

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/20/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VARNUM'S REST HOME LLC

**12167 NW FREEMAN ROAD
BRISTOL, FL 32321**

(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 165 SS=E	429.23(&) FS Risk Mgmt & QA 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 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	A 165		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 165	Continued From page 1 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. 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	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 165	Continued From page 2 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. This Statute or Rule is not met as evidenced by: Based on facility record review and Facility Administrator interview, the facility failed to file an adverse incident report through the Agency for Health Care Administration's electronic Adverse Incident Reporting System (AIRS) for 9 of 9 facility documented elopements involving Resident #16. The findings include: A review of the Resident Observation Log for Resident #16 revealed the following: - walked off from the facility without staff knowledge. Staff went out to find him, called the local sheriff's department and resident was located and returned to the facility. - walked away from the facility without staff knowledge and was later returned by a local sheriff's officer. - attempted to walk away from the facility during morning medication pass, but staff were able to stop him. Resident #16 responded by yelling at staff stating he was going to kill them. Staff were eventually able to get Resident #16 to calm down. - walked away from the facility without	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 165	Continued From page 3 staff knowledge during morning medication pass. The local sheriff's office was notified and he was located up Highway 12 North. Facility staff requested that the sheriff's officer the resident, but the officer stated the resident was not a threat to himself or others. Facility staff reported to mental health case manager and requested that the doctor be notified and as well as requested a medication change. - walked away from the facility again during morning medication pass and was later returned to the facility by a deputy. The deputy informed Resident #16 that he cannot be walking out in a storm because there was a possible hurricane headed this way. - neighbors reported to staff that Resident #16 had walked into their house uninvited several times and read the bible to them. Facility staff reported this to the mental health case manager who informed Resident #16 that he cannot go into people's houses. - walked away from the facility without staff knowledge during morning medication pass. Resident #16 was picked up and returned to the facility. Facility staff reported this event to the mental health case manager. - walked away from the facility without staff knowledge during morning medication pass. Staff located him down the road from the facility and returned him to the facility. Facility staff reported this event to the mental health case manager. - walked away from the facility without staff knowledge. Staff got him to come. He said he was going to Quincy to the ice cream shop. Facility staff reported this event to the mental health case manager. A review of police reports obtained from the local sheriff's office involving Resident #16 revealed	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321			
(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 165	Continued From page 4 two additional elopements that were called into law enforcement by the facility but not documented on the Resident Observation Log: (located approximately 1 mile from the facility) and Review of the reports also revealed that on Resident #16 was located approximately 1.5 miles from the facility and approximately 2 miles away on A review of the Agency for Health Care Administration's electronic Adverse Incident Reporting System (AIRS) revealed no record of reported adverse incidents involving Resident #16. On at approximately 3:07 PM, an interview was conducted with the Facility Administrator who reported that she did not think about filing an adverse incident report for the above incidents. She stated that she now knows these should have been filed as adverse incident reports. Class III	A 165			
AL243 SS=D	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial	AL243			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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	
AL243	Continued From page 5 licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (i) Mental health needs, services, behaviors and appropriate interventions; (ii) Resident progress in achieving treatment	AL243			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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
AL243	Continued From page 6 goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, () Crisis services and the procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all staff members received 3 hours of continuing education in mental health diagnoses, treatment, needs, services, behaviors, or appropriate interventions biennially for 1 of 3 staff records reviewed. (Staff C) The findings include: A review of the facility's personnel records was conducted. A review of Staff C's (Caregiver)	AL243			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/20/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VARNUM'S REST HOME LLC

**12167 NW FREEMAN ROAD
BRISTOL, FL 32321**

(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
AL243	Continued From page 7 personnel record revealed no evidence that 3 hours of continuing education in mental health diagnoses, treatment, needs, services, behaviors, or appropriate interventions had been completed within the past two years. Staff C was hired on and received an initial 6 hour training in working with individuals with mental health diagnoses on . . . The last 3 hours of continuing education in mental health was completed on . On at approximately 11:00 AM, an interview was conducted with the Facility Administrator who reviewed Staff C's personnel record and verified the date of her last completed training . She stated it was due around the time her secretary quit. Class III	AL243		
A 000	Initial Comments An unannounced re-licensure survey with limited mental health and limited nursing services specialty license review was conducted at Varnum's Rest Home . . . through . . . Additional evidence gathering continued offsite through . . . The provider had deficiencies at the time of the visit.	A 000		
A 008 SS=D	429.26() FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321			
(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 008	Continued From page 8 the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 008	Continued From page 9 the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or _____ nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of _____ require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a _____ medical examination completed by a health care practitioner as specified in either	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 008	Continued From page 10 paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or _____ services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of _____ or any other communicable _____, which are likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, _____, which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531 . Faxed or electronic copies of the	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 008	Continued From page 11 completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, _____, or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida _____ Form, for residents who do not wish _____ to be administered in the case of _____ or _____.	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 008	Continued From page 12 (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to update the Resident Health Assessment (AHCA Form 1823) following numerous elopements indicating the resident was at risk for elopement for 1 of 36 residents reviewed. (Resident #16) The findings include: A review of the Resident Observation Log for Resident #16 revealed the following: - walked off from the facility without staff knowledge. Staff went out to find him, called the local sheriff's department and resident was located and returned to the facility. - walked away from the facility without staff knowledge and was later returned by a local sheriff's officer. - attempted to walk away from the facility during morning medication pass, but staff were able to stop him. Resident #16 responded by yelling at staff stating he was going to kill	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 008	Continued From page 13 them. Staff were eventually able to get Resident #16 to calm down. - walked away from the facility without staff knowledge during morning medication pass. The local sheriff's office was notified and he was located up Highway 12 North. Facility staff requested that the sheriff's officer the resident, but the officer stated the resident was not a threat to himself or others. Facility staff reported to mental health case manager and requested that the doctor be notified and as well as requested a medication change. - walked away from the facility again during morning medication pass and was later returned to the facility by a deputy. The deputy informed Resident #16 that he cannot be walking out in a storm because there was a possible hurricane headed this way. - neighbors reported to staff that Resident #16 had walked into their house uninvited several times and read the bible to them. Facility staff reported this to the mental health case manager who informed Resident #16 that he cannot go into people's houses. - walked away from the facility without staff knowledge during morning medication pass. Resident #16 was picked up and returned to the facility. Facility staff reported this event to the mental health case manager. - walked away from the facility without staff knowledge during morning medication pass. Staff located him down the road from the facility and returned him to the facility. Facility staff reported this event to the mental health case manager. - walked away from the facility without staff knowledge. Staff got him to come He said he was going to Quincy to the ice cream shop. Facility staff reported this event to the mental health case manager.	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/20/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VARNUM'S REST HOME LLC

**12167 NW FREEMAN ROAD
BRISTOL, FL 32321**

(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 008	Continued From page 14 A review of police reports obtained from the local sheriff's office involving Resident #16 revealed two additional elopements that were called into law enforcement by the facility but not documented on the Resident Observation Log: _____ (located approximately 1 mile from the facility) and _____. Review of the reports also revealed that on _____ Resident #16 was located approximately 1.5 miles from the facility and approximately 2 miles away on _____. On _____ at approximately 2:27 PM, an interview was conducted with the Assistant to the Administrator who reported that Resident #16 eloped from the facility on _____. She continued that Resident #16 did not show up for snack at 9:00 AM, which staff thought was odd because he loves everything sweet, so all staff stopped and started to look for him and realized he was not at the facility. Staff then called the sheriff's office while another staff member started driving throughout town looking for him. A person from the community called the sheriff's office to report that an unknown man was in their home. When the sheriff arrived at the home and saw the man holding the bible, he immediately knew who he was and that he was a resident of this facility. The sheriff's officer transported Resident #16 _____ to the facility. The surveyor informed the Assistant to the Administrator that there was no documentation of the elopement in the resident's record. The Assistant to the Administrator stated that the facility notified his brother. The surveyor informed the Assistant to the Administrator that there was no evidence in the resident's record that an assessment was performed on the resident after returning to the facility. She also reported that on one occasion Resident #16 walked into a church in the community while a	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 008	Continued From page 15 service was in progress and started preaching. The people at the church asked him to leave and escorted him out of the church. The Assistant to the Administrator further reported that the facility does not know if the resident would do it again because he loves to preach and walks away from the facility to find somewhere to preach. She also reported that facility staff are concerned for his safety, but that he is appropriate for the facility. The Assistant to the Administrator stated this is the first time in a while that Resident #16 has left the facility because when he was first admitted, he used to walk away from the facility a lot and the Sheriff would bring him . She confirmed the Resident Health Assessment had not been updated to indicate Resident #16 was at risk for elopement. On at approximately 3:07 PM, an interview was conducted with the Facility Administrator who reviewed Resident #16's Resident Health Assessment and confirmed that it still indicated that the resident was not an elopement risk. The Facility Administrator reported that she now knows the Resident Health Assessment should have been updated to reflect that Resident #16 was an elopement risk. Class III	A 008			
A 032 SS=G	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 032	Continued From page 16 and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2) (a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises,	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 032	Continued From page 17 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities. 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to identify a resident as an elopement risk despite a facility documented history of 9 elopements since admission, failed to maintain a general awareness of the resident's location, and failed to ensure elopement policies and procedures were followed to ensure the resident's appropriate placement for 1 of 36 residents residing at the facility. (Resident #16) The findings include: On _____ at approximately 12:38 PM, an interview was conducted with Staff A, Caregiver. When asked if any residents had _____ from the facility, Staff A reported that one resident eloped from the facility maybe a couple of weeks ago. Staff A identified that individual as Resident #16. She continued that the resident left walking, and that staff went outside the facility to look for him when he could not be located in the facility. Staff A stated the facility called law enforcement who found the resident and transported him _____.	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 032	Continued From page 18 to the facility. On at approximately 12:54 PM, an interview was conducted with Staff B, Caregiver. When asked if any residents had from the facility, Staff B reported a couple of residents had walked off from the facility. She further stated Resident #16 from the facility and law enforcement had to transport him to the facility. On at approximately 1:09 PM, an interview was conducted with Staff C, Caregiver. When asked if any residents had from the facility, Staff C reported one resident walked off from the facility and law enforcement transported the resident to the facility. On at approximately 2:27 PM, an interview was conducted with the Assistant to the Administrator who reported that Resident #16 eloped from the facility on He continued that Resident #16 did not show up for snack at 9:00 AM, which staff thought was odd because he loves everything sweet, so all staff stopped and started to look for him and realized he was not at the facility. Staff then called the sheriff's office while another staff member started driving throughout town looking for him. A person from the community called the sheriff's office to report that an unknown man was in their home. When the sheriff arrived at the home and saw the man holding the bible, he immediately knew who he was and that he was a resident of this facility. The sheriff's officer transported Resident #16 to the facility. The surveyor informed the Assistant to the Administrator that there was no documentation of the elopement in the resident's record. The Assistant to the Administrator stated that the facility notified his brother. The surveyor	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/20/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VARNUM'S REST HOME LLC

**12167 NW FREEMAN ROAD
BRISTOL, FL 32321**

(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 032	Continued From page 19 informed the Assistant to the Administrator that there was no evidence in the resident's record that an assessment was performed on the resident after returning to the facility. She replied that she did not know when to do an adverse incident. She also reported that on one occasion Resident #16 walked into a church in the community while a service was in progress and started preaching. The people at the church asked him to leave and escorted him out of the church. The Assistant to the Administrator further reported that the facility does not know if the resident would do it again because he loves to preach and walks away from the facility to find somewhere to preach. She also reported that facility staff are concerned for his safety, but that he is appropriate for the facility. The Assistant to the Administrator stated this is the first time in a while that Resident #16 has left the facility because when he was first admitted, he used to walk away from the facility a lot and the Sheriff would bring him . She confirmed the Resident Health Assessment had not been updated to indicate Resident #16 was at risk for elopement. On at approximately 9:39 AM, an interview was attempted with Resident #16. Resident #16 was pacing and responded incoherently to questions. The interview was unable to be conducted. A review of Resident #16's Resident Health Assessment Form (AHCA Form 1823) dated revealed diagnoses including type, intellectual mild. Further review revealed medications including Invega Sustenna. Section 1 of the assessment revealed the box for Elopement Risk was marked	A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/20/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VARNUM'S REST HOME LLC

**12167 NW FREEMAN ROAD
BRISTOL, FL 32321**

(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 032	Continued From page 20 "No" indicating Resident #16 was not an elopement risk. On at approximately 3:07 PM, an interview was conducted with the Facility Administrator who reviewed Resident #16's Resident Health Assessment and confirmed that it still indicated that the resident was not an elopement risk. The Facility Administrator reported that she now knows the Resident Health Assessment should have been updated to reflect that Resident #16 was an elopement risk. On at approximately 1:14 PM, a telephone interview was conducted with Resident #16's brother who reported that every now and then Resident #16 will walk off from the facility and come . According to the brother, the facility did not inform him of Resident #16's elopement on or that when he eloped he was entering into people's homes and into a church building. The brother reported having concerns with Resident #16 crossing busy highways and being in the right , as he does not believe Resident #16 sees as well. The brother stated Resident #16 needs supervision at the facility because he will just go and walk off. A review of the Resident Observation Log for Resident #16 revealed the following: - walked off from the facility without staff knowledge. Staff went out to find him, called the local sheriff's department and resident was located and returned to the facility. - walked away from the facility without staff knowledge and was later returned by a local sheriff's officer. - attempted to walk away from the facility during morning medication pass, but staff	A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 032	Continued From page 21 were able to stop him. Resident #16 responded by yelling at staff stating he was going to kill them. Staff were eventually able to get Resident #16 to calm down. - walked away from the facility without staff knowledge during morning medication pass. The local sheriff's office was notified and he was located up Highway 12 North. Facility staff requested that the sheriff's officer the resident, but the officer stated the resident was not a threat to himself or others. Facility staff reported to mental health case manager and requested that the doctor be notified and as well as requested a medication change. - walked away from the facility again during morning medication pass and was later returned to the facility by a deputy. The deputy informed Resident #16 that he cannot be walking out in a storm because there was a possible hurricane headed this way. - neighbors reported to staff that Resident #16 had walked into their house uninvited several times and read the bible to them. Facility staff reported this to the mental health case manager who informed Resident #16 that he cannot go into people's houses. - walked away from the facility without staff knowledge during morning medication pass. Resident #16 was picked up and returned to the facility. Facility staff reported this event to the mental health case manager. - walked away from the facility without staff knowledge during morning medication pass. Staff located him down the road from the facility and returned him to the facility. Facility staff reported this event to the mental health case manager. - walked away from the facility without staff knowledge. Staff got him to come He said he was going to Quincy to the ice cream	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 032	Continued From page 22 shop. Facility staff reported this event to the mental health case manager. Further review of the log revealed no additional information was documented concerning the elopements including the length of time Resident #16 was out of the facility, where he was eventually located, who specifically found and returned him, his mental/physical state upon return, or his reason for leaving. A review of police reports obtained from the local sheriff's office involving Resident #16 revealed two additional elopements that were called into law enforcement by the facility but not documented on the Resident Observation Log: (located approximately 1 mile from the facility) and Review of the reports also revealed that on Resident #16 was located approximately 1.5 miles from the facility and approximately 2 miles away on A review of Varnum's Rest Home Elopement/Missing Person Policy (undated) revealed "Elopement is when a resident attempts to leave or leaves whom is not mentally and physically capable of leaving the facility without an escort, family, friend, staff or any other person. All residents shall be assessed for elopement risk prior to admission to the facility by the administrator. If a resident is deemed a high risk for elopement they shall not be considered for placement at this facility. In the event a resident attempts to elope or has shown any signs of elopement the staff shall report to the administrator immediately. The administrator along with the mental and physical health care providers shall counsel the resident and attempt to discover the reason they wish to leave. If changes cannot be made to accommodate the	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 032	Continued From page 23 resident the administrator shall work with the case manager and doctors to make arrangements for the resident to be moved to another facility or a place of their choice. In the event the resident is assessed at risk for elopement the staff shall be notified by the administrator. The staff on duty shall ensure that the resident has identification on his/her person that includes their name, the facility's name, address and phone number. The staff directly responsible for that resident shall make frequent checks on the resident's location. In the event a resident elopes the following missing person policy shall be enforced. If a resident is suspected to be missing the staff on duty who is immediately responsible for that resident will immediately have the other staff conduct a in house and grounds search while he/she notifies the administrator or the person in charge when the administrator is not available. If the resident is not found in the building or on the facility grounds the administrator shall contact law enforcement, the resident's family, guardian, health care surrogate and case manager. The administrator and available staff shall start a search by vehicle of the surrounding roadways...The administrator shall meet with law enforcement and provide them with any information about the resident that will aid in the search including photo ID, description of clothing, and any other information needed. The administrator and staff shall keep in contact with law enforcement until the resident is found. The resident's family/guardians shall be notified as well as the case manager when the resident is located. When the resident is found the administrator, case manager and doctors shall determine if the resident is able to remain at the facility with strict supervision or if the resident shall need to be transferred to the hospital."	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 032	Continued From page 24 Class II	A 032			
A 052 SS=D	429.256(. . .); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an . . . syringe that is prefilled with the proper dosage by a pharmacist and an . . . that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her (d) Applying . . . medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a . . . , including removing the cap of a , opening the unit	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/20/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VARNUM'S REST HOME LLC

**12167 NW FREEMAN ROAD
BRISTOL, FL 32321**

(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 052	Continued From page 25 dose of _____ solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the _____. (h) Using a _____ to perform _____ level checks. (i) Assisting with putting on and taking off _____ stockings. (j) Assisting with applying and removing an _____ but not with titrating the prescribed _____ settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with _____ bags. (4) Assistance with self-administration does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____ of the body. (d) Administration of _____ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, or _____ preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 052	Continued From page 26 resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321			
(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 052	Continued From page 27 not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility. 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record. 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 052	Continued From page 28 This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medication was given per physician's order for 1 of 5 sampled residents during medication pass observation. (Resident #14) The findings include: A review of Resident #14's physician's orders revealed an order for Proair Inhaler 108 MCG/ACT (micrograms per actuator) inhale 2 puffs every 6 hours. Every 6 hours would be 4 times within a 24-hour period (4 times per day). On at approximately 1:45 PM, a medication pass observation was conducted for Resident #14. During this observation, Staff C, Caregiver, was observed to review the Medication Observation Record (MOR), which instructed to give Proair inhaler 2 puffs every 6 hours as needed at 7:00 AM, 1:00 PM, and 7:00 PM. Staff C proceeded to give the inhaler to Resident #14 for self-administration. On at approximately 11:51 AM, an interview was conducted with the Assistant to the Administrator. During this interview the Assistant to the Administrator reviewed Resident #14's MOR and physician orders and confirmed they do not match as the MOR indicates an as needed order and the physician's order indicated a routine order. The surveyor informed the Assistant to the Administrator that if the order was to be administered as written, then Resident #14 would receive 4 scheduled doses per day but the	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321			
(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 052	Continued From page 29 MOR only indicates 3 doses. The Assistant to the Administrator confirmed this finding. The Assistant to the Administrator explained the process for new medication orders. They are sent from the doctor to the pharmacy and the pharmacy calls the facility to notify the administrator or office personnel/assistant of the new order, then the medication is picked up from the pharmacy. New orders are put into the resident's chart, entered into the computer prescription database, then the new medication is put on the resident's MOR. The pharmacy always confirms the new medication or medication change before the medication is filled. The Assistant to the Administrator reported that the physician's order for Resident #14 was transcribed wrong. Class III	A 052			
A 057 SS=D	59A-36.008(8) FAC Medication - Over The Counter (OTC) Products (8) OVER THE COUNTER (OTC) PRODUCTS. For purposes of this subsection, the term over the counter includes, but is not limited to, over the counter medications, . . . , nutritional supplements and nutraceuticals, hereafter referred to as OTC products, that can be sold without a prescription. (a) A facility may keep a stock supply of OTC products for multiple resident use. When providing any OTC product that is kept by the facility as a stock supply to a resident, the staff member providing the medication must record the name and amount of the OTC product provided in the resident's medication observation record. All OTC products kept as a stock supply must be stored in a locked container or secure	A 057			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER VARNUM'S REST HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12167 NW FREEMAN ROAD BRISTOL, FL 32321		
(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 057	Continued From page 30 room in a central location within the facility and must be labeled with the medication's name, the date of purchase, and with a notice that the medication is part of the facility's stock supply. (b) OTC products, including those prescribed by a health care provider but excluding those kept as a stock supply by the facility, must be labeled with the resident's name and the manufacturer's label with directions for use, or the health care provider's directions for use. No other labeling requirements are required. (c) Residents or their representatives may purchase OTC products from an establishment of their choice. (d) A health care provider's order is required when a nurse provides assistance with self-administration or administration of OTC products. When an order for an OTC product exists, the order must meet the requirements of paragraphs (b) and (c) of this subsection. A health care provider's order for OTC products is not required when a resident self-administers his or her medications, or when unlicensed staff provides assistance with self-administration of medications. This Statute or Rule is not met as evidenced by: Based on facility record review and staff interview, the facility failed to record the name and amount of the over the counter (OTC) medication provided to 1 of 5 residents during medication pass observation. (Resident #12) The findings include: A review of the facility's Medication Observation Record (MOR) for Resident #12 revealed no documentation of OTC medication. On _____ at approximately 1:30 PM, an _____	A 057			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910546	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/20/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VARNUM'S REST HOME LLC

**12167 NW FREEMAN ROAD
BRISTOL, FL 32321**

(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 057	Continued From page 31 interview was conducted with Staff C, Caregiver, who reported Resident #12 receives OTC meditation daily for issues. Staff C confirmed that this medication has not been documented on the MOR when it has been given. Class III	A 057		