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
	AL11968641	A. BUILDING: _____ B. WING _____	12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW AGE ADULTCARE INC	1105 W 2ND AVENUE HIALEAH, FL 33010

(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 (number 2019012940) was conducted at New Age Adultcare Inc on and concluded on . Deficiencies were identified 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 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. 59A-36.007 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 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	A 025		

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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 provide care and services and to offer personal supervision appropriate to the needs of 1 out of four (Resident #1) sampled residents who eloped from the facility. The facility failed to maintain a written record, updated as needed for a resident who and were transferred to a higher level of care for one out of four (Resident #1) sampled residents. The facility failed to have written documentation for a resident who transferred to the hospital for one out of four (Resident #3) sampled residents. Findings included: On at 9:25 AM, observed one staff member on duty to provide care to 27 residents. Staffing record review dated showed there were one staff member taking care of 27 residents from 10:00 PM to 6:00 AM.	A 025		

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A 025	Continued From page 2 Record review showed Resident #1 was admitted to the facility on . The health assessment completed on indicated the resident was diagnosed with type II, (ASHD), , Gait disturbance, , and , . The record showed that the resident needed assistance with toileting and supervision with the rest of activities of daily living. The physician did not identify the resident as an elopement risk. The resident was assessed for elopement risk by the Administrator on . The assessment document showed the facility needed to establish a Care Plan, because the resident was a high risk for elopement. There were no documentation of resident's care plan in the record. Hospital record review showed that Resident #1 was admitted to the hospital on at 2:18 PM with a with loss of . The resident was diagnosed with Type 2 without complication, , Repeated , Essential , , (Generalized), , , Difficulty walking, , Major , 's , , Communication . The record documented resident in an upright position while walking and sustained injury to the and . A police report showed the police department was called on at about 4:00 AM regarding a missing elderly person. The facility caregiver informed the police officer that Resident #1 was last seen at 3:00 AM. Staff C said the resident jumped the fence using a plastic chair and had gone missing. The Staff L stated the resident eloped multiple times in the past.	A 025		

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A 025	Continued From page 3 Adverse incident report showed Resident #1 took a chair from the second floor and jumped the fence on at about 2:00 AM. Facility's staff contacted the administrator and the police. According to the report, the staff searched for the missing resident inside and outside the facility. The police came and filled out a report. The adverse incident report did not document when the resident returned to the facility. Interview conducted on at 11:55 AM, Administrator stated that Resident #1 did not elope, he went to the bank at 2:00 AM, because he needed some papers. He said the resident knew where he wanted to go, and how to return to the facility. The administrator said that the he put cameras and motion sensors in the facility after the incident. He said the facility had one staff awake from 10:00 PM to 6 AM and he monitored the residents with the facility's cameras. The Administrator stated, he was in the process of obtaining legal documents to monitor the residents using GPS. Interview conducted on at 1:58 PM, Staff L stated that she worked alone at night and her job duties was to check all the residents during the night. She said that she saw a chair next to the fence and went to check all the residents. She found that Resident #1 was not in his bed. She contacted the administrator and called the police. She stated she was unable to search outside the facility because she was working alone until 6:00 AM when the morning staff arrived. She called the administrator, but he did not come to the facility. The staff stated that Resident #1 eloped many times before. She added that the police came and filed a police report.	A 025		

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A 025	Continued From page 4 Interview conducted on at 3:10 PM, Administrator stated Resident #1 was brought to the facility by the police on in the morning. The resident took a bath and changed his clothes. The resident was weak, and we sent him to the hospital via ambulance. The resident did not in the facility at any time. The resident did not have any on his , arms and when he returned. On reviewed a police report that showed Resident #1 was located by a police officer on at 1:20 PM, and was brought to the facility. Record review showed Resident #3 was diagnosed with , , (OA), , ( ), and , . Medication Observation Record showed the resident was hospitalized on . The record did not have documentation that the primary physician and family members were notified that the resident was transferred to the hospital on . On at 11:20 AM, Staff C stated Resident #3 was sent to the hospital via ambulance because she was , . Class III	A 025		
A 032 SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS.	A 032		

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A 032	Continued From page 5 (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 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	A 032		

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A 032	Continued From page 6 minimum, the policies and procedures must provide for: 1. An immediate search of the facility and 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)(i), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to identify and assess for two out of four (Resident #1) sampled residents who were at risk for elopement. The facility failed to develop an elopement preventive plan for one out of four (Resident #1) sampled residents. The facility failed to complete the elopement/ assessment for one out of four (Resident #1) sampled residents. Findings included: A review of an Adverse incident report filed with the Agency for Health Care Administration (AHCA) showed that facility filed a report on , stating Staff L observed a chair against the outside fence at 3:00 am. Staff L then checked all of the resident's rooms and found	A 032		

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A 032	Continued From page 7 that Resident #1 was missing. According to the report, the staff searched for the missing resident inside and outside the facility. The report further stated that the police came and filed a report. The incident reported did not document when the resident returned. A review of the observation notes in the resident record showed that the resident was last seen at 10:30 pm in his room. The observation record further stated that at approximately 3:40 am, the employee looked in the room and did not find the resident. Hospital record review showed that Resident #1 was admitted to the hospital on at 2:18 PM with a and loss of . The resident was diagnosed with Type 2 without complication, , Repeated , Essential , (Generalized), , Difficulty walking, , Major , 's Communication . Record review showed Resident #1 was assessed for elopement risk by the Administrator on . The assessment document dated showed the facility needed to establish a care plan because the resident was at high risk for elopement. There was no documentation of resident's care plan in the record. Record review showed Resident #1 was first admitted to the facility on . The health assessment completed on indicated the resident was diagnosed with type II, (ASHD), , Gait disturbance,	A 032		

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A 032	Continued From page 8 [redacted] and [redacted]. Further review showed that the resident needed assistance with toileting and supervision with the rest of activities of daily living. The physician did not identify the resident as an elopement risk. No documentation in file of elopement assessment being completed. Staffing record review showed there was one staff taking care of 27 residents from 10:00 PM to 6:00 AM on through 11/ 30/2019 and [redacted] through [redacted]. Record review showed there were four residents under elopement risk and seven residents that needed assistance with activities of daily living. Elopement policies and procedures review showed the facility would identify the residents at risk of and eloping. The facility would develop and implement ways to reduce the risk of resident elopement. The facility staff would search inside and outside the facility at the time of the elopement. Interview conducted on at 1:58 PM, Staff L stated that she worked alone at night and her job duties was to check all the residents during the night. She said she saw a chair next to the fence and checked the residents. She found that Resident #1 was not in his bed. She contacted the administrator and called the police. She stated she was unable to search outside the facility because she was working alone until 6:00 AM when the morning staff arrived. She called the administrator, but he did not come to the facility. The staff stated that Resident #1 eloped many times before. She added that the police came and filled a police report. Interview conducted on at 11:55 AM, Administrator stated that Resident #1 did not	A 032		

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A 032	Continued From page 9 elope, he went to the bank at 2:00 AM, because he needed some papers. He said the resident knew where he wanted to go, and how to return to the facility. The administrator said that the he put cameras and motion sensors in the facility after the incident. He said the facility had one staff awake from 10:00 PM to 6 AM and he monitored the residents with the facility's cameras. He said that they were in the process to obtain legal documents to monitor the resident using GPS. On a police report showed the police was called on at about 4:00 AM regarding a missing elderly person. The facility caregiver informed the police that Resident #1 was last seen at 3:00 AM. The Staff L stated that Resident #1 jumped the fence using a plastic chair and had gone missing. The Staff L reported to the officer the Resident #1 eloped multiple times in the past. Review of the police report showed Resident #1 was found at 1:20 PM by the police officer and was brought to the facility. Class III	A 032		
A 079 SS=G	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253	A 079		

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A 079	Continued From page 10	A 079		

26-35 294
36-45 335
46-55 375
56-65 416
66-75 457
76-85 498
86-95 539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and [illegible]
( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.
b. A nurse is considered as having met the course requirements for First Aid. An emergency

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A 079	Continued From page 11 medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C.	A 079		

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A 079	Continued From page 12 (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing	A 079		

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A 079	Continued From page 13 requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 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 ensure that enough qualified staff were available to provide resident supervision and to provide or arrange for resident care in accordance with residents' scheduled and unscheduled service needs. One of four sampled residents left the facility without staff knowledge, later having been found by the police at a bank (Resident #1). Findings included: A review of an Adverse Incident filed by the facility showed Resident #1 took a chair from the second floor and jumped over the six . . . fence on at about 2:00 AM. The report showed that the facility's staff contacted the administrator and the police. According to the report, the staff searched for the missing resident inside and outside of the facility. The police came and filled a report. The incident report did not document when the resident return the facility.	A 079		

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	AL11968641	A. BUILDING: _____ B. WING _____	12/20/2019

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A 079	Continued From page 14 Hospital record review showed that Resident #1 was admitted to the hospital on [redacted] at 2:18 PM with a [redacted] with loss of [redacted]. The resident was diagnosed with Type 2 [redacted] without complication, [redacted], Repeated [redacted], Essential [redacted] (Generalized), [redacted], Difficulty walking, [redacted], Major [redacted] [redacted]'s [redacted] Communication [redacted]. Facility record review showed Resident #1 was admitted to the facility on [redacted]. The health assessment completed on [redacted] indicated the resident was diagnosed with [redacted] type II, [redacted] (ASHD), [redacted], Gait disturbance, [redacted] and [redacted]. The record showed that the resident needed assistance with toileting. and supervision with ambulation, grooming, [redacted] and eating. The physician did not identify the resident as an elopement risk. Resident #1 was assessed for elopement risk by the Administrator on [redacted]. The assessment document showed the facility needed to establish a Care Plan because the resident was a high risk for elopement, however there was no documentation of a care plan [redacted] this issue in the record. Staffing schedule review showed there was one staff taking care of 27 residents from 10:00 PM to 6:00 AM on [redacted]. On [redacted] a review of the facility records showed there were four residents under elopement risk and seven residents that needed assistance with activities of daily living.	A 079		

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A 079	Continued From page 15 A review of the facility's elopement policies and procedures showed the facility would identify the residents at risk of [redacted] and eloping. The policies further stated that the facility would develop and implement ways to reduce the risk of resident elopement and that staff would search for missing residents inside and outside. Interviewed on [redacted] at 1:58 PM, Staff L stated that she worked alone at night and her job duties were to check all the residents during the night. She said she saw a chair next to the fence and checked the residents. She found that Resident #1 was not in his bed. She contacted the administrator and called the police. She further stated she was unable to search outside the facility because she was working alone until 6:00 AM when the morning staff arrived. She said she called the administrator, but he did not come to the facility. Staff L stated that Resident #1 had left the facility without staff knowledge many times before. She added that the police came and took a report. Interviewed on [redacted] at 11:55 AM, the Administrator stated that Resident #1 did not elope, but that he went to the bank at 2:00 AM, because he needed some papers. He said the resident knew where he wanted to go, and how to return to the facility. The Administrator said that the he put cameras and motion sensors in the facility after the incident. He said the facility had one staff awake from 10:00 PM to 6 AM and he monitored the residents with the facility's cameras. He said that they were in the process to obtain legal documents to monitor the resident using GPS. Review of a police report on [redacted] regarding the incident showed the police were called on	A 079		

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A 079	Continued From page 16 . . . . . at about 4:00 PM (fourteen hours after Resident #1 left) regarding a missing elderly person. The caregiver informed the police that Resident #1 was last seen at 3:00 AM. The staff stated that Resident #1 jumped the fence using a plastic chair and had gone missing. The staff told police that the resident had left the facility without staff knowledge many times in the past. On . . . . . at 1:20 PM, the police report showed Resident#1 was found disoriented by the police approximately five miles from the facility. Class II	A 079		
A 081 SS=D	59A-36.011(. .) FAC Training - Staff In-Service (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:	A 081		

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A 081	Continued From page 17 (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs.	A 081		

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A 081	Continued From page 18 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the staff who provided direct care to residents, received in-service training within 30 days of employment for one out of twelve (Staff F) sampled staff. Findings included: Staff record review did not have documentation of the following training's for Staff F: Recognizing and reporting resident . . . . . , neglect, and , , Providing assistance with the activities of daily living and facility's resident elopement response policies and procedures. Staff F was hired on . . . . . . Interview conducted on . . . . . at 12:10 PM, Staff C stated that Staff F received all the training's but she was unable to provide the documentation during the survey.	A 081		

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A 081	Continued From page 19 Class III	A 081		