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
	AL11968667	A. BUILDING: _____ B. WING _____	03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M TRIANAS ALF, CORP	9024 SW 21 TERRACE MIAMI, FL 33165

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint survey (complaint number 2022002799) was conducted at M Trianas ALF, Corp on . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to offer personal supervision as appropriate for each resident and maintain the awareness of the resident's general health, safety, physical, emotional well-being and maintain the general awareness of the whereabouts for one out of seven (Resident #1) sampled residents. Resident #1 eloped from the facility and found approximately 13 hours later and two miles away from the facility by law enforcement. Findings include: A review of the facility's adverse incident report	A 025		

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A 025	Continued From page 2	A 025		

showed Resident #1 eloped from the facility on . The staff realized the resident was not in the facility at 11:08 AM. The staff called the owner at 11:18 AM. The owner called the police and resident #1's daughter. The police found the resident two miles away from the facility at 11:50 PM.

A review of Resident #1's 1823 AHCA health assessment dated showed a medical history and diagnoses of 's , , generalized , , gait instability, history of . The health assessment also revealed resident had diminished visual acuity, poor coordination and balance, walking with some difficulty. Resident was not identified as an elopement risk.

On at 10:10 AM Staff C stated she was checking Resident #1 frequently. She said on , " resident was not in the facility. We looked for her inside and outside the facility. We called the owner around 11:00 AM. The police and Resident #1's daughter came. The police brought the resident to the facility at midnight. The police stated the resident was found at a fast-food restaurant. We put a door alarm after the event."

In an interview with Staff D at 10:35 AM she stated, " Resident #1 opened the door and left sometime in , We looked for her inside and outside the facility. We called the owner and the police. The police found the resident and brought her to the facility at midnight. The police bought food for her. The resident was doing fine. We have been monitoring her and put a door alarm after the incident."

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A 025	Continued From page 3 In an interview on [redacted] at 10:44 AM, Resident #1 physician stated he visited the resident at the facility on [redacted]. He stated the Resident was at risk of [redacted] and eloping. He said at that time he completed another 1823 AHCA health assessment that revealed the resident was at risk for elopement, but he did not sign the health assessment until [redacted], the day the resident eloped. In an interview on [redacted] at 11:19 AM, Administrator stated on [redacted] Resident #1 left the facility, and the staff called her at about 11:00 AM. She stated the staff looked for the resident in the neighborhood and called the police and the resident daughter. She stated the police, and the resident daughter also looked for the resident. The Administrator stated around midnight the staff called her to let her know that the police brought the resident [redacted] to the facility. She stated the resident was found two miles away from the facility and the resident was fine. The Administrator stated as a preventative measure she installed alarms on the door the next day. She said she retrained the staff and called the physician to update the Resident's #1 health assessment the day that the resident eloped. Review of the facility elopement policies and procedures revealed," As "ALF", Elopement" refers to an unauthorized absence of a resident from the facility. The risk of [redacted] and elopement increases when residents are mobile and [redacted]; especially if they suffer from [redacted] or [redacted]. It is the policy of 'ALF', to establish a method of assessing residents for risk of [redacted] and eloping at the time of admission and as needed. Develop and implement preventive measures to make sure to	A 025		

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A 025	Continued From page 4 stop [illegible] and elopement whenever possible. Assessment: At "ALF", the first step in preventing elopement is to identify those residents with identifiable potential to or elope. This initial assessment at ALF will be performed during the admission process to ascertain the resident's history of /elopement, as well as altercations in mental status that could potentially contribute to a /elopement behavior. Experience has demonstrated that any type of new environment may trigger a desire to leave the facility. All new residents with any type of [illegible] or depressed affect will be considered at increased risk during this time frame. Review of the facility record found the facility did not follow its own elopement policy by not considering at risk for elopement for Resident #1 that is diagnosed with [illegible] and mobile. Class II	A 025		
A 032 SS=D	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	A 032		

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A 032	Continued From page 5 has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,	A 032		

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A 032	Continued From page 6 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 elopement policies and procedures for one out of seven (Resident #1) sampled residents. Findings Included: A review of the facility's adverse incident report showed Resident #1 eloped from the facility on [redacted]. The staff realized the resident was not in the facility at 11:08 AM. The staff called the owner at 11:18 AM. The owner called the police and resident #1's daughter. The police found the resident two miles away from the facility at 11:50 PM. A review of Resident #1's record showed an admission date of [redacted]. Review of the 1823 AHCA health assessment dated [redacted] showed a medical history and diagnoses of [redacted], generalized [redacted] gait instability, history of [redacted]. The health assessment also revealed resident had diminished visual acuity, poor coordination and balance, walking with some difficulty. Resident was not identified as an elopement risk.	A 032		

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A 032	Continued From page 7 Further review of Resident #1 record revealed an evaluation & assessment tool dated for Resident #1 that showed the questions, "does the resident have a diagnosis of 's ? The question was not answered. Does resident have a diagnosis of ? The question was not answered. In an interview on at 11:19 AM, Administrator stated on Resident #1 left the facility, and the staff called her at about 11:00 AM. She stated the staff looked for the resident in the neighborhood and called the police and the resident daughter. She stated the police, and the resident daughter also looked for the resident. The Administrator stated around midnight the staff called her to let her know that the police brought the resident to the facility. She stated the resident was found two miles away from the facility and the resident was fine. The Administrator stated as a preventative measure she installed alarms on the door the next day. She said she retrained the staff and called the physician to update the Resident's #1 health assessment the day that the resident eloped. Review of the facility elopement policies and procedures revealed," As "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 . 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	A 032		

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A 032	Continued From page 8 stop [illegible] and elopement whenever possible. Assessment: At "ALF", the first step in preventing elopement is to identify those residents with identifiable potential to [illegible] or elope. This initial assessment at ALF will be performed during the admission process to ascertain the resident's history of [illegible]/elopement, as well as altercations in mental status that could potentially contribute to a [illegible]/elopement behavior. Experience has demonstrated that any type of new environment may trigger a desire to leave the facility. All new residents with any type of [illegible] or depressed affect will be considered at increased risk during this time frame. Review of the facility record found the facility did not follow its own elopement policy by not considering at risk for elopement for Resident #1 that is diagnosed with [illegible] and mobile. Class III	A 032		