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
	AL11969401	A. BUILDING: _____ B. WING _____	12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ALEGRE CORP	1840-42 NW 15 ST MIAMI, FL 33125

(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 2021015093) was conducted at Villa Alegre Corp on to . A deficiency was identified at the time of the 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 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain a general awareness of resident whereabouts for one out of 11 Residents (Resident # 11). Resident #11 eloped from the facility on . Findings Included: Review of the facility incident report to the Agency showed Resident #11 eloped from the facility on and as of today have not been found. Review of Resident #11 record showed he was admitted to the facility on . Review of the 1823 health assessment dated	A 025		

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A 025	Continued From page 2 showed medical history and diagnoses of, The or behavior section showed, '. The nursing/treatment section showed, 'Standard'. Resident was independent with ambulation. bathing, , eating grooming, toileting and transferring. The box for elopement risk was checked, 'No'. Resident needed medication administration. Resident needed assistance with meals, shopping, phone calls, handling personal and financial affairs. Resident needed daily observation of well-being, whereabouts and reminders for important talks. On at 9:20 AM, Staff B stated she was on duty and the first to notice Resident #11 was missing. She stated she contacted the administrator and the police and searched for the resident. On at 12:20 PM the Administrator stated she was not at the facility when Resident #11 eloped on . She stated the staff called her around 8:45 AM and told her the resident was noticed to be missing around 8:30 AM. The Administrator stated the staff reported to her the resident was last seen around breakfast time in the backyard. She stated the police was called and arrived at the facility around 9:05 AM. The administrator stated she believed the resident jumped the side fence, because the gates were locked, and the staff said he did not go through the facility doors. On at 12:50 PM spoke to Resident #11 prior caseworker who stated she was one of the care coordinators for Resident #11 prior to resident being placed at the Assisted Living Facility (ALF) and she was involved in placing resident at the facility. She stated the resident did	A 025		

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A 025	Continued From page 3 not have any prior elopement risk issues. She stated after resident was admitted to the ALF on [redacted], he continued to receive [redacted] support and medication support for 30 days. She stated after 30 days resident case was closed and he received mental health follow up services at a community mental health support center. On [redacted] at 1:24 PM conducted an interview by telephone with a case worker from the community mental health support center. The caseworker stated, around [redacted] Resident #11 started treatment for [redacted] and medication support and he was compliant with his treatment. The case worker also stated the Administrator notified him the resident eloped from the facility. The caseworker stated Resident #11 did not mention he wanted to leave the facility, and gave no indication he would have eloped from the facility. Class III	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: AMENDED: Based on record review and interview the facility failed to maintain a general awareness of resident whereabouts for one out of 11 Residents (Resident # 11). Resident #11 eloped from the facility on . Findings Included: Review of the facility incident report to the Agency showed Resident #11 eloped from the facility on and as of today have not been found. Review of Resident #11 record showed he was	A 025		

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A 025	Continued From page 2 admitted to the facility on . Review of the 1823 health assessment dated showed medical history and diagnoses of, The or behavior section showed, '', The nursing/treatment section showed, 'Standard'. Resident was independent with ambulation. bathing, , eating grooming, toileting and transferring. The box for elopement risk was checked, 'No'. Resident needed medication administration. Resident needed assistance with meals, shopping, phone calls, handling personal and financial affairs. Resident needed daily observation of well-being, whereabouts and reminders for important talks. On at 9:20 AM, Staff B stated she was on duty and the first to notice Resident #11 was missing. She stated she contacted the administrator and the police and searched for the resident. On at 12:20 PM the Administrator stated she was not at the facility when Resident #11 eloped on . She stated the staff called her around 8:45 AM and told her the resident was noticed to be missing around 8:30 AM. The Administrator stated the staff reported to her the resident was last seen around breakfast time in the backyard. She stated the police was called and arrived at the facility around 9:05 AM. The administrator stated she believed the resident jumped the side fence, because the gates were locked, and the staff said he did not go through the facility doors. On at 12:50 PM spoke to Resident #11 prior caseworker who stated she was one of the care coordinators for Resident #11 prior to resident being placed at the Assisted Living	A 025		

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A 025	Continued From page 3 Facility (ALF) and she was involved in placing resident at the facility. She stated the resident did not have any prior elopement risk issues. She stated after resident was admitted to the ALF on [redacted], he continued to receive [redacted] support and medication support for 30 days. She stated after 30 days resident case was closed and he received mental health follow up services at a community mental health support center. On [redacted] at 1:24 PM conducted an interview by telephone with a case worker from the community mental health support center. The caseworker stated, around [redacted] Resident #11 started treatment for [redacted] and medication support and he was compliant with his treatment. The case worker also stated the Administrator notified him the resident eloped from the facility. The caseworker stated Resident #11 did not mention he wanted to leave the facility, and gave no indication he would have eloped from the facility. Class II	A 025		