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
	AL11968028	A. BUILDING: _____ B. WING _____	05/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
K'S HAVEN, INC	7813 SW 8TH COURT NORTH LAUDERDALE, FL 33068

(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 An unannounced Complaint #2021002305, Focused Control and Generator Assessment surveys were conducted on through at K's Haven, Inc. The facility had deficiencies related to the Complaint survey (#2021002305) at the time of the visit.	A 000		
A 007	59A-36.006(1) FAC Admissions - Criteria (1) ADMISSION CRITERIA. (a) An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least 2. Be free from signs and symptoms of any communicable that is likely to be transmitted to other residents or staff. An individual who has ( ) may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule. 3. Be able to perform the activities of daily living, with supervision or assistance if necessary. 4. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or administration of medication. a. If the resident needs assistance with self-administration of medication, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of	A 007		

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A 007	Continued From page 1 medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact. b. The facility may accept a resident who requires the administration of medication if the facility employs a nurse who will provide this service or the resident, or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact, contracts with a third party licensed to provide this service to the resident. 6. Not have any special dietary needs that cannot be met by the facility. 7. Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under chapter 490 or 491, F.S. 8. Not require 24-hour licensed professional mental health treatment. 9. Not be bedridden. 10. Not have any or 4 , . A resident requiring care of a may be admitted provided that: a. The resident either: (I) Resides in a standard or limited nursing services licensed facility and contracts directly with a licensed home health agency or a nurse to provide care; or (II) Resides in a limited nursing services licensed facility and care is provided by the facility pursuant to a plan of care issued by a health care provider; b. The condition is documented in the resident's record and admission and discharge logs; and, c. If the resident's condition fails to improve within 30 days as documented by a health care provider, the resident must be discharged from the facility. 11. Residents admitted to standard, limited nursing services, or limited mental health	A 007		

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A 007	Continued From page 2 licensed facilities may not require any of the following nursing services: a. [illegible] airway management of any kind, except that of continuous positive airway pressure may be provided through the use of a CPAP or bipap machine; b. Assistance with [illegible], c. Monitoring of [illegible] gases, d. Management of post-surgical drainage tubes and [illegible] vacuum devices; e. The administration of [illegible] products in the facility; or f. Treatment of surgical [illegible] or [illegible], unless the surgical [illegible] or [illegible] and the underlying condition have been stabilized and a plan of care has been developed. The plan of care must be maintained in the resident's record. 12. In addition to the nursing services listed above, residents admitted to facilities holding only standard and/or limited mental health licenses may not require any of the following nursing services: a. [illegible] and [illegible] performed in the facility; b. [illegible] performed in the facility. 13. Not require 24-hour nursing supervision. 14. Not require skilled rehabilitative services as described in rule 59G-4.290, F.A.C. 15. Be appropriate for admission to the facility as determined by the facility administrator. The administrator must base the determination on: a. An assessment of the strengths, needs, and preferences of the individual; b. The medical examination report required by section 429.26, F.S., and subsection (2) of this rule, if available; c. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may	A 007		

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A 007	Continued From page 3 not exceed the scope of the facility's license unless specified elsewhere in this rule; and, d. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in rule chapter 69A-40, F.A.C. (b) A resident who otherwise meets the admission criteria for residency in a standard licensed facility, but who requires assistance with the administration and regulation of portable [illegible] or assistance with routine [illegible] care of [illegible] site [illegible] placement, may be admitted to a facility with a standard license as long as the facility has a nurse on staff or under contract to provide the assistance or to provide training to the resident on how to perform these functions themselves. (c) Nursing staff may not provide training to unlicensed persons, as defined in section 429.256(1)(b), F.S., to perform skilled nursing services, and may not delegate the nursing services described in this section to certified nursing assistants or unlicensed persons. This provision does not restrict a resident or a resident's representative from [illegible] with a licensed third party to provide the assistance if the facility is agreeable to such an arrangement and the resident otherwise meets the criteria for admission and continued residency in a facility with a standard license. (d) An individual enrolled in and receiving hospice services may be admitted to an assisted living facility as long as the individual otherwise meets resident admission criteria. (e) Resident admission criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure admission criteria were met for 1	A 007		

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A 007	Continued From page 4 out of 5 sampled residents (Resident #5) as evidenced by the Administrator not assessing Resident #5's appropriateness for admission from the resident's medical examination and not adequately assessing the resident's individual needs and conditions. The findings included: In an interview with caregiver Staff A on at 9:20 AM, she stated she became aware Resident #5 eloped from the facility sometime last year, from caregiver Staff B. She stated Staff B told her this resident had eloped from the facility and since she was not working on the day this happened, she was not provided with more details about this event. She stated she was not aware Resident #5 was an elopement risk during the time the resident lived in the facility. Review of Resident #5's record indicated he was admitted to the facility on or about per a Court Order dated on . . . . . Review of the Resident Health Assessment dated indicated there were no medical history or diagnoses listed or documented on the form. Review of this Health Assessment indicated the resident walked with a cane, was calm without aggressive behavior, was a risk and was at risk for elopement. Review of this Health Assessment indicated the resident was independent with all of his activities of daily living, needed supervision with shopping and required daily oversight for his wellbeing, his whereabouts and reminders for important tasks. Review of the resident's Hospital record revealed a Physician note dated . . . . . at 1:35 PM, documenting the resident did not have the capacity to leave the hospital against medical advice, had a history of . . which affected his judgement and	A 007		

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A 007	Continued From page 5	A 007		

was at high risk for becoming victimized. Further review of the resident's Hospital record revealed an additional Physician note dated . . . at 9:38 PM, the resident was deemed , to live on his own and discharge planning was arranged for the resident through the Department of Children and Families (DCF).

Review of Resident #5's facility Progress Note dated , documented the resident had eloped from the facility at 6:40 AM. Review of this note documented Staff B saw the resident in the . . . patio before she noticed that the resident went missing and she then immediately searched the facility to look for the resident, but the resident was not immediately found. Review of this note documented the resident had taken a bus and was found in (name of city), and later returned to the facility. Further review of this note documented the resident expressed he did not want to live in the facility and he would prefer to live on the streets than to pay to live in the facility.

Review of the facility's undated Elopement Prevention Policies and Procedures, titled " ◡ Risk Scale", indicated that the facility was to provide a safe environment for residents who were at risk for ◡. Review of this document indicated that all residents must be assessed by the facility for ◡ risk upon admission to the facility using the provided ◡ Risk Scale form. This document indicated that each resident must be reassessed whenever there was a change in the resident's clinical condition and for every resident identified to be at risk, the facility must develop an individual Plan of Care for each of the identified residents.

In an interview conducted with the Administrator

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A 007	Continued From page 6 on [redacted] at 11:55 AM, she stated the facility did not perform an elopement assessment on Resident #5 using the [redacted] Risk Scale form upon his admission to the facility. She stated she did not know why the resident was not assessed for this. She stated Resident #5 had expressed to other residents that he did not want to live in the facility about a week before he eloped from the facility. She stated she notified the resident's representative, who was a Case Manager with DCF, and the Case Manager told her DCF was in the process to find another more suitable facility for the resident which had a more secure unit. She stated when the resident eloped on [redacted], she notified the police and she found out about a week later from DCF the resident was found unharmed in a hospital. She stated she did not receive any other information about the resident after he was found. In an interview conducted with the Administrator on [redacted] at 12:45 PM, she stated the facility did not complete an elopement prevention assessment on Resident #5 when he was admitted or when the facility became aware of the resident's desire to live somewhere else. In an interview with the DCF Investigator on [redacted] at 8:40 AM, she stated she responded to the case involving Resident #5's elopements from the facility on [redacted] and [redacted]. She stated although the resident was physically independent, he lacked capacity to make decisions, was [redacted] and had [redacted]. She stated the resident was admitted to the facility under a Court Emergency Order sometime in [redacted] and the facility was not properly equipped to provide adequate care and services for the resident, considering his elopement risk and behavior. She stated that the facility did not	A 007		

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A 007	Continued From page 7 have 24/7 care or was not a locked facility to which was needed for this resident's exit seeking behavior. She stated the facility reported on the resident eloped from the backyard and was found unharmed a couple hours later in a gas station in (name of city). She stated this behavior was consistent with the resident's knowledge and ability to use the busing transportation system. She stated on , the resident left out of his bedroom window and was found on at a hospital in (name of another city) without injury. She stated the resident was subsequently discharged to another facility which was equipped and provided the needed care and services to meet his exit seeking behavior. In an interview conducted with the Administrator on at 11:20 AM, she stated Resident #5 was admitted to the facility on and she was not aware of the resident's elopement risk status until about a week before the resident eloped from the facility. She stated besides notifying the resident's Case Manager about this, the facility did not take any steps to reduce the resident's elopement risk while the resident lived there. She stated she likely reviewed the resident's Health Assessment dated , but she did not notice that this Health Assessment indicated the resident was an elopement risk. She stated she did not notice the resident's Hospital record also indicated the resident was mentally compromised and could not make his own decisions. She stated the facility did not accept residents who were at risk for elopement because it was not equipped to care for these type of residents and it was not a locked-down secure facility. Class III	A 007		

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A 165	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse	A 165		

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A 165	Continued From page 9 incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident. (6) . , neglect, or . , . . must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief	A 165		

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A 165	Continued From page 10 that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to submit an Adverse Incident report to the Agency for Health Care Administration within 1 day after the occurrence of Resident #5's elopement on [redacted], which was an event that placed the resident at risk of harm or injury. The findings included: Review of Resident #5's record indicated that he	A 165		

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A 165	Continued From page 11 was admitted to the facility on or about . . as per a Court Order dated . Review of the Resident Health Assessment dated . . . . , indicated there were no medical history or diagnoses documented. Review of this Health Assessment indicated the resident walked with a cane, was calm without aggressive behavior, was a risk and was at risk for elopement. Review of this Health Assessment indicated the resident was independent with all of his activities of daily living, needed supervision with shopping and required daily oversight for his wellbeing, his whereabouts and reminders for important tasks. Review of the resident's Hospital record revealed a Physician note dated . . at 1:35 PM, the resident did not have the capacity to leave the hospital against medical advice, had a history of which affected his judgement and was at high risk for becoming victimized. Further review of the resident's Hospital record revealed a Physician note dated . . . at 9:38 PM, the resident was deemed , to live on his own and discharge planning was arranged for the resident through the Department of Children and Families (DCF). Review of Resident #5's facility Progress Note dated , indicated the resident had eloped from the facility at 6:40 AM. Review of this note indicated Staff B saw the resident in the patio before she noticed the resident was missing and she immediately searched the facility to look for the resident, but the resident was not found. Review of this note indicated the resident had taken a bus and was found in (name of city), and later returned to the facility. Further review of this note indicated the resident expressed he did not want to live in the facility and he would prefer to live on the streets than to pay to live in the facility. No further documentation of the resident's	A 165		

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A 165	Continued From page 12 condition or behaviors while he lived in the facility were present in the resident's record. In an interview conducted with the Administrator on at 12:05 PM, she stated the Adverse Incident report she submitted to the Agency correctly reflected Resident #5's elopement from the facility on , which was discovered by facility staff on 11-30-20. She stated Resident #5's Progress Notes, which reflected a previous elopement on , was accurate and the facility did not submit an Adverse Incident report to reflect this event which also placed the resident at risk for harm. In an interview with the DCF Investigator on at 8:40 AM, she stated she responded to the case involving Resident #5's elopements from the facility on and . She stated the facility reported on the resident eloped from the backyard and was found unharmed a couple hours later in a gas station in (name of city). She stated on , the resident left out of his bedroom window and was found on at a hospital in (a different city) without injury. Review of the Agency's Adverse Incident reporting system, it indicated the facility submitted one Adverse Incident report relating to Resident #5's elopement that occurred on . Review of this report indicated the facility submitted this report to the Agency on and was last updated on . Further review of the Agency's reporting system indicated the facility did not provide a report relating to Resident #5's elopement event on . Class III	A 165		