

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/06/2021
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CARING ANGELS HOME OF FLORIDA, INC

**118 MEADOWLARK DR
ROYAL PALM BEACH, FL 33411**

(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, Focused Control, and Generator Assessment survey was conducted at Caring Angels Home Of Florida, Inc. on The facility had deficiencies identified 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	A 032		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 032	Continued From page 1 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 interview and record review, the facility failed to conduct a minimum of two resident elopement prevention drills per year. The facility failed to ensure that all administrators and direct care staff participate in the drills which shall include a review of procedures to address resident elopement.	A 032		

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A 032	Continued From page 2 The findings included: On a review of the facility staff schedule was conducted. The following number of direct care staff are scheduled on these shifts: 07:00 AM - 07:00 PM = Administrator, Date of Hire: - Live-in = Staff A, Date of Hire: 01:00 PM - 05:00 PM = Staff B, Date of Hire: - Per Diem (As needed) = Staff C, Date of Hire: The total number of staff for the this facility is 4. On a review of the facility elopement drill folder was conducted. It was revealed that the following drills were conducted: a)The facility conducted an elopement drill on . Only the Administrator is listed as a participant. b)The facility conducted an elopement drill on . Only the Administrator and Staff B are listed as participants. This surveyor reviewed the file for additional elopement drills but no additional information was located. This surveyor informed the Administrator on at 02:06 PM, that not all staff participated in the drills. This surveyor informed the Administrator that all Administrators and direct care staff must participate in the 2 required drills per year. The Administrator was given an opportunity to provide proof of the participation , no additional information was provided. During an interview on at 03:42 PM	A 032		

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A 032	Continued From page 3 the Administrator acknowledged the findings and no additional information was provided. Class III	A 032		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF: (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their	A 078		

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A 078	Continued From page 4 assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that evidence of a negative examination must be documented on an annual basis by a Provider, for 1 of 3 sampled employee personnel records reviewed (Staff B). The findings included:	A 078		

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A 078	Continued From page 5 A review of Staff B's employee record revealed a hire date was on The physician statement indicating that Staff B was free from Communicable (CD) and had a negative () statement was signed by the physician but did not list a date for the examination. This surveyor informed the Administrator that the examination must be documented on an annual basis and gave the Administrator an opportunity to locate the correct document. The Administrator stated that the exam was completed, but she just needs to obtain an updated form. No additional information was provided. During an interview with the Administrator, on at 3:42 PM, she acknowledged the findings and no additional information was provided. Class III	A 078		