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
	AL11942957	A. BUILDING: _______ B. WING _______	02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSAN RESIDENCE CORP	**1754 NW 6 STREET 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 2022002234) was conducted at Bosan Residence, Corp. on , . to . Deficiencies were identified at the time of survey.	A 000		
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 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	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 maintain a general awareness of the whereabouts of one resident (Residents 1). Resident 1 went to a nearby store on , , and was found on the streets by his legal guardian before being hospitalized. The facility also failed to maintain documentation on the resident's record in reference to significant changes. Findings included: 1) A review of an adverse incident report showed that Resident 1 went to a near store in the morning of , , at approximately	A 025		

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A 025	Continued From page 2 9:00 AM. According to the facility's administrator, he would go often to the store and take approximately an hour to return. Review of the facility 'sign in and out log showed on that day that the resident signed out at 9:00 am to a dollar store; the entry did not show a time in. Review of Resident 1's record showed an admission on [redacted] with a photo on record. A health assessment dated 11/19/2021 showed diagnoses of [redacted] prostatic hyperplasia, [redacted]. The resident was alert and oriented; needed [redacted] precautions, and was identified as not an elopement risk. The resident was independent with all activities of daily living, except for supervision on grooming. Review of Resident 1's observation notes on record dated [redacted] showed, "The resident notified the staff he was going to the store to buy soda and walk for a little bit as he has done in the past. When the resident was not [redacted] by 11:00 AM, the staff got worried and began searching inside the facility and around the neighborhood. Police was called after the resident was not found. Police opened a report around noon and are searching for him. Residents, guardian, doctor, and case manager are informed." Interviewed on [redacted], at 3:06 PM, the resident's guardian stated, "I have been his guardian/case manager since 2018. They call me on Thursday to let me know what happened. He goes out with other residents. He was transferred there because the other facility closed, and the owner recommended this facility. At that facility he got lost one time he went out, and they found him because he had an altercation with someone	A 025		

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A 025	Continued From page 3 on the streets and was taken to the hospital. After that, I had a conversation with him, and he told me, "I went for a walk and got lost." Because he is so alert, I didn't want to label him as an elopement risk person; he was lost for about a week in 2021, it happened in , and he did not have a cell phone, he had lost it. We have been calling the hospitals. The owner at this facility knew what happened at the other facility, I informed him." On , an email was received from the facility's owner, stating that the resident was located, and that he was safe. The resident was sent to the hospital for observation. Review of the hospital record for the Resident #1 showed he arrived at the emergency room on . The record showed the emergency unit's response to the facility when they picked up the resident and transferred him to the hospital, stating he was alert, not receiving for over a week, and that he stated no medical complaints, but had involuntary tremors. At the hospital, the resident's diagnoses were , uremia, treated with , hyperkalemia, and . The resident was in , without in greater than a week, with an that was replaced at the hospital. On at 4:05 PM, the owner admitted and took responsibility regarding the resident 's elopement, and stated to be upset with the owner of the previous facility where the resident was transferred from, because they did not disclose the resident's elopement history. 2) Review of Resident 1's record showed a	A 025		

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A 025	Continued From page 4 prescription provided by the previous facility showing that the resident needed to have the , removed on . On , at 5:03 PM, Resident 1's physician stated, "He comes to my office. I saw him on . I gave him a prescription to remove the , the next day, and to come to the office for a follow up, but he did not come ." On , at 6:36 PM, the primary doctor's office nurse stated, "He was seeing a urologist. I saw him in , and he had the ; it was Ok." On , at 4:05 PM, the Owner stated the , could not be removed, that the doctor from the center did not want the , to be removed. Review of the resident's record showed no documentation of an order from the , center doctor, or documentation of a change of care physician. Class II	A 025		
A 027 SS=D	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and	A 027		

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A 027	Continued From page 5 friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that Resident 1 received the medical care needed. Findings included: Review of Resident 1's record showed an admission on . A health assessment dated showed diagnoses of prostatic hyperplasia, , and . The resident was alert and oriented; needed precautions, with no elopement risks. The resident was independent in all activities of daily living, except for supervision on grooming. The record had a prescription provided by the previous facility to remove the on . Interviewed on at 5:03 PM, Resident 1's physician stated, "He comes to my office. I saw him on . I gave him a prescription to remove the) the next day, and to come to the office for a follow up, but he did not come ." On at 6:36 PM, the primary doctor's office nurse stated, "He was seeing a urologist. I saw him in , and he had the ; it was Ok."	A 027		

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A 027	Continued From page 6 Review of the hospital record for the resident, showed an arrival to the emergency room on [redacted]. The record showed the emergency unit's response to the facility when they picked up the resident and transferred him to the hospital, stating he was alert, not receiving [redacted] for over a week, and that he stated no medical complaints, but had involuntary tremors. At the hospital, the resident's mental status was found to be within normal baseline/oriented to person, place, time, and event. His [redacted], and [redacted] were normal. The resident's diagnoses were [redacted], uremia, [redacted] treated with [redacted], hyperkalemia, and [redacted]. The resident was at an [redacted], without [redacted] in greater than a week, with an [redacted] that was replaced at the hospital. On [redacted] at 4:05 PM, the owner stated the [redacted] could not be removed, that the doctor from the [redacted] center did not want the [redacted] to be removed. Review of the resident's record showed no documentation of any new order from the [redacted] center, and no documentation of a change of physician. Class III	A 027		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. [redacted], 3. Race, 4. Date of birth,	A 162		

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A 162	Continued From page 7 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A . . . record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their . . . recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of	A 162		

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A 162	Continued From page 8 the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive	A 162		

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A 162	Continued From page 9 meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an accurate health assessment for Resident 1 who left the facility to go to a store, was found days later, and had a previous elopement.	A 162		

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A 162	Continued From page 10 Findings included: Review of Resident 1's record showed an admission on with a photo on record. A health assessment dated 11/19/2021 showed diagnoses of prostatic hyperplasia, . The resident was alert and oriented; had precautions, with no elopement risk. The resident was independent in all activities of daily living, except for supervision on grooming. Notes on record dated stated, "The resident notified the staff he was going to the store to buy soda and walk for a little bit as he has done in the past. When the resident was not by 11:00 AM, the staff got worried and began searching inside the facility and around the neighborhood. Police was called after the resident was not found. Police opened a report around noon and are searching for him. Residents, guardian, doctor, and case manager are informed." Review of the facility's evacuation and assessment tool for Resident 1 dated showed no , no , has never verbalized intentions, or no history of elopement, and medications did not increase agitation and restlessness. On , at 3:06 PM, the resident's guardian stated, "I have been his guardian/case manager since 2018. They call me on Thursday to let me know what happened; he goes out with other residents. He was transferred there because the other facility closed, and the owner recommended this facility. At that facility he got lost one time he went out, and they found him because he had an altercation with someone on	A 162		

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A 162	Continued From page 11 the streets and was taken to the hospital. After that, I had a conversation with him, and he told me, "I went for a walk and got lost." Because he is so alert, I didn't want to label him as an elopement risk person; he was lost for about a week in 2021, it happened in , and he did not have a cell phone, he had lost it. We have been calling the hospitals. The owner at this facility knew what happened at the other facility, I informed him." On , an email record was reviewed from the facility's owner, stating that the resident was located, and that he was safe. The email further stated that the resident was sent to the hospital for observation. Review of the hospital record for Resident #1, showed an arrival to the emergency room on . The record showed the emergency unit's response to the facility when they picked up the resident and transferred him to the hospital, stating he was alert, not receiving for over a week, and that he stated no medical complaints, but had involuntary tremors. The resident's diagnoses were , uremia, treated with , hyperkalemia, and . The resident was in , without in greater than a week, with an that was replaced at the hospital. On at 4:05 PM, the owner acknowledged the resident elopement, and stated to be upset with the owner of the previous facility where the resident was transferred from, because they did not disclose the elopement history. Class III	A 162		

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