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
	AL11910997	A. BUILDING: _____ B. WING _____	11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIGHTINGALE MANOR	1753 MICHIGAN AVENUE MIAMI BEACH, FL 33139

(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 #2021014894) was conducted at Nightingale Manor, Inc. from to . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=H	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of ... or ... , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , ... The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making ... for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 1 resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being the residents. The facility failed to maintain general awareness of the whereabouts of two out five sampled residents (Residents #1 and #2). Resident #1 who had a history of elopement from Assisted Living Facilities (ALF) eloped from the facility and had not been found. Resident #2 was consistently leaving the facility, and the staff was unaware of the resident's location.	A 025		

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A 025	Continued From page 2 Findings included: Resident #1 Review of facility reports showed Resident #1 eloped on [redacted] around 05:00 PM and was still considered missing at the time of the survey. The report also noted that Resident #1 informed the administrator that he was going out and would return the next day, [redacted] between 04:00 PM and 05:00 PM. There was no documentation indicating that the facility knew the resident's whereabouts during this time. A review of Resident #1's observation notes showed, " [redacted] Resident left the facility and said he will return next day, [redacted] afternoon between [redacted] for dinner. [redacted], its' 5:00 PM Resident has not returned, and he is not answering the phone. Local hospitals were called also legal Guardian and next of kin. A missing person report was filled." Observation on [redacted] at around 09:00 AM showed no direct care staff was at the facility. Observed one maintenance or housekeeping staff (Staff E), one dietary staff (Staff D) in the kitchen cooking for the residents, and one staff (Staff C) sitting in the office area. On [redacted] at 10:10 AM, Staff B (Former administrator/introduced himself as consultant) stated, "The residents can leave and come [redacted]. It's more like an open-door kind of thing because we cannot lock them inside." On [redacted] at 10:13 AM, the Administrator stated, "We don't know exactly where the resident is. I heard he might be in West Palm Beach. Those residents are independent. We cannot	A 025		

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A 025	Continued From page 3 keep them inside. I didn't ask him where he was going. I thought he was going to [...supermarket]." According to the administrator, the resident was already gone for about 24 hours by the time she called the police. A review of Resident #1's health assessment dated showed the resident had medical history and diagnoses of , , abnl (abnormal) CT, , AAA (aneurysm), COPN (,). The resident was not identified as an elopement risk. The resident needed assistance with self-administration of medications. A review of Resident #1's Medication Observation Record (MOR) showed that at the time of the elopement, the resident was prescribed these medications with the purposes given as described by the National Library of Medicine, : , 1 tablet 08:00 AM - Combination of , and , is used to reduce the risk of or in patients who have had or are at risk of these conditions and are also at risk of developing a when taking 1 tablet 08:00 AM - (D3) is used as a dietary supplement when the amount of D in the diet is not enough. 2 capsules 08:00 AM - Helps to soften stools and makes movements easier. 1 tablet 08:00 AM - Help to provide to the body that aren't taken in through the diet. , 2 capsules 08:00 AM - Combination of , and , is used to reduce the risk of or in patients who have had or are at risk of these conditions and are also	A 025		

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A 025	Continued From page 4 at risk of developing a . . . . . when taking . . . . 1 tablet 08:00 AM - Used to help people who have stopped drinking and using street drugs continue to avoid drinking or using drugs. . . . . . 1 tablet 08:00 AM - Used to treat or prevent . . . . . 1 tablet 05:00 PM - Used to help people with sleep . . . . . . ½ tablet 05:00 PM - To treat high . . and triglyceride levels. . . . . . 1 tablet 05:00 PM - To treat mental . . , including , and , ... , . . 5 tablets 05:00 PM - To treat episodes associated with . , ...). Further review of the MOR showed the resident last received his medications on at 05:00 PM. On . . . . . at 10:10 AM, Resident #1's legal guardian stated that Resident #1 had eloped over 5 times from different facilities. He further stated that when Resident #1 gathered up couple of dollars, he would go to see his drug dealers in the Palm Beach area. On at 12:36 PM, Resident #1's friend confirmed that Resident #1 eloped before from many Assisted Living Facilities (ALF). She stated that while Resident #1 was at the facility, she spoke to him on the day [ ] he was leaving the facility. She stated that as soon as Resident #1 saved up a couple of dollars, he would leave any facility and . . . to West Palm Beach. She also stated that Resident #1 had some serious . , . . issues, and he had eloped more than 25 times in the past from	A 025		

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A 025	Continued From page 5 different facilities. A review of Resident #1's Record showed the resident lived in the facility from , to . . . . . Observation notes dated showed, "Resident left home and never returned. Said he was going to visit family, called his next of kin [...] and she said he went . . . to his old ALF in West palm Beach." On at 02:06 PM, Staff F stated, "He (Resident #1) probably went . . . to West Palm. He eloped before in 2017 or 2018. I don't remember exactly the time. He went . . . to West Palm Beach that time." On at 03:14 PM, the Administrator also confirmed that Resident #1 was at risk of elopement. She stated, "The people who know him told me he uses drugs. I know he lived in the facility from 2017 to 2018. He left the facility and went to West Palm Beach. He never returned at that time." Resident #2. A review of Resident #2's observation notes showed the resident continuously would leave the facility and spent days out. The facility did nothing to help and prevent the resident from spending many nights out: On . . . . . , the facility wrote, "Resident stated that he was going to the park." On . . . . . , the facility wrote, "Resident has not returned to facility as of yet". On . . . . . , the facility wrote, "Resident returned to facility." On . . . . //2021, the resident wrote a note stating that he left the facility and would be returned on . . . . . There was no note on when the resident returned to the facility.	A 025		

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A 025	Continued From page 6 On . . . . . , the facility wrote, "Resident left facility." On . . . . . , the facility wrote, "Resident hasn't returned - Resident returned by 5 PM." On . . . . . , the facility wrote, "Resident left to go to the park." On . . . . . , the facility wrote, "Resident has not returned." On . . . . . , the facility wrote, "Resident has returned." On . . . . . , the facility wrote, "Resident left facility after 2 PM - and never returned." On . . . . . , the facility wrote, "hasn't returned", and wrote, "Picked up from park on . . . . . ." On , the facility wrote, "Resident left." On . . . . . , the facility wrote, "Resident brought from the park by resident's Social worker". On , the facility wrote, "Resident left facility and never came . . . ." On , the facility wrote, "will go to [...Park] to pick him up tomorrow." On , the facility wrote, "Picked up resident." On , the facility wrote, "Resident left facility." On , the facility wrote, "Resident returned said he went to [...Park]." On , the facility wrote, "Resident left without warning. Notified family member." On , the facility wrote, "Resident's social worker spoke to resident in the park, stated he was not ready to come, and he loves it in the park." On . . , the facility wrote, "Resident returned stating he was relaxing with friend at the park." On . . . . . , the facility wrote, "Resident left on never returned as of get, notified	A 025		

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A 025	Continued From page 7 family member and Resident's social worker. Resident returned ." On , the facility wrote, "Resident left facility with a blanket stating he was going to the park." On , the facility wrote, "Resident has not returned as of 12:00 noon. Spoke to family member and she said wait for him to get ." On , the facility wrote, "Police called for missing persons' report." On , the facility wrote, "Resident's social worker drove past [...Park], and saw resident, asked him if he was ready to go to facility, resident said yes, was taken resident to [...hospital] to be evaluated, and was released ...." On , the facility wrote, "Resident left late last night and hasn't returned. Social worker said resident called him and said he was moving out; spoke to family member. She said she spoke to him and told him to go home." On , the facility wrote, "Resident family member called stating he was in [...Park] and was not coming ." On , the facility wrote, "Resident called family member again stating he moved out and was not coming ." On , the facility wrote, "Missing person reported; resident returned later that day stating he was on vacation, and everyone knew where he was." On , the facility wrote, "Resident left and came early in the morning said he was in the park with friends." Review of Resident #2's health assessment dated showed the resident had medical history and diagnoses of (, , ,), , , Low , , Tobacco use; not in elopement risk; the health assessment	A 025		

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NAME OF PROVIDER OR SUPPLIER: **NIGHTINGALE MANOR**

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A 025		A 025		

Continued From page 8

indicated that the resident needed help with taking medications but did not show what type of assistance the resident needed to take the medications. The health assessment also showed the resident had a list of prescribed medications: , , 50 MG, 3 MG, 90 MCG INH, Cream 2%, Tiotropium 2.5 MCG, 20 MG, , 50 MG.

Further review of Resident #2's record showed no documentation on how the resident took his medications while he was continuously spending many days and nights out in the street or park.

On at 09:30 AM, Staff B stated that in the past, he would get in his car and pick-up residents who went missing. He stated he remembered picking up Resident #2 before at [...Park].

A review of the facility's elopement drills showed the facility conducted elopement drills on from 09:25 AM to 09:37 AM, on from 10:15 AM to 10:25 AM.
On at 02:06 PM, When asked Staff F if he trained in elopement drills, staff F replied, "I'm not sure what that is (Elopement drills). To be honest with you, I don't know if they do it in the morning. I don't know what it is. I Work from 2 PM to 10 PM. We don't do it in my shift."

A review of the facility's elopement policy and procedures showed:
"All residents assessed at risk or with a history of elopement shall be identified so staff can be alerted to their needs for support and supervision. Staff attention shall be directed towards residents assessed at high risk for elopement, with special

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A 025	Continued From page 9 attentions given to those with 's and related assessed at high risk. Each resident, at all levels are assessed for and elopement upon admission, thirty days after admission, quarterly thereafter and upon indication or incident for utilizing the accepted resident assessment and reassessment tolls. The assessment incorporates several days of observation by staff. It is the policy of this assisted living facility that residents at all levels be assessed for potential of and elopement. Residents deemed to be at risk for wondering and elopement will be monitored and assessed accordingly." Class II	A 025		
A 079 SS=G	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539	A 079		

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A 079	Continued From page 10 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff	A 079		

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A 079	Continued From page 11 member who is at least [illegible] must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately	A 079		

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A 079	Continued From page 12	A 079		

when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met.

1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs.

2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency.

(e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing

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A 079	Continued From page 13 home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain the minimum staffing ration and to have enough qualified staff to provide resident supervision, and failed to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs for a census of 24 residents. Residents continuously left the facility, and no staff knew the residents' whereabouts. Findings included: Observation on [redacted] at around 09:00 AM showed no direct care staff was at the facility. Observed one maintenance or housekeeping staff (Staff E), one dietary staff (Staff D) in the kitchen cooking for the residents, and one staff (Staff C) sitting in the office area. Also observed 20 residents separated in 2 buildings. A review of the facility's record showed the facility had a census of 24 residents including two residents in the hospital, one resident eloped, and one resident traveled to another state. Also observed two logbooks for the residents to sign when they were leaving and coming to the facility; however, only 2 residents signed the logbooks. Review of the Resident #2's observation notes who was one of the residents signing the logbook	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910997	A. BUILDING: _____ B. WING _____	11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIGHTINGALE MANOR	1753 MICHIGAN AVENUE MIAMI BEACH, FL 33139

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A 079	Continued From page 14 showed Resident #2 continuously left the facility and spent several days and nights out of the facility. Interviews with the residents confirmed the facility did not know Resiben #5's whereabouts when the resident was away from the facility: On at 11:20 AM, Resident #5 stated, "I go out. I don't sleep out, but I'll go to [different department stores]. You know there is a lot of places you can go around here. I don't sign no logbook." On at 10:58 AM, Staff E (Housekeeper) stated, "I used to pass medications, assisted with ADL (activities of daily living), but now I only clean because I cannot see well. I'm the only one working right now. It's only me on this building. They will have someone else coming later. They have someone in the other building to cook, I'm here cleaning, and [Staff C] is in the office." On at 11:30 AM, Staff D (Cook) stated, "I cook for them (the residents), I make rounds. I cook and serve the food. I don't do breakfast. I cook lunch and dinner. I don't serve dinner. Before I leave at 4 PM, I cook. I'm mostly in the kitchen here because the time I come I start preparing for lunch; after lunch I prepare diner. Other staff come in the afternoon to serve the dinner. In the morning it's only me and Staff E. She is only cleaning." A review of the staffing schedule showed the facility had: One staff working Sunday to Saturday from 12:00 AM to 08:00 AM (56 hours) Two staff working Sunday to Saturday from 08:00 AM to 04:00 PM. (112 hours)	A 079		

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 079	Continued From page 15 One staff working Sunday to Saturday from 06:00 AM to 02:00 PM. (56 hours) One staff working Sunday to Saturday from 04:00 PM to 12:00 AM. (56 hours) One staff working Sunday to Saturday from 02:00 PM to 10:00 PM. (56 hours) The total listed staffing hours were 236 hours, however observation revealed that no care staff were on duty on . . . . . . On . . . . . at 10:26 AM, the Administrator stated, "Those residents are independent. They leave all the time and come . . . . Some of them stay out during the night, but they always come . . . . We cannot lock them inside." On . . . . . at 11:07 AM, Staff B (Former administrator/introduced himself as consultant) stated, "The residents can leave the facility. They just need to sign the signing sheets. I know they don't sign it, but we cannot force them. We have the sign in sheets in the 2 exits." When asked if the staff know when the residents leave the facility and where they go, Staff B replied, "No, no staff knows when they're leaving. I mean the staff do rounds. You know, the staff at the kitchen [Staff C], and the administrator do rounds too." When asked when and how would the facility know a resident is missing, Staff C replied, "I'm not sure. I think during medications, they will see that. I'm not sure what to tell you." Class II	A 079		