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
	AL11910977	A. BUILDING: _____ B. WING _____	01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS MERCEDES BOARDING HOME	3418 SW 23RD TERRACE MIAMI, FL 33145

(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 Survey (complaint number 2020000041) was conducted at Las Mercedes Boarding Home on , , to , , . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=G	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 maintain a general awareness of the whereabouts of one of 20 sampled residents (Residents 1). Resident 1 eloped from the facility, was found on the next day by a good Samaritan and taken to the hospital by the local emergency services. The resident had previous elopements. Findings included: A review of media, facility and police reports showed Resident 1 eloped from the facility on , at around 11:00 AM. According to documents reviewed, the facility was getting ready to have a holiday lunch for all residents and family members. Once the facility staff realized that the resident was missing, they began to look for him and called the local police. The local police contacted the resident's daughter, letting her know that they had reviewed the facility's videos from the cameras and were	A 025		

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A 025	Continued From page 2 looking for him. The resident's daughter joined the search but all efforts were unsuccessful. The next morning, the daughter received a phone call from the local emergency services letting her know that they had her father and that he was going to be transferred to a local hospital. A review of Resident 1's record showed an admission date [illegible]. The resident was identified as at risk for elopement. He was diagnosed with [illegible], high [illegible] and [illegible]'s [illegible]. The resident had an unsteady gait, memory and concentration problems, and needed [illegible] precautions. The resident was assessed as independent on all activities of daily living, and needing supervision with bathing and [illegible]. The resident was prescribed a regular diet and needed assistance with self-administration of medications. An evaluation and assessment tool completed two days after Resident 1's admission showed as per family, the resident occasionally had verbalized intent to [illegible] or elope when living on his own. The documents further stated 'Explanation: Resident 1 has a history as per family, of elopement when living alone, the resident tried to [illegible] out to the market and at 2:30 AM, the police will call the family to advise they had found him [illegible].' Observation Notes in Resident 1's record for [illegible] at 8:30 AM stated that the resident's daughter contacted the facility to inform that Resident 1 was found and taken to the hospital in stable condition. The records did not have an Elopement Risk Assessment after the resident came [illegible] on [illegible]. Review of the hospital record showed that the resident was admitted on [illegible] and	A 025		

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A 025	Continued From page 3 discharged on [redacted] with a chief complaint - Disoriented. The diagnoses listed were [redacted] and [redacted]. The notes stated "Patient presented to ED after walking around Miami since 11:00 AM yesterday unknown what happened to him. He lives in an ALF [assisted living facility] and escaped from it at around 11:30 AM. Family reported him missing and it wasn't until now that police/paramedics were able to find him and brought him to the ED. Daughter says that he has been fine and thinks that since yesterday there was a lot of family going in and out of the facility because of the New Year's celebration, he might have went out without being noticed." Ambulatory status- Independent. General - Awake, Alert, not toxic appearing, looks tired.' The discharge documents showed to that the resident was to follow up with his primary doctor and to take the list of medications within one week. On [redacted] at 12:40 PM, Resident 1's son stated that on the initial interview with the current facility, the family discussed how important was for the facility to keep an [redacted] on him, especially that he was new at the facility. On [redacted] at 7:35 PM, the resident's daughter stated that Resident 1 was transferred to the facility because they had personnel working all night and that the facility knew "from the get go" that he had issues with elopement and that he had done it before. She stated "I know they already put alarms at the doors. My brother and I discussed it with the administrator that my father had an elopement issue. The police is the one who called me to let me know and they said, he left the facility about an hour before they call me; they called me around 12:30 PM."	A 025		

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A 025	Continued From page 4 On [redacted] at 2:45 PM, Staff B stated,"I work from 6 am to 6 PM, I worked on [redacted]. That day, the family members were also invited. He was participating. We were five staff working that day. The administrator looked for him on the streets and we continued with serving and taking care of all the residents." On [redacted] at 3:07 PM, Staff C stated, "He was coming from his bedroom and was in the group, then, just like that, we noticed he was not longer in the group, we all started looking for him in all rooms, closets; we verified all doors and the door on the front was open, then, we started looking outside; he had to take the trolley or something because it was only minutes and he was not around the area. When the police came around two hours later, they brought dogs, they asked for his clothes and went around the neighborhood and came and said that the dog lost the smell about five blocks away." Review of the facility's record showed a elopement drill conducted on . Review of the facility's elopement policy and procedures showed that elopements should be conducted twice a year. It explained the purpose of drills and definition of elopement and missing resident. The policy stated "Elopement refers to an unauthorized absence of a resident from the facility. The risk of [redacted] and elopement increases when residents are mobile and [redacted], especially if they suffer from [redacted] or [redacted]. All residents assessed at risk for elopement or with a history of elopement shall be identified so staff can be alerted to their needs for support and supervision. As part of its resident elopement response policies and procedures, the facility shall make, at a minimum, a daily effort to determine that at risk	A 025		

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A 025	Continued From page 5 residents has identification on their persons that includes their name and the facility's name, address, and telephone number. Staff attention shall be directed towards residents assessed at high risk for elopement, with special attention given to those with 's and related assessed at high risk." On at 2:00 PM, the Administrator stated that the facility was not aware that the resident had an elopement risk. Class II	A 025		
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	A 032		

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A 032	Continued From page 6 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 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.	A 032		

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A 032	Continued From page 7 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow its policy and procedures regarding elopement when one resident, Resident 1 eloped from the facility and did not have the facility's information on him. In addition, the resident was not assessed for Elopement Risk as required after he came from the hospital. Findings included: Review of the facility's elopement policy and procedures showed that elopement drills would be conducted twice a year however additional review of the facility's records showed one elopement drill conducted on . The policy also stated that "All residents assessed at risk for elopement or with a history of elopement shall be identified so staff can be alerted to their needs for support and supervision. As part of its resident elopement response policies and procedures, the facility shall make, at a minimum, a daily effort to determine that at risk residents has identification on their persons that includes their name and the facility's name, address, and telephone number. Staff attention shall be directed towards residents assessed at high risk for elopement, with special attention given to those with and related assessed at high risk." Review of Resident 1's record showed the resident eloped from the facility on , at around 11:00 AM. Further review showed an admission date , when Resident 1 was determined to be at risk for elopement. The resident's diagnoses were , high and	A 032		

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A 032	Continued From page 8 's . The records did not have an Elopement Risk Assessment after the resident came on . On at 2:00 PM, the Administrator stated that the facility was not aware that the resident had an elopement risk and that after the incident, the facility installed alarms on both exit doors and when the alarm would go off, any employee would check the door to see who opened it and would keep the door locked. Class III	A 032		