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
	AL11910733	A. BUILDING: _____ B. WING _____	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIP CARE PAVILION LLC	6810 SW 7TH STREET MARGATE, FL 33068

(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] and [redacted] at VIP Care Pavilion, LLC. The facility had deficiencies at the time of the survey.	A 000		
A 032 SS=B	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		

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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 observation, record review and interview, the facility failed to conduct/or document at least two elopement drills per year and ensure that all direct care staff participated in the drills as required. The Findings Include:	A 032		

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A 032	Continued From page 2 During Relicensure Survey conducted on , this surveyor reviewed the facility's Elopement drills contained in the binder that was presented by the Administrator. Observation of the binder revealed the following drills: . . . . . at 11:20 AM, an Elopement Drill was conducted in which 18 staff attended. The document states that "This included all departments and all four resident areas." Under the section entitled Staff Attending Drill: All departments were represented. However, a review of the facility's employee roster revealed that there were over 40 direct staff employed. The current staffing schedule provided indicates there are 60 direct care staff. As such all staff from all shifts were not in attendance. . . . . . (Disaster Drill), however, observation revealed that it was an elopement drill in which 16 staff attended. The employee roster revealed that the facility had more than 35 employees. As such, not all direct staff participated in the drill. . . . . . at 10:30 AM, an Elopement Drill was conducted in 13 staff were in attendance. Observation of the facility's employee roster revealed that the facility had more than 40 direct staff. . . . . . at 4:45 PM, an observation of the document revealed that there was no person indicated who conducted the drill, or the missing member suspected of eloping for the purpose of the drill. In addition, the signature page for attendees had no signatures. at 1:00 PM, observation of the document revealed that it did not contain any signatures of those who attended/or may have	A 032		

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A 032	Continued From page 3 attended the Drill. . . . . . (no time indicated), observation of the document revealed that 22 employees attended the drill. The facility's roster revealed that the facility had more than 40 direct staff, thus not all employees attended the drill. During interview with the Administrator on , this surveyor informed him that not all staff had attended the drills observed. He was also reminded of the requirements regarding drills, and that all direct staff from all shifts must participate in at least two drills per year. On the Surveyors met with the Administrator, Resident Care Director and Maintenance Director to conduct the Exit Interview. Shared with them was the findings of the survey; Specifically, observation that the facility did not conduct Elopement Drills twice per year in which all direct care staff participated. They acknowledged the findings. This surveyor also informed them that all surveys receive a supervisory review and that they will receive a report from our office within ten (10) business days. Class	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 4 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 ensure that their Comprehensive Emergency Management Plan (CEMP) was up to date/or approved by the Local County Emergency Management Division. The Findings Include: On and , a Relicensure Survey was conducted at the facility. During	A 181		

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A 181	Continued From page 5 review of the facility's Comprehensive Emergency Management Plan provided, it was revealed that the facility did not have a current CEMP approval. During interview the Administrator on [redacted], he provided this surveyor a copy of an approved CEMP letter dated [redacted] with an approval through [redacted]. This surveyor informed him that the CEMP approval had expired. The Administrator reviewed the letter then stated they had just submitted the (renewal) request. He looked again through their CEMP binder and could not locate a copy of an approval. He then stated that they had just submitted it on [redacted]. A copy of the submittal to the Local County Emergency Management Division dated [redacted] was presented to this Surveyor, who reminded the Administrator that request should be submitted at least sixty (60) days prior to the expiration date. During observation of the facility's alternative power supply, it was observed that the facility has installed two fixed generators Per the Maintenance Director, the facility is installing two fixed generators; 75KW and 38KW Generator that will use gas, both generators were observed by this surveyor. They are installed and operational and can be used in an emergency. He states that they are waiting one signature from the City and then can implement. The Maintenance Director states that the system self-test once per month. The facility was granted their prior approval (expired) based on their use of portable gas operated generators. Therefore, this is considered a substantial change warranting a new CEMP review and approval. On [redacted] the Surveyors met with the	A 181		

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A 181	Continued From page 6 Administrator, Resident Care Director and Maintenance Director to conduct the Exit Interview. Shared with them was the findings of the survey; Specifically, observation that the facility's CEMP approval had expired. They acknowledged the findings. This surveyor also informed them that all surveys receive a supervisory review and that they will receive a report from our office within ten (10) business days. Class III	A 181		