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
	AL11910890	A. BUILDING: _____ B. WING _____	01/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE AND LOVE RETIREMENT HOME, LLC	642 EAST 21ST STREET HIALEAH, FL 33013

(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 (#2020003783) and complaint survey (#2021000320) was conducted at Care and Love Retirement Home, LLC. on . . . . . thru . . . . . . Deficiencies were identified at the time of survey.	A 000		
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), 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		

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A 032	Continued From page 1	A 032		

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)(i), 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 for one out of the twenty sampled residents (Resident#20), who left the facility without staff knowing his whereabouts. The resident was not reassessed after he eloped on . The facility also failed to provide

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A 032	Continued From page 2 documentation of having conducted a minimum of two resident elopement prevention and response drills per year. The facility failed to follow its own policy and procedure by documenting that staff had been retrained on elopement after Resident#20 eloped. Findings Included: 1) A review of the facility's records dated showed Resident#1 eloped on . The report stated "At 11:20 pm, Resident#1 jumped the fence to go outside the facility, immediately he knocked on the door to notified the employee that was leaving and said "Good Bye", and left. Staff B tried to persuade him not to leave but it was impossible. In the previous evening, he had an argument with his mom regarding money, Resident#1 was very upset with his mom. At 11:23 pm, the police was called and arrived to the premises, they looked for him, but he was not found. At 11:30 pm, the residents 's mother was called and at 11:50 pm local hospital were called, and he was not there." (sic) A review of the facility's elopement policy showed, "It is the policy of the facility to 1) Establish a method of assessing residents for risk of and eloping at the time of the admission and as needed; 2) Develop and implement preventive measures to make sure to stop and elopement whenever possible; 3) Conduct and document a minimum of 2 elopement drills per year." On at 1:50 pm the Administrator stated as a preventative method against reoccurrence of the resident leaving, she and Resident#1's family member informed the resident on the dangers of the leaving the facility.	A 032		

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A 032	Continued From page 3 On at 12:58 pm Resident#1's mother stated she informed Resident#1 how dangerous it was to leave the facility and confirmed he wouldn't do it again. On at 3:05 pm Resident#1 stated," My mom and the Administrator told me it's dangerous and not to do it again. I won't do it again because it's pretty dangerous and plus with the . I was just mad because I really wanted some Popeye's chicken and my mom bought me pizza". A review of the facility's records showed that there was no documentation of any preventive measure that was put in place to prevent the resident from the eloping again. On at 1:49 pm the administrator stated," His mother and I talked to the resident, educated him that he couldn't do it again. I don't think he will do it again. He knows. I don't believe he is an elopement risk". A review of the Resident#1's behavioral health clinical discharge summary dated on showed the resident had discharge diagnosis of an unspecified ; with acute exacerbation. A review of Resident#1's health assessment dated on showed the resident did not have any medical history or diagnosis. The resident was independent with all activities of daily activities. The resident was not listed as an elopement risk. A review of the Resident#1's record showed there was no documentation that the resident was	A 032		

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A 032	Continued From page 4 reassessed for elopement risk after the resident eloped on . On at 1:09 pm Resident#1's mother stated regarding the reassessment," No, not yet. He has , , coming up next week. I will have the doctor assess him". On at 1:56 PM Resident#1's physician stated," The administrator called and told me Resident#1 eloped from the facility. I didn't order any medication for him. He went to his mother's house. She dropped him off an . I have not assessed him yet. I will be coming to the facility this week to have him reassessed". 2) A review of the facility's policies and procedures showed the facility would conduct a minimum of two elopement drills per year. A review of the facility's records showed that the last elopement drill was conducted on . There was no documentation showing the facility conducted an elopement drill in the year of 2020 or after Resident#1 eloped on . On at 3:15 pm Staff B stated she didn't remember the last time the facility had elopement drill. On at 1:45 pm the Administrator stated," We conducted a elopement drill on , , and on ". Then, she stated that she didn't have written verification of the drills, however she'd saved the dates in her personal planner. A review of the facility's elopement policies and	A 032		

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A 032	Continued From page 5 procedures showed that, in response to a resident elopement, staff would receive in-service training regarding the facility's elopement response policies and procedures within 30 days of elopement. A review of Staff C's file showed the employee completed an Elopement training on . A review of Staff D's file showed the employee completed an Elopement training on . A review of Staff E's file showed the employee completed an Elopement training on . A review of Staff F's file showed the employee completed an Elopement training on . A review of Staff G's file shoed the employee completed an Elopement training on . A review of Staff H's file showed the employee completed an Elopement training on . There was no documentation that any staff completed an Elopement training after Resident#1 left on On at 12:18 pm the Administrator stated," The staff haven't completed the training." Class III	A 032		
A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be	A 160		

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A 160	Continued From page 6 readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [illegible]; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of [illegible]. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of	A 160		

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A 160	Continued From page 7 the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with . . . . 's . . . . or related , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health,	A 160		

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A 160	Continued From page 8 extended congregate care, or limited nursing services, records required as stated 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 observation, record review, and interview the facility failed to have an up-to-date admission and discharge log. One out of twenty sampled residents (Resident#20) was not listed. The facility also failed to keep the facility's record readily available for one of the nineteen sampled residents (Resident#20). Findings Included: 1) On at 10:30 am, did not observed resident#20 in the facility during the time of the visit. A review of the admission and discharge log showed the resident was admitted to the facility on and was not discharged. On at 11: 27 am, Staff C stated," I don't know Resident#1. He doesn't live here". A review of Resident#20's progress notes showed that the resident had , on from a . On at 1:47 pm the Administrator stated," Resident#20 had , from a massive . I will update the log". 2)	A 160		

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A 160	Continued From page 9 A review of the facility's adverse incident report filed on showed Resident#20 was taken to an outpatient medical procedure by transportation services offered by his insurance company and did not return to the facility. The report noted" At approximately 5:45 pm, resident had not returned to the facility. Administrator told Staff to inform her as soon as the resident returned. Administrator never received a call from staff regarding the resident's return. The following day on Administrator arrived at approximately 9:15 am and immediately found out that Resident had not returned to the facility." It also stated, "At approximately 2:30 pm we received a call from the case manager that resident was admitted to [ ] Hospital. Administrator called and spoke with Nurse at the Hospital and confirmed resident was there and stable." A review of the Resident# 20's record showed there was no documentation about the incident. A review of the ambulance run record showed that the resident received ( ) from the staff on duty until Emergency Medical Services arrived. On at 2:15 pm the Administrator stated that she was not the administrator or hired by the facility during the time of the incident. She stated," Let me call the former administrator and maybe she can help better". On at 2:26 pm, the former administrator stated she didn't write any notes about the event. She further stated that she printed out the adverse incident report, put it in the resident's file and that was 'used as notes'.	A 160		

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A 160	Continued From page 10 Class III	A 160		
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. [illegible], 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 [illegible], 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, [illegible], 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 [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily	A 162		

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A 162	Continued From page 11 living must have their [illegible] 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 [illegible] 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 made a good faith effort to obtain the required documentation from the Department of Children and Families.	A 162		

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A 162	Continued From page 12 (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 departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended	A 162		

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CARE AND LOVE RETIREMENT HOME, LLC	642 EAST 21ST STREET HIALEAH, FL 33013

(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 162	Continued From page 13 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 an accurate health assessment for one out of twenty sampled residents (Resident#1). Findings Included : A review of Resident#1's health assessment dated showed no medical history or diagnosis . The resident requires assistance with self- administration of medication however was listed as independent with all other activities of daily activities. A review of the Resident#1's behavioral health clinical discharge summary dated on showed the resident had discharge diagnosis of an unspecified ; with acute exacerbation. On at 1:47pm, the Administrator stated, "I received the health assessment from court. I'll have the health assessment updated. Class III	A 162		