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
	AL11967166	A. BUILDING: _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAEJCA'S CASTLE, LLC	13393 SW 32ND STREET MIRAMAR, FL 33027

(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 Relicensure survey was conducted on [redacted] at Saejca's Castle, LLC. The facility had deficiencies at the time of the survey.	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), 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.	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967166	A. BUILDING: _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAEJCA'S CASTLE, LLC	13393 SW 32ND STREET MIRAMAR, FL 33027

(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 1 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 interview and record review, the facility failed to ensure that the resident elopement requirements were met. As evidence of the facility failure to ensure that all Administrators and Direct Care staff participate in yearly elopement drills (2 per year for each person); which shall include a review of procedures to address resident elopement.	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967166	A. BUILDING: _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAEJCA'S CASTLE, LLC	13393 SW 32ND STREET MIRAMAR, FL 33027

(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 2 The findings included: On at 10:21 AM, a request was made to the Administrator to provide a list of all direct care staff. The list included 7 direct care staff employed in the Assisted Living Facility (ALF). On , a review of the facility mock elopement drills was conducted. The Administrator provided the following documentation: A review of the Elopement Drills reveal the drills were conducted on the following dates. 1. On , 01 of 07, staff members were present. There were 6 staff members who were missing. 2. On , 03 of 07 staff members were present. There were 4 staff members who were missing. 3. On , 02 of 07 staff members were present. There were 5 staff members who were missing. 4. On , 02 of 07 staff members were present. There were 5 staff members who were missing. On at 02:16 PM, an interview was conducted. The surveyor informed the Administrator that not all staff were listed on the elopement mock drills and that all administrators and direct care staff must participate in the drills. The Administrator acknowledged the findings. No additional information was provided. Class III	A 032		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS.	A 054		

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
	AL11967166	A. BUILDING: _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAEJCA'S CASTLE, LLC	13393 SW 32ND STREET MIRAMAR, FL 33027

(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 054	Continued From page 3 (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; 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 [illegible] 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 [illegible], 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 an interview, it was determined the facility failed to ensure the Medication Observation Record (MOR) was accurate for 2 out of 6 sampled residents (Resident # 2 and Resident # 5) who required assistance with the self-administration of medication.	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967166	A. BUILDING: _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAEJCA'S CASTLE, LLC	13393 SW 32ND STREET MIRAMAR, FL 33027

(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 054	Continued From page 4 The findings included: On at 11:03AM, Staff A informed the surveyor that Resident # 2 has not received his 8:00 AM medications. He is , and he gets up late and they give him his medications when he wakes up. This Surveyor informed her that she needs to speak with his doctor regarding the time changes for Resident #2's medications. It has been 2 hours and he has not received his 8:00 AM medications. Observed med pass for Resident # 2 at 11:15 AM and 8:00 AM medications were given at that time. a) An observation of medication pass conducted with Staff A at 11:15 AM revealed the following. The medication for Resident # 2 was 6.25 mg tab. Staff A sanitized , reviewed the MOR and obtained medication. Staff A stated the name of the medication, gave it to the resident, and watched him swallow the medication. Staff A signed the MOR immediately after. The MOR was not signed at 8:00 AM. The MOR was signed at 11:15 AM for the 8:00 AM medication. An observation of medication pass conducted with Staff A at 11:19 AM. The medication for Resident # 2 was D 5000 IU. Staff A sanitized , reviewed the MOR and obtained the medication. Staff A stated the name of the medication, gave it to the resident, watched him swallow the medication. Staff A signed the MOR immediately after. The MOR was not signed at 8:00 AM . The MOR was singed at 11:19 AM for the 8:00 AM medication. 2) A random review of the MOR was conducted for accuracy at 11:23 AM. The MOR revealed the 8:00 AM medications for Resident # 6 40 mg tab and 300	A 054		

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
	AL11967166	A. BUILDING: _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAEJCA'S CASTLE, LLC	13393 SW 32ND STREET MIRAMAR, FL 33027

(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 054	Continued From page 5 mg had no signature for the medications. In an interview with the Administrator on ... at 12:00 PM, she was informed that Resident # 2 8:00 AM medication was not given until 11:30 AM. She stated he is , and he sleeps late and the doctor said to let him sleep. This surveyor informed her to speak with the physician regarding the medication times and update the MOR. Surveyor informed the Administrator that the 8:00 AM medications were not signed for Resident # 5 on the MOR. She reviewed the MOR and stated that she is aware. She informed Staff A that the MOR was not signed. She acknowledged the findings and no additional information was provided. Class III	A 054		