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
	AL11965890	A. BUILDING: _____ B. WING _____	R 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TROPICAL HEAVEN, INC	14201 SW 48 LANE MIAMI, FL 33175

(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
{CZ814}	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain an updated employee roster within the background screening clearinghouse database for two out of four sampled staff (Staff B and Staff D). Findings include:	{CZ814}		

AHCA Form 3020-0001

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

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{CZ814}	Continued From page 1 On at 10:00 AM Staff B stated she had been working in facility for about 14 years. On at 8:15 AM Staff B was observed assisting residents with the activities of daily living. A review of the facility's roster on the Background Screening Clearinghouse database showed Staff B was terminated as a facility employee on . A review of the facility's staffing schedule revealed that Staff D was hired on with no end date. On at 1:33 PM the Administrator acknowledged Staff B was not listed on the Roster as facility's employee. She added Staff D was not working at the facility since . Uncorrected Unclassified	{CZ814}		
{CZ815}	408.809(1)( ); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of	{CZ815}		

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{CZ815}	Continued From page 2	{CZ815}		

the provider.
(c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider.
(d) Any person who is a controlling interest.
(e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, [illegible] with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or [illegible] with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee.

(3) All [illegible] must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf.

(4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an [illegible] awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of

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{CZ815}	Continued From page 3	{CZ815}		

nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:
(a) Any authorizing statutes, if the offense was a felony.
(b) This chapter, if the offense was a felony.
(c) Section 409.920, relating to Medicaid provider fraud.
(d) Section 409.9201, relating to Medicaid fraud.
(e) Section 741.28, relating to domestic violence.
(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
(g) Section 784.03, relating to battery, if the victim is a adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429.
(h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
(i) Section 817.234, relating to false and fraudulent insurance claims.
(j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
(k) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.
(l) Section 817.505, relating to patient brokering.
(m) Section 817.568, relating to criminal use of personal identification information.
(n) Section 817.60, relating to obtaining a credit card through fraudulent means.
(o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
(p) Section 831.01, relating to forgery.
(q) Section 831.02, relating to uttering forged

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{CZ815}	Continued From page 4 instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3).	{CZ815}		

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{CZ815}	Continued From page 5 The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining [illegible] pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the	{CZ815}		

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{CZ815}	Continued From page 6 agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter.	{CZ815}		

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{CZ815}	Continued From page 7 (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers.	{CZ815}		

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{CZ815}	Continued From page 8 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that one out of four sampled staff conducted a new level II background screening every five years (Staff B). Findings include: In an interview on at 10:43 AM, Staff B stated, "I have been working here for 14 years." Review of Staff B's personnel records showed a hire date of . . . . . . A review of the background screening database showed Staff B's prints were expired and the determination status was "A New Screening is Required." On at 1:00 PM the Administrator acknowledged Staff B's prints were expired. She did not not explain why Staff B did not have a new screening conducted. Uncorrected Unclassified	{CZ815}		
CZ828	408.813(3) FS Administrative Fines; Violations 408.813 Administrative fines; violations.-As a penalty for any violation of this part, authorizing statutes, or applicable rules, the agency may impose an administrative fine. (3) The agency may impose an administrative fine for a violation that is not designated as a class I, class II, class III, or class violation. Unless otherwise specified by law, the amount of	CZ828		

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CZ828	Continued From page 9 the fine may not exceed $500 for each violation. Unclassified violations include: (a) Violating any term or condition of a license. (b) Violating any provision of this part, authorizing statutes, or applicable rules. (c) Exceeding licensed capacity. (d) Providing services beyond the scope of the license. (e) Violating a moratorium imposed pursuant to s. 408.814. (f) Violating the parental consent requirements of s. 1014.06 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to operate within its licensed capacity. The facility was licensed for six residents, and it was providing services to a census of ten residents. Findings included: On . . . . . during the facility tour between 8:15 AM to 8:25 AM observation showed: In # were Resident #8 and Resident #9 both lying in bed. In . . #. was Resident #6 seated in her bed. In . . . #. were Resident #2 and Resident #7 both lying in bed. Resident #3 and Resident #11 were seated in the family room. Resident #13 was lying in bed in a room in the of the facility. Resident #15 was walking in the patio.	CZ828		

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CZ828	Continued From page 10 Resident #10 was seated in the patio. On at 8:25 AM Staff B (caregiver) stated that there were ten residents in the facility and two were in the hospital. A review of the facility's admission and discharge log only showed admissions for three out of the ten residents. Resident #2 was admitted , Resident #6 was admitted and Resident #7 was admitted . On at 10:54 AM, the Administrator stated that the only residents at the facility were Resident #2, Resident #6, Resident #7, Resident #8, Resident #9. She added that Resident #3 and Resident #10 were staying temporary, Resident #11 was mistakenly left in the facility by the transportation after he was discharged from the hospital on but he belonged to another facility. Lastly, she said that Resident #13 was staying as a charity and because he was not paying, she did not consider him a resident. A review of licensure records showed the facility was approved for a capacity of six residents. Unclassified	CZ828		

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A 160 SS=E	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [illegible]; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of [illegible]. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as	A 160		

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A 160	Continued From page 1 described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years.	A 160		

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A 160	Continued From page 2 (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated 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 observation, record review and interview the facility failed to maintain an up-to-date admission and discharge record listing the names of all residents, place from which the resident was admitted, date of discharge and reason for discharge for nine out 18 sampled residents (Resident #3,#6, #8, #9, #10, #11, #13, #15 and #18) Findings as follow: On at 8:15 AM observed in the facility Residents #3, #8, #9, #10, #11, #13, #15. Review of the admission and discharge record showed Resident's #3, # #9, #10, #11, #13 and #15 were not listed on the admission and discharge log. Further review of the admission and discharge log showed Resident #6 and #18 was discharged from the facility and no discharge date noted. On at 1:00 PM the Administrator acknowledged the admission and discharge was not up-to-date. Class III	A 160		

Agency for Health Care Administration

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	AL11965890	A. BUILDING: _____ B. WING _____	R 03/18/2022

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{A 162} SS=F	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. , 3. Race, 4. Date of birth, 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	{A 162}		

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{A 162}	Continued From page 4	{A 162}		

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 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,

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{A 162}	Continued From page 5 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 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.	{A 162}		

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{A 162}	Continued From page 6 This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to have a copy of the residents contract with the facility and 1823 AHCA health assessment for nine out of 18 sampled residents (Resident # 3, #5, #6, #7,#8,#9, #10, #12 and #13). The facility failed to ensure residents had order for the use of siderails for one out of 18 sampled residents (Resident #9) Findings as follow: Review of Residents #3, #5, #6, #7, #8, #9, #10, #12, #13 records found there were no copy of a resident contract the facility. Review of Residents # 3, #6, #9, #10, #12 and #13 records showed there were no 1823 AHCA health assessments in file. On . . . . . at 8:15 AM Resident #9 was observed lying in bed with full bedrails in upright position. Review of Resident #9 record showed there was no prescription for the use of the bed rails. On . . . . . at 1:10 PM the Administrator stated family of Resident #3 and #9 took the residents records home to be signed. The Administrator stated the records for Resident's #5, #6, #7,#8,#9,#10,#12,#13 were either incomplete or were not completed because the residents were not facility residents. Uncorrected Class III	{A 162}		

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A 165	Continued From page 7	A 165		
A 165 SS=D	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	A 165		

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A 165	Continued From page 8 incident, through the agency's online portal, or if the portal is offline, by electronic mail, a 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	A 165		

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A 165	Continued From page 9 licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report 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 interview and record review, the facility failed to provide, within 1 business day after the occurrence of an adverse incident a preliminary report, and within 15 days after the occurrence of an elopement, a full report to the Agency for Health Care Administration that included the results of the facility's investigation into the adverse incident. Findings included: 1) On at 12:39 PM, the Administrator stated that Resident #17 eloped on after she went to church. The resident went to the church using private transportation and had a cellular phone to call the facility when the church service finished in order to pick her up. After the church service the resident went to a restaurant with other church members who later left, and Resident #17 remained at the restaurant. The Administrator further stated that Resident #17 did not know how to use the cellular phone to call the facility. So, the restaurant's Manager called the police and informed resident was there. Resident	A 165		

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A	Continued From page 10	A 165		

#17 was with the police when the Administrator arrived at the restaurant and then, she took the resident with her to the facility. The Administrator stated she did not complete an incident report because Resident #17 did not elope. The Administrator informed that in other occasion on , Resident #17 was watching television in the family room and Staff B went to give medications to Resident #2. Staff B went out from the room after minutes and realized that Resident #17 was not in the facility. The Administrator also stated that on that day Staff B and Staff C were working. She added that did not remember what Staff C was doing when Resident #17 eloped. They called the police who arrived about 30 minutes later. At about 7:30 PM, a lady called the facility with the resident's cellular phone, to inform that Resident #17 was at a Metrorail station (located about 12 miles from the facility). Resident was carrying an alarm bracelet. The Administrator stated that she called the police who picked up Resident #17 and transferred her to a local hospital. Then, on , the hospital notified the Administrator that Resident #17 was allowed to return to the facility. So, Resident #17 returned that day to the facility.

2)
On at 1:12 PM, the Administrator stated that Resident #18 eloped from the facility on after they went to sleep. The resident opened the door and walked with the wheelchair for about three blocks. Someone saw her on the street and called the police, when the police arrived a police officer that knew that this was an assisted living facility (ALF) sent a unit to ask if the resident was from the facility. Staff B (caregiver) was on duty and went with the police to identified Resident #18 and then the police

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A 165	Continued From page 11 brought the resident to the facility. A review of the Incident Report System (AIRS) revealed Resident #17 eloped from the facility on . . . . . The facility submitted the preliminary report on . Further reviewed revealed that the Agency for Health Care Administration requested additional information and the facility did not respond. There was no documentation in the system of the previous Resident #17's elopement nor Resident #18's elopement. On . . . . . at 1:21 PM, the Administrator stated that she did not remember if she completed the full report because it was long time ago. Class III	A 165		
{A 000}	Initial Comments A revisit to a re-licensure survey, in conjunction with a complaint investigation (complaints #2021015231 and #2021014214) was conducted at Tropical Heaven, Inc from to . . . . . Deficiencies were identified at the time of the survey.	{A 000}		
{A 025} SS=H	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such . . . or , . . . The notification must occur within 30 days after the	{A 025}		

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{A 025}	Continued From page 12	{A 025}		

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 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.

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{A 025}	Continued From page 13 (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 observation, record review and interview, the facility failed to offer personal supervision as appropriate for each resident and failed to maintain a general awareness of the resident's whereabouts for 2 out of 18 sampled Residents (Residents #17 and #18). Resident #17 eloped twice and was found approximately 12 miles away after one elopement and 10 miles away after the second elopement by law enforcement. Resident #18 eloped from the facility and was found about two blocks away by law enforcement. Findings included: 1) A review of an incident report dated revealed Resident #18 was found next her to wheelchair in the middle of the road. The report showed she was found lying in the roadway unable to get up on her own and law enforcement had to be notified. A review of the police report regarding the incident revealed that: "Upon arrival, we found [Resident #18] lying in the middle of the roadway as she had . . . out of her wheelchair when she attempted to roll her wheelchair off the curb of the sidewalk while sitting in it. [Resident #18] advised that she had been visiting a friend nearby and	{A 025}		

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{A 025}	Continued From page 14 now she wanted to get to a bus stop to go home at [address]. Units assisted [Resident] off the floor and . . . into her wheelchair [Emergency Transportation] refused. [Resident] had very little ability to walk unassisted and had no real identification on her. [Resident] seemed slow to respond to questions and was not sure what area she was in. A routine records check revealed a home address in [name of city]. However, knowing the area, and knowing that an A.L.F (assisted living facility) called [name of the facility] was nearby, a unit went to the A.L.F and spoke to [Staff B] who advised [Resident] was a resident at the facility. However, Staff B was not aware that [Resident] had escaped. The police officer contacted Resident #18's son who advised that he was out of town and was unable to come. Police then contacted the Administrator and asked to respond to the home. Units then assisted [Resident] to her home by pushing her in her wheelchair . . . to the ALF, which was five blocks away. Upon further investigation, neither [Staff B] nor [Administrator] were able to provide the case file, or patient book pertaining to [Resident]. Neither could advise what time was the last time [Resident] was seen in the group home nor were any of her documents were for the days' activities. This unit was told by [Administrator] that the home does not lock patients in and advised that patients are free to come and go as they please. Furthermore, [Administrator] advised that [Resident] does not need constant supervision and that although [Resident] walked away today she does not know how it could have happened. [Staff] advised she last saw [Resident] at dinner and that she shortly after that gave [Resident] her medications (unable to provide a time) and then both she and [Resident] went to bed."	{A 025}		

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{A 025}	Continued From page 15 Review of Resident #18's health assessment completed showed medical history and diagnoses of type II ( ), ( ) with lunar infarcts, , major , (MDD), and . The resident needed supervision with self-care (grooming) and transferring; and required assistance with ambulation (used wheelchair), bathing and ; and assistance with the self-administration of medication. Resident exhibits periods of . Resident was not identified as an elopement risk. On at 1:12 PM, the Administrator stated Resident #18 left the facility on Saturday, , after the staff went to sleep. The Administrator stated, "the resident wanted to go to live with her husband, so she opened the door and walked with the wheelchair out of the facility, for about three blocks. Someone saw her on the street and called the police, when they arrived a police officer that knew that this was an assisted living facility sent a unit to ask if the resident was from the facility. Staff B was on duty and went with the police to identify Resident #18 and then the police brought the resident to the facility. The next Monday, [ ], the resident was sent to a behavioral hospital. Someone from Department of Children and Families (DCF) investigated, and they concluded that it was safe for Resident #18 to return to the facility, but the resident decided not to come ." Review of hospital records received showed that Resident #18 was transferred from	{A 025}		

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	AL11965890	A. BUILDING: _____ B. WING _____	R 03/18/2022

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{A 025}	Continued From page 16 the facility in an ambulance to the emergency room on . The record revealed, "Patient presented for disorganized behavior from her ALF. Per ALF she was found to be ambulating around the neighborhood without permission and was brought by police several days ago. She has been increasingly disorganized and behaving strangely so they wanted her transferred to [Hospital] for evaluation." 2) Review of the agency incident report showed on Resident #17 eloped from the facility. Staff on duty at the time was providing care to another resident and was not aware the resident left the facility. The staff at some point noticed a door of the facility was open and the resident was not inside the facility. Review of Resident #17's health assessment completed showed medical history and diagnoses of , unspecified, type 2 with unspecified complications, unspecified , essential (primary) , age-related , without current , unspecified , and , unspecified. unspecified with behavioral disturbance. The health assessment also showed the resident had memory and a . The resident was not identified as an elopement risk. The resident needed assistance with the self-administration of medication. On at 10:25 AM Staff B stated Resident #17 left the facility on several occasions	{A 025}		

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{A 025}	Continued From page 17	{A 025}		

without telling the staff (she was not able remember specific dates). She stated the police was contacted each time the resident left the facility, and the police would always bring her . . . . . Staff B stated on . . . . . she was working alone in the facility and the resident left the facility without telling her and when she realized resident was not in the facility, she called the police. She stated the police found the resident at 6:30 PM in a restaurant about 13 miles away from the facility. She stated resident ambulated independently and always eloped exiting through the front door.

On . . . . . at 12:39 PM The Administrator stated Resident #17 eloped from the facility on . . . . . She stated the staff was not aware resident was not inside the facility until, about . . . . minutes later. The Administrator stated the police was called and arrived about 30 minutes later. She stated about 7:30 PM, a lady called the facility, using the resident's cellular phone, and informed her that Resident #17 was at a Metrorail station (located about 12 miles from the facility). The Administrator stated that she called the police and a police officer picked up Resident #17 and transferred her to a local hospital. The Administrator stated on . . . . . , she was contacted by someone at the hospital who told her Resident #17 was ready to return to the facility and the resident returned to the facility on . . . . . The Administrator stated that Resident #17 also eloped from the facility before, on . . . . . , after she went to church. She stated the resident went to the church using private transportation. The administrator stated after the church service was over, the resident went to a local restaurant with other church members. The Administrator stated the other church members left the restaurant, but the

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{A 025}	Continued From page 18 resident remained at the restaurant alone. The Administrator further stated that Resident #17 did not know the number to call the facility and the restaurant's Manager called the police. The Administrator stated she went to the restaurant and when she arrived the police officer was with the resident. The Administrator stated she brought resident to the facility. Review of hospital records received showed that Resident #17 was admitted to the hospital from to after she was found off from her ALF (assisted living facility) and was found on a Metrorail station (located approximately 12 miles from the facility). The records indicated that it was unclear how she got there and revealed that: " show a at the base of the phalanx of the third ray. 136, 360, UA [ ] positive, state, and base of the phalanx base of the third of the left Hyponatremia." Review of the facility's elopement policies and procedures revealed that: "At "ALF", "Elopement" refers to an unauthorized absence of a resident from the facility. The risk of and elopement increases when residents are mobile and ; especially if they suffer from or -Policy: It is the policy of ALF to: Establish a method of assessing residents for risk of and eloping at the time of admission and as needed. Develop and implement preventive measures to make sure to stop and elopement whenever possible. -Procedure: Assessment: At "ALF", the first step	{A 025}		

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{A 025}	Continued From page 19 in preventing elopement is to identify those residents with the identifiable potential to or elope. This initial assessment at "ALF" will be performed during the admission process to ascertain the resident history of _____/ elopement, as well as alterations in mental status that could potentially contribute to a _____/elopement behavior." Review of Resident #17 records revealed resident was diagnosed with memory _____ and _____, unspecified _____ with behavioral disturbance, and mobile; the resident was identified as not being an elopement risk. Further review of the resident records showed the resident eloped two times and there was no documentation resident was reassessed for elopement and preventative measures were put in place to prevent repeated elopement occurrences. On _____ at 1:21 PM, the Administrator stated, "I guide myself by what the doctor indicated on the health assessment, and none of the residents were at risk for elopement." Class II Uncorrected	{A 025}		
{A 026} SS=F	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified	{A 026}		

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{A 026}	Continued From page 20 individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to encourage residents to participate in social, recreational, educational, and leisure activities. Findings included: A review of the facility's activity calendar showed	{A 026}		

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{A 026}	Continued From page 21 that on [redacted], activities were scheduled to be conducted from 2:00 PM-4:00 PM. Observation on [redacted] from 2:00 PM to 2:20 PM showed the activity schedule was not followed and no activities was offered or observed. Observation on [redacted] from 2:00 PM to 2:15 PM showed the activity schedule was not followed and no activities was offered or observed. On [redacted] at 2:15 PM the Administrator stated she had coordinated activities through a website. She was asked how residents were going to participate in the website activities? She stated, "All of them had tablets." Observation showed the residents did not have tablets and the Administrator acknowledged no activities was conducted or offered to the residents. Uncorrected Class III	{A 026}		
{A 030} SS=E	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule	{A 030}		

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{A 030}	Continued From page 22 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . . , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery	{A 030}		

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{A 030}	Continued From page 23 of services to residents by third party providers; 9. Assistive devices; and 10. Physical [illegible] (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can	{A 030}		

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{A 030}	Continued From page 24 demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . for health care services, the provision of or	{A 030}		

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{A 030}	Continued From page 25 arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that	{A 030}		

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{A 030}	Continued From page 26 a written notice of the rights, , , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or	{A 030}		

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{A 030}	Continued From page 27 representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to honor resident rights and ensure residents were treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy for 5 out of 10 sampled residents. Findings include: On at 10:00 AM and 10:15 AM observed . . # . , occupied by Residents #13 and #15 and observed # occupied by Residents #3, # 10 and # 11. Observed . . #. residents had to crossover through the residents in . . #. to enter and exit the room. On . . . . . at 2:15 PM, the Administrator acknowledged Residents in # had to go through residents in . . #. to enter and exit the room. Uncorrected Class III	{A 030}		

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A 032	Continued From page 28	A 032		
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 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	A 032		

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TROPICAL HEAVEN, INC	14201 SW 48 LANE MIAMI, FL 33175

(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 29 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, 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 record review and interview, the facility failed to follow its policies and procedures regarding residents assessed for elopement or with any history of elopement for one out of eighteen sampled residents (Resident #17). Findings included: Incident #1 On . . . . . at 12:39 PM The Administrator stated Resident #17 eloped from the facility on . . . . . She stated the staff was not aware resident was not inside the facility until, about	A 032		

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A 032	Continued From page 30 . . . minutes later. The Administrator stated the police was called and arrived about 30 minutes later. She stated about 7:30 PM, a lady called the facility, using the resident's cellular phone, and informed her that Resident #17 was at a Metrorail station (located about 12 miles from the facility). The Administrator stated that she called the police and a police officer picked up Resident #17 and transferred her to a local hospital. The Administrator stated on , she was contacted by someone at the hospital who told her Resident #17 was ready to return to the facility and the resident returned to the facility on . The Administrator stated that Resident #17 also eloped from the facility before, on , after she went to church. She stated the resident went to the church using private transportation. The administrator stated after the church service was over, the resident went to a local restaurant with other church members. The Administrator stated the other church members left the restaurant, but the resident remained at the restaurant alone. The Administrator further stated that Resident #17 did not know the number to call the facility and the restaurant's Manager called the police. The Administrator stated she went to the restaurant and when she arrived the police officer was with the resident. The Administrator stated she brought resident to the facility. Review of Resident #17's health assessment completed . . . . . showed medical history and diagnoses of , , , unspecified, type 2 . . . . . with unspecified complications, unspecified , unspecified . . . . . with behavioral disturbance, essential (primary) , , , age-related , without current , ... , unspecified . . . . and , , , unspecified. The	A 032		

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A 032	Continued From page 31 records revealed resident was diagnosed with memory , and , unspecified with behavioral disturbance, mobile, and the resident was identified as not being an elopement risk. The resident needed assistance with the self-administration of medication. Review of medical records received showed that Resident #17 had past medical history significant for and was admitted to the hospital from to after she was found off from her ALF (assisted living facility) and was found on a Metrorail station (located approximately 12 miles from the facility). The records indicated that it was unclear how she got there and revealed that: " show a at the base of the , phalanx of the third ray. 136, 360, UA [ ] positive, state, ["The allows for the temporary detention and examination of people showing evidence of mental illness and who are in danger of harming themselves or others. This includes danger from self-neglect as well as physical harm."]. [ ]. Uncontrolled type 2 base of the , phalanx base of the third of the left Hyponatremia." Review of the facility's elopement policies and procedures revealed that: "At "ALF", "Elopement" refers to an unauthorized absence of a resident from the facility. The risk of and elopement increases when residents are mobile and ; especially if they suffer from or Policy:	A 032		

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A 032	Continued From page 32 It is the policy of ALF to: Establish a method of assessing residents for risk of [illegible] and eloping at the time of admission and as needed. Develop and implement preventive measures to make sure to stop [illegible] and elopement whenever possible. Conduct and document at minimum two elopement drills a year. Procedure: Assessment: At "ALF", the first step in preventing elopement is to identify those residents with the identifiable potential to [illegible] or elope. This initial assessment at "ALF" will be performed during the admission process to ascertain the resident history of [illegible] elopement, as well as alterations in mental status that could potentially contribute to a [illegible] elopement behavior." Review of Resident #17 records revealed resident was diagnosed with memory [illegible], and [illegible], unspecified [illegible] with behavioral disturbance, mobile, and the resident was identified as not being an elopement risk. Further review of the resident records showed the resident eloped two times and there was no documentation resident was reassessed for elopement and preventative measures were put in place to prevent repeated elopement occurrences. On [illegible] at 1:21 PM, the Administrator stated that she did not conduct elopement assessments to the residents at the time of admission. She added, "I guide myself by what the doctor indicated in the health assessment, and none of the residents were at risk for elopement." Class II	A 032		

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{A 054}	Continued From page 33	{A 054}		
{A 054} SS=E	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a daily medication observation record (MOR) for three out of sixteen sampled	{A 054}		

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{A 054}	Continued From page 34 residents who received assistance with self-administration of medications (Resident #3, #10, #13). The facility failed to immediately update the MOR each each time the medication is offered or administer for one out of sixteen sampled residents (Resident #2). Findings include: On at 8:45 AM Medications for Residents #3, #10 and #13 were observed unlocked inside the facility's dryer machine. A review of the facility ' s records revealed there were no MORs for Residents #3, #10 and #13 on file. Review of Resident #2' MOR showed the medications was not signed/initial as given; - , , 5 mg tab 1 tab oral 2 times a day prescribed for 7 am was not signed on , and . - , 0.25 mg one tablet 2 times prescribed for 7 PM was not signed/initialed as given in . - TMP DS one tab every 12 hours prescrbed for 7 AM was not signed on and and the 7 PM doses was not signed in . On at 12:05 PM The Administrator stated Residents #3 and #10 did not have a MOR because they were not facility residents. The Administrator added Resident #13 did not have a MOR because resident was independent with medications; there was no documentation or 1823 health assessment that showed resident administered his own medications. The	{A 054}		

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{A 054}	Continued From page 35 Administrator stated Resident #2 took medications regularly, but Hospice staff and family member (sister) failed to sign the MOR. Uncorrected Class III	{A 054}		
A 055 SS=F	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of	A 055		

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A 055	Continued From page 36 medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family,	A 055		

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A 055	Continued From page 37 or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure centrally stored medications were kept in a locked cabinet;locked cart; or other locked storage receptacle, room, or area at all times. The facility failed to ensure medications that have been abandoned must be disposed of within 30 days. On ..... at 8:25 AM observed the medication ..... prescribed for Resident #1, #3, #4, #6, #10, #13 and #16 inside the facility dryer, located in the kitchen area, accessible to all residents. Also observed a bottle of (SPS) suspension polystyrene 15 gm/6 ml CMP prescribed for Resident #11's located inside an unlocked kitchen cabinet. On ..... at 8:25 AM At 8:30 AM observed in ..... # a bottle of ..... SA 100 MG/5 ML SYR and a syringe and box of 250	A 055		

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A 055	Continued From page 38 MG tablets belonged to Resident #9 on the night stand, unsecured and accessible to other residents. On . . . . . at 8:25 AM Staff B stated Resident #1 , ... , a month ago and Resident #4 , ... , long time ago. She stated Resident #16 has not lived in facility for a long time. On . . . . . at 12:50 PM The Administrator stated Resident #16 was never admitted to the facility. On . . . . . at 1:00 PM The Administrator stated Residents #1 and #4 were and she was waiting for the pharmacy to pick up the medications. The Administrator acknowledged the medications for Residents #3, #6, #9, #10, #11 and #13 were unlocked. Class III	A 055		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and,	A 056		

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A 056	Continued From page 39 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care	A 056		

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A 056	Continued From page 40 provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on interview and observation the facility failed to ensure that the prescriptions for one out of eighteen sampled residents who receive assistance with self-administration of medication were refilled in a timely manner (Resident #6).	A 056		

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A 056	Continued From page 41 Findings included: On . . . . . at 1:24 PM, during an interview with Resident #6 she stated that she was not receiving her medications on time. She added that she was missing three medications and that the Administrator had not brought them. On . . . . . at 1:28 PM, medication reconciliation showed Resident #6 was missing six medications. Observation showed empty bottles of . . , 50 mcg, , 5 mg, . . 0.125 mg, ... 180 mg, ... , 5 mg, and 12.5 mg. On at 1:30 PM, the Administrator stated that she had to pick up the medications at the hospital because they did not deliver the medications and she had not been able to go. Class III	A 056		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 . . 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457	A 079		

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A 079	Continued From page 42 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the	A 079		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TROPICAL HEAVEN, INC	14201 SW 48 LANE MIAMI, FL 33175

(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 079	Continued From page 43 administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least [illegible] must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their	A 079		

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A 079	Continued From page 44 representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff	A 079		

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A 079	Continued From page 45 hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to maintain minimum staff on duty to meet the scheduled and unscheduled needs of 10 residents, including one resident under . . . and three residents receiving hospice services. The facility had only one staff member on duty to take care of 10 residents. Also, the facility did not have an accurate staffing pattern that reflected its 24-hour day. Findings included: Observation on at 8:15 AM showed Staff B (caregiver) working alone in the facility with a census of 10 residents. A review of the facility's staffing schedule for . . . . . showed that Staff B and the Administrator were scheduled to work from 7:00 AM to 7:00 PM. Observation on . . . . . at 9:15 AM showed Staff B (caregiver) working alone in the facility with a census of 10 residents. A review of the facility's staffing schedule for showed that Staff C (caregiver) and the Administrator were scheduled to work from 7:00 AM to 7:00 PM.	A 079		

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
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A 079	Continued From page 46 Class III	A 079		
{A 152} SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and	{A 152}		

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{A 152}	Continued From page 47 personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe living environment free of hazards and to ensure that all existing architectural, mechanical, electrical, and structural systems and appurtenances are maintained in good working order. Findings include: During the facility tour on at 8:15 AM observed the air conditioning vent in the bathroom between # # covered by a black substance. The toilet in the same bathroom had the bottom part attached to floor with a brownish color. On . . . . . at 1:00 PM the Administrtaor acknowledged the bathroom between # . . . # needed a repair. Uncorrected Class III	{A 152}		