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
	AL11966541	A. BUILDING: _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW WOOD HOMES LLC	25799 SW 122 PLACE HOMESTEAD, FL 33032

(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 2021005837) was conducted at Meadow Wood Homes, LLC on and concluded on . The provider had deficiencies at the time of the survey.	A 000		
A 025 SS=J	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 interview and record review, the facility failed to provide adequate supervision and to maintain a general awareness of one out of six sampled residents (Resident #1). Resident #1 left the facility and was found by a passerby on the ground in , distress, transferred by rescue to the hospital on . The resident was not able to be identified, was unresponsive, intubated and admitted in the with diagnoses of , , and , distress. Findings included:	A 025		

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A 025	Continued From page 2 A review of the Incident Report System (AIRS) revealed Resident #1 eloped from the facility on [redacted]. The report showed that Resident #1 was last seen in the facility on [redacted] after lunch time. Also, the report showed that the facility called the police on [redacted] at around 2:00 PM to report the resident missing. A review of Resident #1's health assessment dated [redacted] showed diagnoses and medical history of [redacted] ([redacted]), [redacted] ([redacted]), xerosis and onychomycosis. The resident was independent in ambulation and eating; needed supervision with bathing, [redacted], self-care (grooming), toileting and transferring; and needed assistance with the self-administration of medication. Review of the hospital record dated [redacted] showed Resident #1 was found by a passerby on the ground in [redacted] distress and was transferred by Emergency Medical Services to the hospital on [redacted], two days before the facility reported the resident missing. The record further stated that the resident was not able to be identified, and that he was unresponsive, intubated and admitted in the [redacted] with diagnoses of [redacted], and [redacted] distress. Further review of the hospital record showed the resident's POC [redacted] level was 4.77 mmol/L, considered critical. According to Mayo Clinic, any sort of [redacted] or tissue [redacted] can cause the elevation, and [redacted] levels above 4.0 mmol/L had an approximate 95% mortality rate. During an interview on [redacted] at 10:45 AM, Staff B (live-in caretaker) stated that Resident #1	A 025		

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A 025	Continued From page 3 went out for the day on . She stated, "he went out as usual, but he did not come . We waited 24 hours to call the police. A few days later someone from a local hospital called and said that the resident was admitted. The police found him with some ." According to Staff B the facility does not keep a written record of residents leaving the premises and they have no way of knowing resident whereabouts. On at 11:17 AM during a telephone interview, Staff C (live-in caretaker) stated that Resident #1 went out on and he never came . After noticing that he was not Staff C went out to look for him at a store, where the resident often went, located on a main intersection approximately 2 miles from the facility. Staff C further stated that Resident #1 used to go out walking by himself, but sometimes somebody would bring him . Staff C further stated that the next day (on) he called the police. Then, the hospital called on and informed Staff C that Resident #1 had been in the hospital for a few days. During a second interview on at 11:50 AM Staff C stated that he did not remember exactly the day when Resident #1 left but it was after lunch. Staff C added that Resident #1 used to go out and 'might not come the same day', so they waited around 1 or 2 days to call the Owner and the police. Staff C confirmed that the facility did not keep a written record of residents leaving the premises and have no way of knowing resident whereabouts. On at 11:39 AM during a telephone interview with Resident #1's sister-in-law, she stated on that facility owner's sister	A 025		

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A 025	Continued From page 4 called and said the resident had left the facility the previous day, and had not came . She stated that the resident had left the facility before for approximately a week or so, and he used to go out and not come for days. She further stated that the police called her to inform her that Resident #1 was in the hospital. On at 2:52 PM during a telephone interview, the Owner stated that the Administrator informed him that Resident #1 went out on and did not come . He further stated that Resident #1 used to go out and sometimes did not return the same day, but he always informed or called the facility staff. The Owner stated that since this was the first time Resident #1 did not come without calling, they reported the resident missing to the police the next day, . During a second interview on at 4:19 PM the Owner stated that Staff B and Staff C called him to tell that Resident #1 was not at the facility. The Owner also stated that he did not remember the exact day Resident #1 left but it was approximately days later that he told the staff to report to the police, because the resident used to go out, but that the resident had not been absent for many days without informing someone at the facility. A review of Resident #1's record showed there was no documentation that he had left the facility before, without staff knowing his whereabouts. There was no documentation of any interventions put in place. There was no documentation the physician was notified of resident previously leaving the facility and returning several days later. There was no documentation resident was reassessed for elopement.	A 025		

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A 025	Continued From page 5 During a telephone interview on at 12:56 PM the Administrator stated that she was not at the facility when Resident #1 left, but the staff informed her that the resident left on and they reported his absence to the police on . When asked, the Administrator could not explain the discrepancies of why staff reported Resident #1 went missing on his birthday, and the hospital record showed resident had been found on the street and admitted to the hospital on . Review of the facility's elopement risk assessment and policy showed that "the resident will be reassessed if "the resident is exhibiting restlessness and/or agitation." Review of Resident #1's progress notes completed on , , and revealed that the resident had repeatedly reported being restless/ and wanted to leave the facility, but there was no documentation of an assessment. Class I	A 025		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the	A 054		

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A 054	Continued From page 6 resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a daily medication observation record for each resident who receives assistance with self-administration and update the medication observation record each time the medication is offered or administered for one out of six sampled residents (Resident #1). Findings included: A review of hospital records showed Resident #1 was in the hospital on [illegible] and	A 054		

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A 054	Continued From page 7 Review of Resident #1 medication observation record (MOR) showed the medications was signed by staff as given on, , and at 7:00 AM; , 1 mg, , 0.5 mg, 0 mg, 50 mg, , 20 mg, and 10 mg. and medications signed as given on and at 7:00 PM; , 1 mg, , , 10 mg, 30 mg and 10 mg. On at 10:58 AM, Staff B stated, "I signed the MOR because I made a mistake." Class III	A 054		