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
	AL11910951	A. BUILDING: _____ B. WING _____	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALMOS 23 #4 LLC	70 EAST 21ST STREET HIALEAH, FL 33010

(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 (complaint number 2020012816) was conducted at Salmos #4 LLC from to . A deficiency was identified at the time of the survey.	A 000		
A 025 SS=E	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 resident diets in accordance with rule	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 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 record review and interview, the facility failed to maintain a general awareness of the whereabouts of two out of 68 sampled residents (Resident #1 and #2). Resident #1 eloped from the facility, found by law enforcement. Resident #2 jumped the fence and whereabouts were unknown for approximately 7 hours. Findings included: 1) A review of the Incident Report System (AIRS) revealed that on Resident #1 jumped the facility fence at around 4:37 PM and whereabouts was unknown. Resident returned to	A 025		

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A 025	Continued From page 2 the facility at around 11:21 PM. Review of Resident #1 facility progress note dated revealed resident jumped the facility backyard fence at 4:37 PM and returned to the facility on his own at around 11:21 PM. Review of Resident #1 health assessment dated showed diagnosis of and . Resident was not identified as being an elopement risk. Resident identified as being independent with ambulation, ,,eating, toileting and transfers and required assistance with bathing, grooming and self-administration of medications. During an interview on at 1:51 PM, Resident #1 stated he jumped over the fence because he wanted to go to the store to buy cigarettes and the staff would not unlock the gait. He stated one of the staff members saw him leaving the facility and asked him to come . He stated, "I was locked up inside the facility for eight months and needed to get out". 2) A review of the Incident Report System (AIRS) revealed Resident #2 eloped from the facility on . The report showed that Resident #2 was last seen in the facility on at around 09:54 PM. Resident was seen by police on at around 1:37 PM walking on the street and he was returned to the facility. A review of the police report for Resident #2 showed law enforcement arrived at facility on at 01:33 PM. The report revealed that Staff C reported she last saw Resident #2 on	A 025		

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A 025	Continued From page 3 at around 09:00 PM. A review of a second police report for Resident #2 revealed on at 02:32 PM, law enforcement responded to a call on a person who seemed lost and walking the street. According to the police report, Resident #2 was found the street about 0.4 miles from the facility. Law enforcement brought Resident #2 to the facility. A review of Resident #2's health assessment dated showed medical history and diagnoses of and . Resident #2 was identified as an Elopement Risk, precautions and universal precautions. Resident #2 identified as being independent with ambulation, eating, and transfers and needed assistance with bathing, , grooming, and toileting. The resident also needed assistance with self-administration of medications. During an interview on at 01:00 PM, The administrator stated Resident #2 eloped from the facility in . She stated Resident #2 was identified as an elopement risk. During an interview on at 11:20 AM, Staff C (supervisor and direct caregiver), stated on at around 9:30 PM, she went to assist resident with changing his clothes and she noticed Resident #2 was not at the facility. Staff C stated Resident #2 was identified as an elopement risk. Class III	A 025		