81 mg once daily, _____ 3.125 mg twice a day with meals, valproci 500 mg twice a day, _____ 8 units at 8:00 am, _____ 10 mg 3 times a day, _____ 2.5 mg once a day, _____ 20 mg once a day, rosuvastatin 10 mg at bedtime, _____ 50 mg once a day, _____ 100 mg at bedtime. Review of Resident # 4 record dated _____ showed the staff assumed Resident #4 was sitting on the front porch. When the staff went to check on the resident she was discovered not on the facility grounds. The note showed a housemate stated to the staff member that Resident #4 was seen walking down the street. The Administrator stated Resident #4 walked out to the street and the staff followed her. The	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/14/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SHARON'S SENIOR SERVICES, INC

**2270 NW 64TH ST
MIAMI, FL 33147**

(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 032	Continued From page 8 Administrator stated, "I did not contact the police or her primary physician because she was not under my care." On _____ at 12:18 PM, Resident #4 stated she went to her daughter- in- law house. She said "My daughter- in law- called the police and took me to a mental health facility. "I was depressed." "I spent three days at the mental health facility." On _____ at 10:46 AM, Resident # 4 daughter-an-law reported on _____ a staff member from the facility notified her and informed her Resident #4 was walking down the street. She stated the staff member followed Resident # 4 to a bus stop. She stated the staff member left Resident #4 at the bus stop and returned to the facility to call the police. She stated Resident # 4 later showed up at her house and stated she caught the bus to her house. She stated she had taken Resident #4 to the hospital and Resident # 4 remained at the hospital for 3 days and then she returned to the facility. She stated this was the second time Resident #4 eloped from the facility. Review of Resident #2 record showed admission date for _____ Health Assessment dated _____ showed diagnosis of _____ , independent with activities of daily living , required assistance with medications and _____ precautions. Review of the admission and discharge log showed Resident #2 had special precautions of _____ and elopement risk. Review of facility records showed no proof of documentation that the physician had been notified of Resident #2 and #4 elopement risk.	A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/14/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SHARON'S SENIOR SERVICES, INC

**2270 NW 64TH ST
MIAMI, FL 33147**

(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 032	Continued From page 9 Review of facility records showed no proof law enforcement had been notified of Resident #1 and #4 elopement. Review of the facility elopement policies and procedures showed the facility would identify the residents at risk of elopement and develop and implement ways to reduce the risk of elopement. The facility records showed no proof of documentation the facility implemented preventive measures to prevent further elopement. Class II	A 032		
A 165 SS=D	429.23(&) FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements. (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ;	A 165		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/14/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SHARON'S SENIOR SERVICES, INC

**2270 NW 64TH ST
MIAMI, FL 33147**

(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 165	Continued From page 10 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6), neglect, or must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially	A 165		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/14/2019
NAME OF PROVIDER OR SUPPLIER SHARON'S SENIOR SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2270 NW 64TH ST MIAMI, FL 33147		
(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 165	Continued From page 11 involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/14/2019
NAME OF PROVIDER OR SUPPLIER SHARON'S SENIOR SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2270 NW 64TH ST MIAMI, FL 33147		
(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 165	Continued From page 12 submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit an adverse incident report within one day of the incident and a completed report within 15 days of the incidents to the Agency for Healthcare Administration (AHCA) for two out of five sampled residents (Residents #1 and #4) that eloped from the facility. Findings Included: Review of adverse incident database showed the facility did not report Resident # 1 and #4 eloped from the facility. On at 10:25 AM, the Administrator stated, Resident's #1 took her belonging's and left the facility. The Administrator stated, "no contact was made after she left because she was not an elopement risk". The Administrator stated, " incident report was not file with the AHCA." Record review showed on Resident #4 was observed walking down the street. Interview conducted on at 12:18 PM, with Resident #4. Resident #4 stated she walked out of the facility. She stated, "I went to my daughter -in- law house." "My daughter- in- law called the police and I was taken to mental health facility." On at 10:25 AM, the Administrator stated, " I did not called the police, doctor or AHCA because Resident #4 was not under my care."	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/14/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SHARON'S SENIOR SERVICES, INC

**2270 NW 64TH ST
MIAMI, FL 33147**

(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 165	Continued From page 13 Class III	A 165		