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
	AL11922234	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HETERY HOME FOR THE ELDERLY INC	825 SE 7TH AVENUE HIALEAH, FL 33010

(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 #2022001674 was conducted at Hetery Home for the Elderly Inc on . The provider had a deficiency identified at the time of the 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 resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain a general awareness of the residents's whereabouts for one out of 13 residents (Resident #1) who eloped from the facility. Findings Included: Review of the the adverse incident database showed the facility reported Resident # 1 eloped from the facility on at 3:30 AM and was found by law enforcement same day at 4:18 PM. Review of Resident #1 health assessment dated had the resident diagnosed with	A 025		

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A 025	Continued From page 2 [illegible] and [illegible] precautions. Was independent with ambulation, [illegible], eating, toileting and transferring, supervision with bathing and assistance with grooming. The resident was identified as an elopment risk. Interviewed on at 8:23 AM attempted to interview Resident # 1 about the day that he eloped, and he stated, "Nothing happened, I just went out, the hospital opened the door." He was [illegible]. Review of the facility elopement policies and procedures revealed, "Elopement", is referred to as an unauthorized absence of a resident from the facility. The risk of [illegible] and elopement increases when residents are mobile and [illegible], especially if they suffer from [illegible] or [illegible]." On at 11:20 AM Staff F, who worked the night shift when Resident # 1 eloped, stated, "He did not have my signal of wanting to go. I gave him his coffee and milk with his medications between 7 and 8 PM. He was in his room took his milk and medication and stayed there watching TV. I went to his room about 2:30 AM and he was in his room and then I went to change other residents that needed diaper change. I went in the morning, and he was not in his bed, and I thought that he was in the bathroom, because that is the time, he takes a shower. I did not knock on the bathroom door." Class II	A 025		