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
	AL11966601	A. BUILDING: _____ B. WING _____	02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BJ HOME CARE INC	2218 SW 26 LANE MIAMI, FL 33133

(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 number 2020000161 Survey was conducted at BJ Home Care, Inc. 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 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 whereabouts of one of two sampled residents (Resident 1). Resident 1 eloped from the facility, asked for help in a nearby business and was taken [illegible] to the facility by a family member after the business contacted them. The resident had a diagnosis of [illegible]. Findings included: Review of Resident 1's record showed an admission dated [illegible] and a discharge dated [illegible]. The resident's health assessment dated [illegible] showed no [illegible], no elopement risks, early [illegible], [illegible] problems, and [illegible]. The resident was independent in all activities of daily living. Notes on record showed: [illegible] - "The resident went outside for fresh air as he always does. As the employee noticed that the resident was taking too long, she went outside to get him. One hour later we received a	A 025		

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A 025	Continued From page 2 call that he was a few blocks from the facility." Review of the police report regarding the incident showed stated, "Person reporting: [Staff C]. I was dispatched to the facility in reference to a missing elderly person. Upon arrival contact was made with [Staff C] who stated that Resident 1 usually goes for walks, but he always returns within minutes but his time he went for a walk from home. He was found nearby. He was found in good health conditions and rescue wasn't needed." On , at 11:15 AM, Staff C stated, "Resident 1 went out that day; he was very active but did not have too much control of him; he was tough and strong and liked to do whatever he wanted to do. Around 11:00 AM is when we noticed he was not in the house. He used to sit outside and about 15 to 20 minutes later he was no longer outside. We called the owner. I walked around the and did not see him. I called the family and spoke to the daughter; she told me not to worry, that he had his phone and would call her. At 2:00 pm, he was already ; they found him in a nearby restaurant; he was eating. Staff B called the police and they came to look; we had to call them, and we did. Now, we have alarms on the exit doors; we also put a bracelet to Resident 1 because he was very ambulatory." On , at 11:30 AM, Staff B stated, "I have been here for 10 years; we did the elopement drill last year; we pretend a resident is lost and we follow the procedures we have to look for the resident and report it. When Resident 1 left; he used to go out to get coffee at his family's, who lives around here. That day he told me that he was going to get coffee, that was in the morning after breakfast around 9:00 am; we were	A 025		

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A 025	Continued From page 3 waiting for him around 11 am; I told Staff C, I am going to call 911; when they came, while here, the daughter called to let us know that he was with them; the police did not have to look for him. It was about ½ hr." Review of the facility's elopement policy and procedures showed last drills performed . . . . . There was no other documentation indicating that other drills were conducted. On . . . . , ... at 4:20 PM, Resident 1's family member stated, "They called me to let me know that they could not get in touch with him, that he was not answering the phone; I also called him and did not answer. I think that this facility would let him go out to walk and come . . . . He called me around midday after we had lunch and told me that he was walking and could not find the house. He called me like 3 times during the time he was at this facility. This time, he got to a place and asked for help, I think it was a restaurant and when they called me, I called a family member who lives near the facility so she could pick him up. He had a bracelet that I put on him but he took it off and did not want to carry another one; the only ID he had was the resident card and he lost it a long time ago and I never requested a Florida ID." On , at 6:30 PM, Resident 1's family member stated, "We picked him up about four times when he was at this house. One time, he was reclined to the fence of this house by 23 rd Ave SW and 3rd St. He was sweating; my husband would help in the search. Another time, he was around NW 3 Ave and 3 St. One time, Staff C called me to let me know that he was not again, but his daughter had called me	A 025		

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A 025	Continued From page 4 already to pick him up. The last time, he knocked on a house, I think it was around SW 2nd St. and 7th Ave. but when we arrived the police was already there. The people from the house called the police and I guess the police saw the bracelet with his daughter's phone number and called her. She called me and we went to pick him up; he said that he went out to buy shaving blades." Class II	A 025		
A 032 SS=G	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 5 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 observation, record review and interview, the facility failed to follow its policy and	A 032		

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A 032	Continued From page 6 procedures regarding elopement for two of two sampled residents (Residents # 1 and 2). Resident 1, who eloped from the facility, and Resident 2, who was also identified as at risk of elopement, did not have the facility's contact information. Resident #1 was not assessed for Elopement Risk on several occasions after returning from . Findings included: Review of the facility's adverse incident reports showed no incidents reported since . Review of Resident 1's observation notes dated showed "The resident went outside for fresh air as he always does. As the employee noticed that the resident was taking too long, she went outside to get him. One hour later we received a call that he was a few blocks from the facility." There were no other notes on record and there was no documentation of a new elopement risk assessment performed by the primary health provider. Review of the facility's Elopement Policy and Procedures showed "The risk of and elopement increases when residents are mobile and , especially if they suffer from or ." The procedures stated, "Identify those residents with the identifiable potential to or elope. It will be performed during the admissions process to ascertain the resident's history of /elopement, as well as alterations in mental status that could potentially contribute to a /elopement behavior. All new residents with any type of , or depressed affect will be considered at increased risk during this time frame. After the initial	A 032		

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A 032	Continued From page 7 assessment routine reassessment will be completed to determine changes in mental status, behavior and effectiveness of the chosen intervention. Staff will monitor the resident's behavior because these types of changes may occur subtly and gradually over time. In addition, each resident my exhibit individual behavior patterns for /elopement calling for a variety of intervention tailored to specific patterns." Review of Resident 2's Health assessment dated showed diagnoses of Type 2, D deficiency, The resident was considered at risk of elopement, used a walker to ambulate and a wheelchair for long distances. She needed precautions and assistance with bathing, , grooming, toileting, transferring. On at 11:25 AM, observed Resident 2 with a bracelet with the following information: Resident's name; memory and a Toll free number(Medical Alert Emergency Response Team). The bracelet did not contain any information about the facility's contact information. Class II	A 032		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgrnt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and	A 165		

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A 165	Continued From page 8 reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the	A 165		

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A 165	Continued From page 9 identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) [redacted], neglect, or [redacted] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this	A 165		

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A 165	Continued From page 10 section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to submit an adverse incident report within one business day after the incident and a full report within 15 days to the agency. Resident 1 eloped several times within months of residency. Findings included: Review of the facility's adverse incident reports showed no incidents reported since Review of the local police department's report stated, "Person reporting: Staff C, I was dispatched to the facility in reference to a missing elderly person. Upon arrival contact was made with Staff C who stated that Resident 1 usually	A 165		

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A 165	Continued From page 11 goes for walks, but he always returns within minutes but his time he went for a walk from home. He was found near by. He was found in good health conditions and rescue wasn't needed." On , , at 11:15 AM, Staff C stated, "Resident 1 went out that day; he was very active but did not have too much control of him; he was tough and strong and liked to do whatever he wanted to do. Around 11:00 am is when we noticed he was not in the house. He was used to seat outside and about 15 to 20 minutes later he was no longer outside. We call the owner. I walked around the and did not see him. I called the family and spoke to the daughter; she told me not to worry, that he had his phone and would call her. At 2:00 PM, he was already ; they found him in a near restaurant." On , , at 11:30 AM, Staff B stated, "When Resident 1 left; he used to go out to get coffee at his family that lives around here. That day he told me that he was going to get coffee; that was in the morning after breakfast around 9:00 am; we were waiting for him around 11 am; I told Staff C, I am going to call 911; when they came, while here, the daughter called to let us know that he was with them; the police did not have to look for him. It was about ½ hr." On , at 4:20 PM, Resident 1's family member stated, "He called me around midday after we had lunch and told me that he was walking and could not find the house. He called me like 3 times during the time he was at this facility. He got to a place and asked for help, I think it was a restaurant and when they called me, I called a family member who lives near the facility so she could pick him up. He had a	A 165		

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A 165	Continued From page 12 bracelet that I put on him but he took it off and did not want to carry another one; the only ID he had was the resident card and he lost it a long time ago and I never requested a Florida ID." On , , at 6:30 PM, Resident 1's family member stated, "We picked him up about four times when he was at this house. One time, he was reclined to the fence of this house by 23rd Ave SW and 3rd St. He was sweating; my husband would help in the search. Another time, he was around NW 30th Ave and 30th St. One time, Staff C called me to let me know that he was not again, but his daughter had called me already to pick him up. The last time, he knocked on a house, I think it was around SW 22nd St. and 17th Ave. but when we arrived the police was already there. The people from the house called the police and I guess the police saw the bracelet with his daughter's phone number and called her. She called me and we went to pick him up; he said that he went out to buy shaving blades." On , , at 7:00 PM, the Administrator stated the resident did not elope or . He said they called the police because the resident was not answering his phone; he thought it was not considered elopement. Class III	A 165		