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
	AL11965387	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DULCE CORAZON INC	11475 QUAIL ROOST DRIVE MIAMI, FL 33157

(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 # 2020000783) was conducted at Casa Dulce Corazon Inc. on . Deficiencies were identified at the time of the 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 independently in the community.	A 025		

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A 025	Continued From page 1 (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 resident's whereabouts for one out of the four sampled residents (Residents#1). Resident #1 was found in the supermarket and the staff had no knowledge that the Resident #1 left until a security guard from the market informed the facility. Findings Include: A review of Resident # 1's progress notes dated stated "[Resident #1] opened the door and went out by herself. I was at the facility with 4 residents (other employee at Department of Children's and Family (DCF) for Limited Mental Health (LMH) training). I was in the kitchen doing dishes, rescue was called by supermarket in the corner of the house. That happened a few minutes after 3pm and she was missing for only few minutes. I called immediately her son". On at 10:21 am, the Administrator stated,	A 025		

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A 025	Continued From page 2 regarding the resident's elopement, "I was working that day on the and it happened at around 3pm. She wanted to lay down a bit and I was in the kitchen preparing dessert, and she opened the door, and went to the supermarket without telling me. I found out because the security (from supermarket) knocked on my door and told me; and that's when I realized that she was gone. The security guard knew her and knew that this was an Assisted Living Facility (ALF) and asked us. The police officer brought her because I was alone, and I couldn't leave the residents alone to pick her up. She saw her doctor after the incident and was referred to a because she had mild 's. I also did an in-service with the employees with a nurse consultant and told them what happened and to keep a closer ". A review of the facility's records showed a 'Facility Elopement/Missing Resident Drill' dated , where the administrator documented the drill as the actual incident. The report showed the following: 'Time the resident was determined missing by Staff # 1: 3:35pm. Resident located and identified by Staff # 1 at 3:48pm. Where? Neighborhood (corner of house) close to [supermarket]. Search completed at 3:49pm.' There was no documentation that showed at what time local law enforcement took Resident # 1 to the facility. On at 11:15 am, the Administrator stated, "I would say that it didn't pass not even ½ hour because we make coffee at 3pm and I passed by her room to give coffee to Lucila and saw Blanca in her room. She returned like at 3:45 by the police". Review of Resident # 1's records of the health	A 025		

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A 025	Continued From page 3 assessment completed on showed she was diagnosed with 's , ( ), and . The health assessment documented Resident # 1 was not an elopement risk. There was also no evidence of a new health assessment that stated Resident # 1 was an elopement risk after eloping once from the facility. Additionally, there was no documentation that showed Resident # 1 was seen by her Primary Care Physician (PCP) after the significant change. Review of Resident # 1's medical history revealed Resident # 1 had been diagnosed with , Memory Loss, and disoriented for at least five years since . Further review of the medical history also showed Resident # 1 was diagnosed with and memory since . A second progress note dated 11/9/19 stated "Today came a human service program , from DCF. [Investigator] doing the investigation for [Resident # 1's] elopement yesterday. She also was informed that as prevention, we have now a safety lock very low on the door, able to open in case of fire, but not easy for her. She is the only at risk now. That never happened because until a few months ago, she was able to go out (we have an authorization letter from her son) to go to stores close by and came ." On at 10:23 am, Resident #1's son confirmed that he received a call from the facility about the incident. He stated that his mother used to be able to walk out on her own, go to the stores by herself and knew where she was. He confirmed that he had signed an authorization	A 025		

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A 025	Continued From page 4 form with the facility for her to go out because she was alert, oriented and knew where she was going; however, after the incident, she's been declining, and he didn't want her going out alone anymore. Review of the Resident#1's file showed no evidence of any Power of Attorney (POA) documents or any evidence the son was Resident # 1's Healthcare Surrogate. Review of Resident #4's records showed she was admitted on . . . . . and was also diagnosed with . Further review showed Resident # 4 was not an elopement risk. On . . . . . at 11:42 am, the Administrator stated "I bought [Resident # 4] a bracelet with her information, but [Resident # 4] didn't want to wear the bracelet I got her either, so I can't force her. The only precaution I had before the incident was closer supervision". 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	A 032		

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A 032	Continued From page 5 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 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,	A 032		

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A 032	Continued From page 6 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 follow its policies and procedures regarding elopement when one out of four sampled residents had eloped from the facility (Resident # 1). The facility also failed to implement any preventive measures to prevent residents from eloping before Resident # 1 was found at a local supermarket. Findings Included: A review of the facility's elopement policies and procedures showed that "Any resident diagnosed with or which has the potential for elopement will have a current picture in their file that the facility can give to the police authorities and use for identification purpose". A review of Resident # 1's records showed a completed health assessment dated and showed she was diagnosed with 's ( ), and . Further review of Resident # 1's records showed a State of Florida Identification card that was issued in 2014. There was no	A 032		

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A 032	Continued From page 7 evidence of a current picture in Resident # 1's records. An additional review of Resident # 1's records revealed a progress note dated that stated "[Resident # 1] opened the door and went out by herself. I was at the facility with 4 residents (other employee at Department of Children's and Family (DCF) for Limited Mental Health (LMH) training. I was in the kitchen doing dishes, rescue was called by supermarket in the corner of the house. That happened a few minutes after 3pm and she was missing for only few minutes. I called immediately her son". Further review of the facility's records showed no documentation of a or elopement risk assessment after Resident # 1 was diagnosed with and . There was no other documentation that showed any preventive measures were put in place to prevent residents from eloping. On at 10:21AM, the Administrator stated "Before she had eloped, we didn't have anything in place other than knowing where they are because [Resident # 1] would always tell us where she's leaving to and come . Now since she eloped, I brought her a bracelet that has her name, date of birth, address to the Assisted Living Facility (ALF), and my cellphone. I also added an extra lock to the door and added an alarm every time the door opens". On at 11:42AM, the Administrator stated "I don't have any forms. I ' m not qualified to diagnose 's or . I know them because of their behavior and what they do or how they act. But I don't have any documentation that assess's them for behavior. The only precaution I had before the	A 032		

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A 032	Continued From page 8 incident was closer supervision. Class III	A 032		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A record that is initiated on admission.	A 162		

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A 162	Continued From page 9 Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌣ recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , [illegible] ( ), CF-ES 1006, [illegible] , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has	A 162		

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A 162	Continued From page 10 made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon	A 162		

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A 162	Continued From page 11 departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 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 have documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for one out of four sampled residents (Resident # 1). Findings Include: A review of Resident # 1's records showed she was admitted to the facility on and showed a written document that stated "To Whom It , Concern: This is to notify you that I [Son's name] Am Authorizing Casa Dulce Corazon to allow [Resident # 1] to be able to go out of the ALF at any given time, thank you". The document was signed by Resident # 1's son and dated . Further review of Resident#1's records showed no evidence of any Power of Attorney (POA) documents or any evidence the son was Resident # 1's Healthcare Surrogate. At 11:42am the administrator stated, "I don't have her POA documents because the son took them to do some other legal paperwork and hasn't brought it yet". Class III	A 162		