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
	AL11966548	A. BUILDING: _____ B. WING _____	01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEAVENLY HOME CARE OF FLORIDA, INC	17321 SW 109 AVENUE 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 (#2020017904) was conducted at Heavenly Home Care of Florida Inc on and concluded 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 shall 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 must notify the resident ' s representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for 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	A 025		

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A 025	Continued From page 1 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. (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 observation, record review, and interview, the facility failed to provide care and services and to offer personal supervision appropriate to the needs of one out of five sampled residents (Resident #1). Resident #1 eloped twice from the facility. During the first incident on . . . . . the resident eloped for an unknown number of days. During the second incident on . . . . . the resident eloped for four days and his whereabouts were unknown. Findings included: Incident 1	A 025		

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A 025	Continued From page 2 A review of the facility reports filed on revealed that Resident #1 left the facility without staff knowing his whereabouts on . There was no information about when Resident #1 returned to the facility. During a complaint investigation on between approximately 9:00 am and 2:00 pm, observation revealed Resident #1 was not at the facility for the duration of the inspection. During an interview on at 9:45 AM, the administrator stated Resident #1 went to the store around 8 or 9 AM. Review of the Resident Sign in and Sign out Log revealed the most recent sign out was completed on by Resident #1. However, the facility did not have written documentation that Resident #1 signed the log on or . During an interview on at 9:45 AM, the administrator stated that "the residents don't always sign in and out the log. Resident #1 refuses to sign in and out." Review of Resident #1's record revealed the resident was admitted to the facility on . Resident #1's health assessment (AHCA Form 1823) completed on , revealed a medical history and diagnoses of , , , and ( ). Resident #1 was considered an elopement risk and needed assistance with ambulation, bathing, , grooming, transferring, and self-administration of medication.	A 025		

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A 025	Continued From page 3 Review of Resident #1's progress notes dated [redacted] revealed "Resident #1 was here for breakfast, he ate and said he was going on his walk and he did not return for lunch. We are calling and filing a missing person report. We checked and searched, and I called the hospital, nearby stores, and his family." Review of Resident #1' Medications Observation Records (MOR) showed that at the time he eloped, he was taking [redacted] 1 Tablet daily, [redacted] 500 MG tab 3 tablets at bedtime, [redacted] 2 MG 1 tablet two times a day, [redacted] 4 MG 1 Tablet two times a day, [redacted] 150 mg 2 tablets at bedtime. Review of Resident #1's progress notes dated [redacted] revealed "Resident #1 was found walking home. I picked him up and brought him home. He was given a bath and his meds and went to lie down. I asked Resident #1 where he was, and he said he didn't know. I asked him not to leave anymore and he laughed. I called the family and updated the AHCA [Agency for Health Care Administration] report." During an interview on [redacted] at 11:00 AM, the administrator stated that Resident #1 eloped from the facility on [redacted]. The administrator further stated that "Resident #1 ate breakfast and took his meds, then he went for a walk to the gas station where he normally hangs. She stated it was not unusual for Resident #1 to miss lunch and return to the facility for dinner. She further stated "When I did not see him at 6 pm, I followed our procedure to check in and around the facility. Then I called the police to report him missing and called the family. About four days later, around [redacted], I found him one [redacted] from the facility	A 025		

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A 025	Continued From page 4 and once he returned, I told the family and police. Resident #1 did not go to the hospital and his routine doctor's visit was coming up. I believe the doctor came to see Resident #1 on ." When asked what precautions the facility took to prevent future elopement, the administrator stated, "a doorbell sensor with a chime was installed on the front door and a gate was going to be installed on the side of the facility." On at 11:08 AM, the administrator stated " I don't remember who was working that day in when Resident #1 went missing. I did not have it written down in notes, I am going off of memory." The administrator further stated, "I asked Resident #1 where he was for those 4 days and he said he couldn't tell me." On at 11:48 AM, Resident #1's case manager stated " I was aware this resident had an issue earlier last year with leaving the facility, so I am aware that he is prone to elopement. I am not aware of any other issues with him leaving the facility. I was not made aware of the resident eloping in ." Review of Resident #1's record revealed no documentation of a follow up visit with a medical provider after the elopement on . There was also no documentation that the resident was reassessed by a medical provider following the elopement on . Incident 2 A review of the facility adverse incident reports filed on on the incident report database revealed that Resident #1 eloped on . There was no information about when Resident #1 returned to the facility.	A 025		

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A 025	Continued From page 5 Review of Resident #1's progress notes completed on . . . . . showed "On . . . . . , Resident #1 went missing. I did not see him return during dinner time. I've spoken to the sister and she advised that I call him medicine and wait 24 hours I did so I made a police report and incident report. When Larry returned home the sister picked him up from the gas station with a police officer and she had a long talk with him about not walking away from the facility anymore. Resident #1 returned home and was okay." During an interview on at 11:15 AM, the administrator stated "On . . . . . , I noticed Resident #1 did not come to the dinner table around 6 pm. I called the hospitals, police station, and family and we did a search for him in and around the facility and could not find him. I made a police report the same day. Resident #1 was brought . . . to the facility by the police and his sister, but I can't remember the exact date he returned. When asked what precautions the facility took to prevent future elopement; The administrator stated, "we implemented a sign in and sign out log for the residents and we got Resident #1 a bracelet and ID necklace." On . . . . . at 1:48 PM, Resident #1's sister stated "Every now and then Resident #1 will drift off and forget how to get home. I was aware that he went missing in , he told me he stayed overnight with friends. The administrator found him the next day walking around the neighborhood. In . . . . . of 2020 he was missing for about three days and the police found him at a store." On at 9:52 AM, Resident #1's psychiatrist stated "Resident #1 has a history of	A 025		

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A 025	Continued From page 6 elopement. I was informed that he eloped last year , and we decided to give him an injection since he was not complying with his medication. This resident eloped more than once in 2020." Review of Resident #1's record revealed no documentation of a follow up visit with a medical provider after the elopement on . A review of the resident record showed no intervention after either elopement which would prevent reoccurrence. Interviewed on at around 12:00 pm, the administrator stated that the staff could not recall who was on duty during the elopements because it was 'too long ago', and she had not written it down. She further stated that the facility gave Resident #1 a wristband containing identifying information. The administrator conformed that the Resident returned to the facility on . 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 032		

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A 032	Continued From page 7	A 032		

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. 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

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A 032	Continued From page 8 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 policies and procedures regarding elopement when one out of five sampled residents eloped from the facility twice (Resident #1). Resident #1 had a history of elopement and no interventions were implemented to prevent the occurrence from happening at the facility. The facility failed to conduct two elopement drills per year as outlined in their elopement policy and procedures. Findings included: Review of the facility adverse incident reports filed on . . . . . on the incident report database revealed that Resident #1 eloped on . There was no information about when Resident #1 returned to the facility. Review of the facility elopement policies and procedures revealed "It is the policy of the facility to conduct and document a minimum of 2 elopement drills per year."	A 032		

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A 032	Continued From page 9 Review of the facility elopement drills showed that the last elopement drill was conducted on [redacted]. There was no documentation that showed any other elopement drills conducted in 2020. During an interview on [redacted] at 11:40 AM Staff C stated" the owner does elopement drills, but I cant remember when the last one was." Record review of Resident #1's record revealed the resident was last reassessed by a healthcare provider on [redacted]. There was no documentation of the resident being reassessed after eloping on [redacted]. Review of Resident #1's record revealed the resident was admitted to the facility on [redacted]. Resident #1's health assessment (AHCA Form 1823) completed on [redacted], revealed a medical history and diagnoses of [redacted], and [redacted]. Resident #1 was considered an elopement risk and needed assistance with ambulation, bathing, grooming, transferring, and self-administration of medication. During an interview on [redacted] at 10:58 AM, the administrator stated she had no residents that were an elopement risk. Resident #1's family and doctor do not consider him an elopement risk, he is [redacted]. But we had him reassessed after eloping in [redacted], and he is now considered an elopement risk." Review of the facility's incident reports filed on [redacted] revealed that Resident #1 eloped on [redacted]. There was no information about when	A 032		

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A 032	Continued From page 10 Resident #1 returned to the facility. During an interview on at 11:15 AM, the administrator stated that when the resident eloped in , "Resident #1 was brought to the facility by the police and his sister, but I can't remember the exact date he returned. When asked what precautions the facility took to prevent future elopement; The administrator stated, "we implemented a sign in and sign out log for the residents and we got Resident #1 a bracelet and ID necklace." During an interview on at 11:36 AM, the administrator stated that the staff was retrained on elopement sometime after . The consultant came on and retrained all of us." When the administrator was asked for documentation of staff retraining on elopement; the administrator did not provide any. Observation on at 9:30 AM revealed Resident #1 was not at the facility for the duration of the survey. Record review of the Resident Sign in and Sign Out log revealed Resident #1 did not sign out on when he eloped. Further review revealed Resident #1 did not sign out on . During an interview on at 9:45 AM, the administrator stated Resident #1 went to the store around 8 or 9 AM. During an interview on at 9:45 AM, the administrator stated that "the residents don't always sign in and out the log. Resident #1 refuses to sign in and out."	A 032		

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A 032	Continued From page 11 Class II	A 032		