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
	AL11964423	A. BUILDING: _____ B. WING _____	05/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARIA PIA	322 NW 43 PLACE MIAMI, FL 33126

(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 2021006585) was conducted at Villa Maria Pia Inc. on . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=D	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		

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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 resident's whereabouts for one out of thirteen residents (Resident #1). Findings Included: Review of the facility report submitted to the agency portal revealed Resident #1 eloped from the facility on . . . . The day of the elopement he advised the caretaker he was going for a walk, as usual, but did not return to the facility. Review of the admission and discharge log	A 025		

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A 025	Continued From page 2 showed Resident #1 was admitted to the facility on . He eloped from the facility on and discharged from the facility on . Resident #1 was readmitted to the facility and eloped from the facility a second time on . Resident was discharged from the facility . Review of Resident #1 health assessment dated found Resident was not identified as an elopement risk after elopement form the facility on . The health assessment revealed Resident had diagnoses of , and unspecified . Resident was independent with bathing, , ambulating, eating, toileting, grooming and transfers. Resident required assistance with self-administration of medications. On at 09:05 AM Staff B stated Resident #1 had several elopement attempts by jumping the facility's fence. She said he had always expressed he did not want to live in facility. She said, "on , he left the facility about noon and about 20 minutes later staff realized he had left, they looked for him without success. They called the police, but resident was not found." at 9:25 AM Staff C stated Resident #1 always expressed he did not want to live in facility. " He always said; I am going out from here". On resident eloped from facility by jumping the facility's fence and he had not been found by the police." On at 9:50 AM the Administrator stated when Resident #1 could not be found, she called the police and she has been in contact with his case managers.	A 025		

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A 025	Continued From page 3 On at 10:01 AM, Resident #1 case manager stated the resident had several previous elopements and was under court supervision. He stated resident eloped from the facility on at 8.30 AM. He told the staff he was was going for a morning walk. He was later found and readmitted to the facility. The case manager further stated, on at 9:37 AM resident eloped from the facility again, by jumping a fence, and has not returned to the facility. Review of the facility's elopement policies and procedures revealed: - Establish a method of assessing residents for risk of and eloping at the time of admission and as needed. - Develop and implement preventive measures to make sure to stop and elopement whenever possible. Review of Resident #1 records showed the facility reported resident eloped from the facility on and readmitted resident to the facility on . Resident was not identified as an elopement risk and no elopement precautions/preventative measurements were put in place. On at 11:50 AM, the Administrator stated Resident #1 was not reassessed after readmission on for elopement, despite his previous elopement on , Further review of Resident #1 records showed resident eloped from the facility on and have not been found as of this date.	A 025		

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A 025	Continued From page 4 Class III	A 025		
A 032 SS=D	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 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	A 032		

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A 032	Continued From page 5 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 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 record review and interview the facility failed to follow the elopement standards and ensure all residents at risk for elopement or with history of elopement are assess by a health care provider or mental health care provider for elopement so staff can be alerted to their needs for support and supervision. Resident #1 eloped from the facility on . . . . . and was not reassessed for elopement after his return, and later eloped again on	A 032		

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A 032	Continued From page 6 Findings Included: Review of the facility report submitted to the agency portal revealed Resident #1 eloped from the facility on [illegible]. Review of the admission and discharge log showed Resident #1 was admitted to the facility on [illegible]. He eloped from the facility on [illegible] and discharged from the facility on [illegible]. Resident #1 was readmitted to the facility [illegible] and eloped from the facility a second time on [illegible]. Review of Resident #1 health assessment dated [illegible] found Resident was not identified as an elopement risk after elopement from the facility on [illegible]. The health assessment revealed Resident had diagnoses of [illegible] and unspecified [illegible]. Resident was independent with bathing, [illegible], ambulating, eating, toileting, grooming and transfers. Resident required assistance with self-administration of medications. Review of the facility's elopement policies and procedures revealed: - Establish of a method of assessing residents for risk of [illegible] and eloping at the time of admission and as needed. - Develop and implement preventive measures to make sure to stop [illegible] and elopement whenever possible. Review of Resident #1 record found no documentation the facility established a method to assess Resident for the risk of elopement after readmission on [illegible]. There was no documentation the resident was reassessed for elopement by the health care provider's.	A 032		

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A 032	Continued From page 7 On at 11.50 AM the Administrator acknowledged Resident #1 was not reassessed for elopement after his readmission to the facility on , despite of his previous elopement on . Class III	A 032		