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
	AL11967960	A. BUILDING: _____ B. WING _____	R 12/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIBISCUS PALACE WELLINGTON LLC	1074 C/D HYACINTH PLACE WELLINGTON, FL 33414

(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 An unannounced revisit to the Change of Ownership (CHOW) survey was conducted on at Hibiscus Palace Wellington LLC. The facility had uncorrected deficiencies at the time of the survey. (An unannounced licensure complaint survey was conducted in conjunction with the above CHOW revisit survey. Please see separate report for findings.)	{A 000}		
{A 032} SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (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 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),	{A 032}		

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{A 032}	Continued From page 1 F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 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. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all residents at risk for elopement	{A 032}		

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{A 032}	Continued From page 2 had a daily check to ensure, they had facility identification on their person at all times after an Elopement, for 1 of 2 sampled residents (Resident#2). The findings include: 1) On at approximately 9:15 AM, during an interview with Staff A, it was revealed Resident#2 eloped form the facility (not sure of date). Per Staff A, there were workers on the premises, and they left a secure gate open and the resident got out. Staff A stated the premises were searched, law enforcement were called, and a photo was provided. The resident was returned to the facility about 2 hours later (unsure of times) by law enforcement. At the time of the elopement, Resident#2 did not have facility identification on her persons. On at 12:00 PM, Resident#2 was observed walking outside in the courtyard area of the facility. Resident#2 did not have any facility identification on her person. Further review of Resident#2's health assessment documents "yes" the resident is an elopement risk. Class III Uncorrected	{A 032}		
{A 181} SS=D	59A-36.019(2) FAC Emergency Plan Approval (2) EMERGENCY PLAN APPROVAL. The plan must be submitted for review and approval to the local emergency management agency. (a) If the local emergency management agency requires revisions to the emergency management plan, such revisions must be made and the plan resubmitted to the local office within 30 days of	{A 181}		

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{A 181}	Continued From page 3 receiving notification that the plan must be revised. (b) A new facility as described in rule 59A-36.014, F.A.C., and facilities whose ownership has been transferred, must submit an emergency management plan within 30 days after obtaining a license. (c) The facility must review its emergency management plan on an annual basis. Any substantive changes must be submitted to the local emergency agency for review and approval. 1. Changes in the name, address, telephone number, or position of staff listed in the plan are not considered substantive revisions for the purposes of this rule. 2. Changes in the identification of specific staff must be submitted to the local emergency management agency annually as a signed and dated addendum that is not subject to review and approval. (d) The local emergency management agency is the final administrative authority for emergency management plans prepared by assisted living facilities. (e) Any plan approved by the local emergency management agency is considered to have met all the criteria and conditions established in this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit a Comprehensive Emergency Management Plan (CEMP) to the local Emergency Management Agency for review and approval. The findings Include: 1) On at approximately 11:15 AM, the facility approved CEMP was requested. The	{A 181}		

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{A 181}	Continued From page 4 Administrator stated the facility has never received an approved CEMP. The Administrator provided a receipt for submitted CEMP revealing the plan was submitted while the survey was being conducted on [redacted] at 9:33 AM. The facility provided no additional information for review at this time. On [redacted] at approximately 3:15 PM, the findings were discussed and acknowledged by the Administrator and Designee. 2) On [redacted] at approximately 10:00 AM, the facility approved CEMP was requested. The Administrator provided a rejection letter dated [redacted]. As of [redacted], the facility's CEMP revision had not been submitted to the local Emergency Management Agency for review and approval. Class III Uncorrected	{A 181}		