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
	AL11969536	A. BUILDING: _____ B. WING _____	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISED LAND ALF INC, THE	1041 N PINE ISLAND LN CAPE CORAL, FL 33909

(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 survey #2021004999 was conducted on ..... at Promised Land ALF Inc, an assisted living facility, in Cape Coral, Florida. Complaint #2021004999 had 1 allegation which was substantiated with citations. The following related and unrelated deficiencies found at the time of the visit. .	A 000		
A 010 SS=D	429.26{ } FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who	A 010		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 010	Continued From page 1 requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident ' s representative or designee or the resident ' s family, guardian, surrogate, or attorney in fact. In the case of a resident who has	A 010		

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A 010	Continued From page 2 been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and,	A 010		

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A 010	Continued From page 3 3. 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. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are	A 010		

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A 010	Continued From page 4 described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the administrator failed to determine appropriateness of continued residency for each resident as evidenced by one (Resident #1) of three residents reviewed. Failure of the Administrator to review the Health Assessment Form 1823 when an up-dated form was provided, resulted in an elopement of Resident #1 while on an outing with the Administrator and Staff A. The findings included: Interview on at 8:49 a.m., the Administrator said on at around 9:00 a.m., the administrator along with Staff A went for an outing to a house that the administrator was renovating. The Administrator said they took Resident#1 with them because he looked kind of , and they though it will be good for him to go out. Around 9:10 a.m. he got a call from Staff A saying that she could not find the resident. Staff A said Resident #1 jumped over the fence while they were sitting outside, and he was gone. The Administrator called the police and started looking for the resident. The Administrator said the police found Resident #1 in an hour. Reportedly the resident jumped over the fence, went to another house, trespassed, and was found by the police laying in a bed. Resident #1 was taken by the police to the hospital, and he did not return from the hospital. Record review on found a new Health Assessment (HA) Form 1823 for Resident #1. The HA Form 1823 was completed by the Advanced Registered Nurse Practitioner (ARNP)	A 010		

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A 010	Continued From page 5 on , and documented Resident #1 to be an elopement risk. Record review found no supporting documentation of administrator's statement and no notice of discharge. On at 11:00 a.m., when shown the up-dated HA Form 1823, the administrator had obviously never read it. The Administrator the Spanish word for elopement (Fuga) with the Spanish word for fire (Fuego). While discussing elopement the Administrator handed the surveyor a fire inspection report. He was not aware of the language on the HA Form 1823, nor had knowledge that resident was an elopement risk. He did not know how the form ended up on the record. He blamed his previous consultant who came from Miami and completed the paperwork for him. The Administrator said he was aware Resident #1 had , issues, but he was stable. He said that morning he woke up . He took him to the outing with the caregiver to calm him down. Administrator said an unknown person from the hospital called him, he did not remember the date or time, and told him that the resident needed 24/7 care and he did not have the appropriate license and he refused to allow the resident to return to the facility. Interview on at 1:00 p.m., the Administrator acknowledged the lack of supporting documentation for the discharge and elopement. As the Administrator did not know the resident was an elopement risk, he did not review the appropriateness of continued residency, did not institute the regulation for staff ensuring identification is the resident's person daily, and did not plan for the prevention of an elopement attempt.	A 010		

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A 010	Continued From page 6 Class II	A 010		
A 011 SS=D	59A-36.006(5) FAC Admissions - Discharge (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care provider, the resident must be discharged in accordance with section 429.28, F.S. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to properly discharge a resident for one (#1) of three resident reviewed. The findings included: Interview on at 8:49 a.m., the Administrator said on at around 9:00 a.m., the administrator along with Staff A went for an outing to a house that the administrator was renovating. The Administrator said they took Resident#1 with them because he looked kind of and they though it will be good for him to go out. Around 9:10 a.m. he got a call from Staff A saying that she could not find the resident. Staff A said Resident #1 jumped over the fence while they were sitting outside, and he was gone. The Administrator said the police found Resident #1 in an hour. Resident #1 was taken by the police to the hospital on , and he did not return from the hospital. Administrator said an unknown person from the hospital called him, he did not remember the date or time, and told him that the resident needed 24/7 care and he did not have the	A 011		

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A 011	Continued From page 7 appropriate license and he refused to allow the resident to come to the facility. Record review found no supporting documentation of administrator's statement and no notice of discharge, no contact with the hospital or referral to Department of Chaildren and Families to assist with placement to a secured facility. Interview on at 11:00 a.m., the Administrator said that his previous consultant was the one that handled the elopement for Resident #1 and knew were all related documentation was. He said the consultant was in Miami and he tried unsuccessfully to get in touch with her in order to obtain the supporting document needed. The Administrator acknowledged the lack of supporting document on at 1:00 p.m. The Administrator said that if he knew ahead of the up-dated health assessment, he would had discharged the resident sooner since he could not meet his needs. He said, "I didn't know. The consultant never told me off the new assessment. I found out after the fact when they call me from the hospital. He was fine up to that day. I don't even know what triggered that behavior." Class II .	A 011		
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	A 025		

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A 025	Continued From page 8 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 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.	A 025		

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A 025	Continued From page 9 (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 staff interview, facility failed to properly supervise each resident for 1 (Resident #1) out of 3 records reviewed. The facility failed to notify resident's next of kin of residents elopement. Failure to provide adequate supervision and a secure environment for Resident #1 led to the resident's elopement on . The findings included: Record review found Resident #1 was admitted to the facility on . The Health Assessment (HA) Form 1823 dated , listed diagnoses including , without behavioral disturbance. Resident was not identified to be elopement risk. A follow-up HA Form 1823 dated , was found on the record and identified Resident #1 being as elopement risk and beside "Require 24-hour nursing or , care" the doctor wrote, "Yes currently under psyc care." Record review found no evidence that facility notified resident's next of kin of resident's elopement on . Interview on at 8:49 a.m., the Administrator said that on at around 9:00	A 025		

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A 025	Continued From page 10 a.m., the administrator along with Staff A went for an outing to a house that the administrator was renovating. The Administrator said they took Resident#1 with them because he looked kind of . . . . . , and they though it will be good for him to go out. The Administrator said he went out for a minute to get breakfast and coffee for everyone. A few minutes after, around 9:10 a.m., he got a call from Staff A saying that she could not find the resident. He jumped over the fence while they were sitting outside, and he was gone. The Administrator called the police and started looking for the resident. The Administrator said the police found Resident #1 in an hour. Reportedly the resident jumped over the fence, went to another house, trespassed, and was found by the police laying in a bed. Resident #1 was taken by the police to the hospital. Interview on at 11:00 a.m., the administrator said that he was not aware that there was an updated HA Form 1823 on record identifying the resident as an elopement risk and required 24/7 , , care. The Administrator said his previous consultant was the one that handled resident records and all related documentation. He said the consultant was in Miami and he tried unsuccessfully to get in touch with her in order to obtain the supporting document needed. The Administrator said that if he knew ahead of the up-dated health assessment he would had discharged the resident sooner, since he could not meet his needs. He said, "I didn't know. The Consultant never told me of the new assessment. I found out after the fact when they called me from the hospital. He was fine up to that day. I don't even know what triggered that behavior." Interview on at 1:49 p.m., the	A 025		

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A 025	Continued From page 11 Administrator said he called resident's brother to let him know, but he forgot to document it on the record. Class II .	A 025		
A 165 SS=D	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	A 165		

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A 165	Continued From page 12 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 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.	A 165		

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A 165	Continued From page 13 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 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 record review and staff interview facility failed to file an adverse incident report as	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969536	A. BUILDING: _____ B. WING _____	07/22/2021

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A 165	Continued From page 14 required for 1(1) out of 3 residents reviewed. Findings included: Interview on at 8:49 a.m., the Administrator said on . . . . . at around 9:00 a.m., the Administrator along with Staff A went for an outing to a house that the administrator was renovating. The Administrator said they took Resident#1 with them because he looked kind of , and they though it will be good for him to go out. Around 9:10 a.m., Staff A said Resident #1 jumped over the fence while they were sitting outside, and he was gone. The Administrator said the police found Resident #1 in an hour. Reportedly the resident jumped over the fence, went to another house, trespassed, and was found by the police laying in a bed. Resident #1 was taken by the police to the hospital, and he did not return from the hospital. Record review found no adverse incident related to resident #1's elopement. A phone call was placed to the Office on . . . . at 9:30 a.m. The ALF Supervisor said she did not have an adverse incident on record related to Resident#1's elopement. Interview on at 11:00 a.m., the Administrator said his previous Consultant was the one that handled the elopement paperwork for Resident #1 and knew were all related documentation was. He said the consultant was in Miami and he tried unsuccessfully to get in touch with her in order to obtain the supporting document needed. The Administrator said when the police arrived, they did not provide him with a case number. He did not obtain the name of the police officer. The	A 165		

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
	AL11969536	A. BUILDING: _____ B. WING _____	07/22/2021

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A 165	Continued From page 15 Administrator said an unknown Department of Children and Families (DCF) agent came on an unknown date and time (few days after the elopement) and told him he was in the clear. They told him he did not do anything wrong and that is why he did not file an adverse incident. He did not know that DCF and Agency for Health Care Administration (AHCA) had different regulations. Class III	A 165		

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
	AL11969536	A. BUILDING: _____ B. WING _____	07/22/2021

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A 000	Initial Comments An unannounced complaint survey #2021004999 was conducted on at Promised Land ALF Inc, an assisted living facility, in Cape Coral, Florida. Complaint #2021004999 had 1 allegation which was substantiated with citations. The following related and unrelated deficiencies found at the time of the visit.	A 000		
A 010 SS=D	429.26(-) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who	A 010		

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
	AL11969536	A. BUILDING: _____ B. WING _____	07/22/2021

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A 010	Continued From page 1	A 010		

requires the use of assistive devices.
(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.
(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:
a. Move, turn, or reposition without total physical assistance;
b. Transfer to a chair or wheelchair without total physical assistance; or
c. Sit safely in a chair or wheelchair without personal assistance or a physical
2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.
3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.
(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident ' s representative or designee or the resident ' s family, guardian, surrogate, or attorney in fact. In the case of a resident who has

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
	AL11969536	A. BUILDING: _____ B. WING _____	07/22/2021

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A 010	Continued From page 2	A 010		

been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.
(3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility.

59A-36.006
(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:
(a) The resident may be bedridden for no more than 7 consecutive days.
(b) A resident requiring care of a may be retained provided that:
1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider,
2. The condition is documented in the resident's record; and,

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
	AL11969536	A. BUILDING: _____ B. WING _____	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISED LAND ALF INC, THE	1041 N PINE ISLAND LN CAPE CORAL, FL 33909

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A 010	Continued From page 3	A 010		

3. 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.
(c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;
2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;
3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,
4. Documentation of the requirements of this paragraph is maintained in the resident's file.
(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.
(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.
(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.
(g) Continued residency criteria for facilities holding an extended congregate care license are

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISED LAND ALF INC, THE	1041 N PINE ISLAND LN CAPE CORAL, FL 33909

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A 010	Continued From page 4 described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the administrator failed to determine appropriateness of continued residency for each resident as evidenced by one (Resident #1) of three residents reviewed. Failure of the Administrator to review the Health Assessment Form 1823 when an up-dated form was provided, resulted in an elopement of Resident #1 while on an outing with the Administrator and Staff A. The findings included: Interview on at 8:49 a.m., the Administrator said on at around 9:00 a.m., the administrator along with Staff A went for an outing to a house that the administrator was renovating. The Administrator said they took Resident#1 with them because he looked kind of , and they though it will be good for him to go out. Around 9:10 a.m. he got a call from Staff A saying that she could not find the resident. Staff A said Resident #1 jumped over the fence while they were sitting outside, and he was gone. The Administrator called the police and started looking for the resident. The Administrator said the police found Resident #1 in an hour. Reportedly the resident jumped over the fence, went to another house, trespassed, and was found by the police laying in a bed. Resident #1 was taken by the police to the hospital, and he did not return from the hospital. Record review on found a new Health Assessment (HA) Form 1823 for Resident #1. The HA Form 1823 was completed by the Advanced Registered Nurse Practitioner (ARNP)	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 010	Continued From page 5	A 010		

on , and documented Resident #1 to be an elopement risk. Record review found no supporting documentation of administrator's statement and no notice of discharge.

On at 11:00 a.m., when shown the up-dated HA Form 1823, the administrator had obviously never read it. The Administrator the Spanish word for elopement (Fuga) with the Spanish word for fire (Fuego). While discussing elopement the Administrator handed the surveyor a fire inspection report. He was not aware of the language on the HA Form 1823, nor had knowledge that resident was an elopement risk. He did not know how the form ended up on the record. He blamed his previous consultant who came from Miami and completed the paperwork for him.
The Administrator said he was aware Resident #1 had issues, but he was stable. He said that morning he woke up . He took him to the outing with the caregiver to calm him down.
Administrator said an unknown person from the hospital called him, he did not remember the date or time, and told him that the resident needed 24/7 care and he did not have the appropriate license and he refused to allow the resident to return to the facility.

Interview on at 1:00 p.m., the Administrator acknowledged the lack of supporting documentation for the discharge and elopement. As the Administrator did not know the resident was an elopement risk, he did not review the appropriateness of continued residency, did not institute the regulation for staff ensuring identification is the resident's person daily, and did not plan for the prevention of an elopement attempt.

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A 010	Continued From page 6 Class II	A 010		
A 011 SS=D	59A-36.006(5) FAC Admissions - Discharge (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care provider, the resident must be discharged in accordance with section 429.28, F.S. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to properly discharge a resident for one (#1) of three resident reviewed. The findings included: Interview on [redacted] at 8:49 a.m., the Administrator said on [redacted] at around 9:00 a.m., the administrator along with Staff A went for an outing to a house that the administrator was renovating. The Administrator said they took Resident#1 with them because he looked kind of [redacted] and they though it will be good for him to go out. Around 9:10 a.m. he got a call from Staff A saying that she could not find the resident. Staff A said Resident #1 jumped over the fence while they were sitting outside, and he was gone. The Administrator said the police found Resident #1 in an hour. Resident #1 was taken by the police to the hospital on [redacted], and he did not return from the hospital. Administrator said an unknown person from the hospital called him, he did not remember the date or time, and told him that the resident needed 24/7 [redacted] care and he did not have the	A 011		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969536	A. BUILDING: _____ B. WING _____	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISED LAND ALF INC, THE	1041 N PINE ISLAND LN CAPE CORAL, FL 33909

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A 011	Continued From page 7 appropriate license and he refused to allow the resident to come to the facility. Record review found no supporting documentation of administrator's statement and no notice of discharge, no contact with the hospital or referral to Department of Chaildren and Families to assist with placement to a secured facility. Interview on at 11:00 a.m., the Administrator said that his previous consultant was the one that handled the elopement for Resident #1 and knew were all related documentation was. He said the consultant was in Miami and he tried unsuccessfully to get in touch with her in order to obtain the supporting document needed. The Administrator acknowledged the lack of supporting document on at 1:00 p.m. The Administrator said that if he knew ahead of the up-dated health assessment, he would had discharged the resident sooner since he could not meet his needs. He said, "I didn't know. The consultant never told me off the new assessment. I found out after the fact when they call me from the hospital. He was fine up to that day. I don't even know what triggered that behavior." Class II .	A 011		
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	A 025		

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
	AL11969536	A. BUILDING: _____ B. WING _____	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 025	Continued From page 8	A 025		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 025	Continued From page 9	A 025		

(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 staff interview, facility failed to properly supervise each resident for 1 (Resident #1) out of 3 records reviewed. The facility failed to notify resident's next of kin of residents elopement. Failure to provide adequate supervision and a secure environment for Resident #1 led to the resident's elopement on .

The findings included:

Record review found Resident #1 was admitted to the facility on . The Health Assessment (HA) Form 1823 dated , listed diagnoses including , without behavioral disturbance. Resident was not identified to be elopement risk.
A follow-up HA Form 1823 dated , was found on the record and identified Resident #1 being as elopement risk and beside "Require 24-hour nursing or care" the doctor wrote, "Yes currently under psyc care."
Record review found no evidence that facility notified resident's next of kin of resident's elopement on .

Interview on at 8:49 a.m., the Administrator said that on at around 9:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 025	Continued From page 10	A 025		

a.m., the administrator along with Staff A went for an outing to a house that the administrator was renovating. The Administrator said they took Resident#1 with them because he looked kind of , and they though it will be good for him to go out. The Administrator said he went out for a minute to get breakfast and coffee for everyone. A few minutes after, around 9:10 a.m., he got a call from Staff A saying that she could not find the resident. He jumped over the fence while they were sitting outside, and he was gone. The Administrator called the police and started looking for the resident. The Administrator said the police found Resident #1 in an hour. Reportedly the resident jumped over the fence, went to another house, trespassed, and was found by the police laying in a bed. Resident #1 was taken by the police to the hospital.

Interview on at 11:00 a.m., the administrator said that he was not aware that there was an updated HA Form 1823 on record identifying the resident as an elopement risk and required 24/7 , , care. The Administrator said his previous consultant was the one that handled resident records and all related documentation. He said the consultant was in Miami and he tried unsuccessfully to get in touch with her in order to obtain the supporting document needed. The Administrator said that if he knew ahead of the up-dated health assessment he would had discharged the resident sooner, since he could not meet his needs. He said, "I didn't know. The Consultant never told me of the new assessment. I found out after the fact when they called me from the hospital. He was fine up to that day. I don't even know what triggered that behavior."

Interview on at 1:49 p.m., the

Agency for Health Care Administration

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	AL11969536	A. BUILDING: _____ B. WING _____	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISED LAND ALF INC, THE	1041 N PINE ISLAND LN CAPE CORAL, FL 33909

(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 025	Continued From page 11 Administrator said he called resident's brother to let him know, but he forgot to document it on the record. Class II	A 025		
A 165 SS=D	429.23([illegible] & [illegible]) 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. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] 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	A 165		

Agency for Health Care Administration

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A 165	Continued From page 12	A 165		

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 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.

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A 165	Continued From page 13	A 165		

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 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 record review and staff interview facility failed to file an adverse incident report as

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A 165	Continued From page 14	A 165		

required for 1(1) out of 3 residents reviewed.

Findings included:

Interview on at 8:49 a.m., the Administrator said on at around 9:00 a.m., the Administrator along with Staff A went for an outing to a house that the administrator was renovating. The Administrator said they took Resident#1 with them because he looked kind of , and they though it will be good for him to go out. Around 9:10 a.m., Staff A said Resident #1 jumped over the fence while they were sitting outside, and he was gone. The Administrator said the police found Resident #1 in an hour. Reportedly the resident jumped over the fence, went to another house, trespassed, and was found by the police laying in a bed. Resident #1 was taken by the police to the hospital, and he did not return from the hospital. Record review found no adverse incident related to resident #1's elopement.

A phone call was placed to the Office on at 9:30 a.m. The ALF Supervisor said she did not have an adverse incident on record related to Resident#1's elopement.

Interview on at 11:00 a.m., the Administrator said his previous Consultant was the one that handled the elopement paperwork for Resident #1 and knew were all related documentation was. He said the consultant was in Miami and he tried unsuccessfully to get in touch with her in order to obtain the supporting document needed.
The Administrator said when the police arrived, they did not provide him with a case number. He did not obtain the name of the police officer. The

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A 165	Continued From page 15 Administrator said an unknown Department of Children and Families (DCF) agent came on an unknown date and time (few days after the elopement) and told him he was in the clear. They told him he did not do anything wrong and that is why he did not file an adverse incident. He did not know that DCF and Agency for Health Care Administration (AHCA) had different regulations. Class III	A 165		