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
	AL11910896	A. BUILDING: _____ B. WING _____	04/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM F/F INC	34 W 14TH 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 (#2020020394) was conducted at Adam F/F Inc. on . The provider had deficiencies 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 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 residents' whereabouts for one out of 18 residents (Resident #1) who eloped from the facility. Findings Included: Review of the adverse incident database showed the facility reported Resident#1 eloped from the facility on ; record review revealed that the police report was done on . The resident was found 12 miles away by law enforcement on , he was due to acute neglect and admitted to the hospital	A 025		

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A 025	Continued From page 2 with a diagnosis of [redacted] with Acute Exacerbation. He remained at the hospital 7 days. Record review revealed Resident # 1 was taking [redacted], 0.5 mg daily, [redacted], 10 mg twice a day, [redacted] 325 mg daily, [redacted] 1 mg daily, [redacted], 10 mg twice a day, [redacted], 10 mg daily, [redacted] DR 20 mg daily, [redacted] 20 mg at bedtime, [redacted], 30 mg at bedtime and [redacted] D 50000 units once a week; all medications were taken by [redacted]. Review of Resident #1 health assessment dated [redacted] showed resident had a Diagnoses of [redacted], [redacted] Type, [redacted], Dyslipidemia and [redacted] Deficiency. Failure to take the medications would exacerbate his diagnoses. On [redacted] at 8:50 AM the Administrator stated, "I had given him the $54.00 that day. I was here. He is a [redacted] and was not used to being enclosed and jumped the fence. Staff E had been at the laundry at about 11:20 AM and saw him and Resident # 5 sitting in the backyard, as soon as Resident # 5 and Staff E came inside, he jumped the fence and left." Photo showed from video camera by administrator showed Resident # 1 on [redacted] at 11:27:43 AM walking in the direction of the chain link fence and looking to the entrance of the facility as if making sure nobody was watching him. Review of Resident #1 health assessment dated [redacted] showed resident had the diagnoses already listed above. Alert and oriented times 3. He was independent with activities of daily living and required assistance with self-administration of medications. He was not diagnosed as elopement risk, even though he had already	A 025		

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A 025	Continued From page 3 eloped once from the facility. Progress notes revealed that on the resident left the facility without authorization; he was behaving angry when he came and was sent to the hospital, after discharged he was sent to another facility due to moratorium of this facility; he came to the facility on and was seen by the psychiatrist on and was increased to twice a day. On at 12:00 PM Resident # 1 was called for lunch time, he was last seen in the backyard at 11:05 AM. On the police found him walking in Miami Beach, disoriented, and sent him to the hospital. On the Administrator called resident # 1 at the hospital and he stated that he did not want to return to the facility. Resident # 1 did not return to the facility. On at 11:15 AM the Administrator stated that on , the resident came 2 or 3 hours after leaving. He had left after someone left the facility and did not lock the front gate, and he got mad because he did not understand why because of Covid-19 he could not go out. He was discharged from the hospital on and was sent to Adam Home # 2 because Adam F/F was on moratorium; came to Adam F/F on and eloped on . The facility's backyard had a wall in the and the right side, but in the left side there was a chain link fence the same as the wall, there were benches closed to the fence that could easily be used as a boost to jump the fence. Resident # 1 had a history of eloping from the facility once, and was left with no staff supervision in the backyard. Review of the facility elopement policies and procedures revealed, "Elopement", is referred to	A 025		

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A 025	Continued From page 4 as an unauthorized absence of a resident from the facility. As per policies and procedures, the residents are assessed for risk of [redacted], and elopement at the time of admission and as needed. They must develop and implement preventive measures to stop [redacted] and elopement whenever possible. The police will be notified of as soon as it has been determined that the resident is not in the facility and is missing by the administrator. They must conduct elopement drills twice a year; record review revealed that the last 2 elopement drills had been conducted on [redacted] and [redacted]. Record review revealed that the facility had not reassessed Resident # 1 for elopement after he was re-admitted to the facility. The last elopement risk assessment was dated [redacted]. The police was notified on [redacted] at 12:02 PM, 24 hours after Resident # 1, with a diagnosis of [redacted], had eloped. Revealed that Resident # 2 was on elopement risk, the last time the resident was assessed for elopement by the facility was on [redacted]. On [redacted] at 11:20 AM the Administrator stated that Resident # 1 refused to wear the [redacted] guard bracelet. On [redacted] at 12:00 PM the administrator stated, "After what happened, I spoke to all the employees and told them that they needed to pay more attention to the residents in the backyard, also the cameras are now pointing to the fence to see when someone is trying to leave. Now the residents can go out freely and I do not think it is going to happen again. When it happened, because of the pandemic, they could not go out as they used to."	A 025		

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A 025	Continued From page 5 Class II	A 025		
A 030 SS=D	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided	A 030		

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A 030	Continued From page 6 pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident	A 030		

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A 030	Continued From page 7 chooses to use and can remove or avoid without assistance, is not considered a physical . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the	A 030		

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A 030	Continued From page 8 facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care ., and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally ., the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care	A 030		

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A 030	Continued From page 9 Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without [illegible], interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, [illegible], and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and, if applicable, [illegible] Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for	A 030		

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A 030	Continued From page 10 exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . . , ... or . . , ... under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure that one resident was treated with dignity, respect, and free from (Resident #1).Residents were 'not allowed' to leave the facility. Resident #1 jumped the fence in order to go outside. Findings included: A review of the AHCA Incident Report System (AIRS) showed Resident #1 jumped the backyard	A 030		

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A 030	Continued From page 11 fence on . . . . According to the report, the facility's supervisor called local authority next day to report resident missing. Photo showed from video camera by Administrator showed Resident # 1 on at 11:27:43 AM walking in the direction of the chain link fence and looking to the entrance of the facility as if making sure nobody was watching him. On at 10:03 AM the Administrator stated that Resident # 1 never said that he wanted to leave the facility, but that before Covid-19 he used to go in and out freely and because of the pandemic the residents were not allowed to go in and out. She stated that it was hard to make an , resident understand that he could not go out. On . . . . . at 12:04 PM Resident # 1's psychiatrist stated, "he did not verbalize anything, he said that everything was fine. He never said that he did not want to live at the facility or that he wanted to leave. In my opinion, he was not an elopement risk." On at 12:00 PM the Administrator stated, "after what happened I spoke to all the employees and told them that they needed to pay more attention to the residents in the backyard, also the cameras are now pointing to the fence to see when someone is trying to leave. Now the residents can go out freely and I do not think it is going to happen again. When it happened, because of the pandemic, they could not go out as they used to." Class III	A 030		

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AL243 SS=D	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing	AL243		

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(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
AL243	Continued From page 13 education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files.	AL243		

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
	AL11910896	A. BUILDING: _____ B. WING _____	04/13/2021

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AL243	Continued From page 14 This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that one out of seven sampled staff (E) completed the initial training in limited mental health within 6 months of being hired. Findings included: Facility record review revealed that the facility had limited mental health component in its license. Employee record review revealed that Staff E had been hired on . . . . . There was no documentation of limited mental health training. On at 10:29 AM the Administrator stated that there were no . . . . . to take the training due to COVID-19 and that Staff E had an . . . . . for . . . . . Class III	AL243		