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
	AL11968947	A. BUILDING: _____ B. WING _____	R 09/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SENIOR LIVING DREAM LLC	13442 SW 284TH ST HOMESTEAD, FL 33033

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{A 000}	Initial Comments Based on record review and interview, the facility failed to provide documentation of a satisfactory annual health inspection of its facility. Findings included: A review of the facility records showed that the Department of Health (DOH) Group Care Inspection Report was last conducted on In an interview on at 11:40 AM the Administrator stated that they should have been there, and that the Health Department was late on their inspection. A review of facility records on showed that the inspection had not been updated. Further review showed that the facility paid their inspection fee to DOH on Interviewed on at 7:00 am, the Administrator stated that DOH had not yet arrived to complete the inspection. Uncorrected Class III	{A 000}		
{A 004} SS=D	59A-36.004 FAC Licensure - Requirements 59A-36.004 License Requirements. (1) SERVICE PROHIBITION. An assisted living facility may not represent that it provides any service other than a service for which it is licensed to provide. (2) CHANGE IN USE OF SPACE REQUIRING AGENCY CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity must not be made	{A 004}		

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{A 004}	Continued From page 1	{A 004}		

without prior approval from the Agency Central Office. Approval must be based on the compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection requirements referenced in Rule 59A-36.005, F.A.C.
(3) CHANGE IN USE OF SPACE REQUIRING AGENCY FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, must not be made without prior approval from the Agency Field Office. Approval must be based on compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection standards referenced in Rule 59A-36.005, F.A.C.
(4) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on contiguous property. "Contiguous property" means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Chapters 408, Part II, 429, Part I, F.S. and rule Chapter 59A-35, F.A.C., and this rule chapter.
(5) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 59A-36.005, F.A.C., must be submitted annually to the Agency Central Office. The annual inspections must be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result

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{A 004}	Continued From page 2 in administrative action pursuant to Chapter 408, part II, and Section 429.14, F.S., and rule Chapter 59A-35, F.A.C. (6) RESIDENTS RECEIVING STATE-FUNDED SERVICES. Upon request, the facility administrator or designee must identify residents receiving state-funded services to the agency and the department for monitoring purposes authorized by state and federal laws. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of a satisfactory annual health inspection of its facility. Findings included: A review of the facility records showed that the Department of Health (DOH) Group Care Inspection Report was last conducted on [redacted]. In an interview on [redacted] at 11:40 AM the Administrator stated that they should have been there, and that the Health Department was late on their inspection. An additional review of facility records on [redacted] revealed that the facility paid its relicensure fee to DOH on [redacted], however there was no documentation of a Group Care Inspection. Interviewed on [redacted] at 7:00 am, the Administrator stated that DOH had not yet come to conduct the inspection. Class III	{A 004}		

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{A 032}	Continued From page 3	{A 032}		
{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 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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{A 032}	Continued From page 4 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 elopement policies and procedures. Resident #3 was absent from the facility for several hours without staff knowing his whereabouts. When he returned, no reassessment or elopement precautions were put in place. Findings: A review of an incident report showed that resident #3 left the facility on without staff knowing his whereabouts. The report showed that the resident returned several hours	{A 032}		

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{A 032}	Continued From page 5 later, stating that he went out for cigarettes. A review of Resident #3's health assessment dated showed that he was diagnosed with , , , and , . The resident was identified as an elopement risk. Further review of Resident #3's record found no documentation of the elopement. Interviewed on , the Administrator stated, "I thought doing the elopement drill was sufficient. I will now update the file." Uncorrected Class III	{A 032}		
{A 033} SS=D	59A-36.007(8) PHYSICAL . (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of	{A 033}		

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{A 033}	Continued From page 6 this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a written physical care plan for one out of four sample residents (Resident #4). Finding include: A review of Resident #4's "Resident Consent to the use of Physical " it showed that the resident signed the consent on . The resident consented to the use of Full Bed Rails. A review of Resident #4's Hospice Physician Orders dated showed that the physician ordered full side rails. A review of Resident #4's Record showed that there was no documentation of a physical care plan. Interviewed on at 8:07 am, the Administrator showed the physician's order. He stated that he did not understand that a plan of care was needed. Uncorrected Class III	{A 033}		