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
	AL11965596	A. BUILDING: _____ B. WING _____	C 02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAINES MANOR ALF	301 SOUTH 10TH STREET HAINES CITY, FL 33844

(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 biennial survey, a limited mental health survey, a complaint investigation (complaint number: 2023000201), and a generator monitoring were conducted at Haines Manor ALF on [redacted]. Deficiencies were identified at the time of survey.	A 000		
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	A 032		

AHCA Form 3020-0001

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

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A 032	Continued From page 1 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, 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 observation, record review, and interview, the facility failed to ensure that all staff were aware of which residents were at risk for elopements. Additionally, the facility failed to ensure that all administration and direct care staff participated in the facility's elopement drills. Furthermore, the facility failed to make a daily effort to ensure residents that were at risk for	A 032		

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A 032	Continued From page 2 elopements had identification on their person that included their name and the facility's name, address, and telephone number for three Residents (#1 and #14) of three sampled residents that were at risk for elopements. Findings Included: A review of record review of the facility's self-report for Resident #1, conducted on [redacted], revealed that Resident #1 eloped from the facility's first floor memory care locked unit on [redacted] at some time between 11:30pm and 07:30am. An unidentified staff person failed to ensure that the door was shut completely after taking out the trash. The staff also failed to do their every two-hour resident check during the night. Resident #1 was not discovered, as missing, until the morning shift performed their first resident checks. A record review for Resident #1, conducted on [redacted], revealed that Resident #1 was assessed as at risk for elopements according to Resident #1's health assessment form dated [redacted]. The last Elopement Risk Assessment Form dated [redacted] noted that Resident #1 was at risk for elopements. There was no updated Elopement Risk Assessment after Resident #1 eloped from the facility on [redacted]. During an observation of Resident #14, conducted on [redacted], at 09:30am, 09:50am, 11:15am, and 02:35pm, Resident #14 was outside in front of the facility pacing and talking to himself. There were no staff present during any of the observations of Resident #14. Resident #14 did not have any identification on his person.	A 032		

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A 032	Continued From page 3 A record review for Resident #14, conducted on , revealed that Resident #14 was assessed as at risk for elopements according to Resident 14's health assessment form dated . There was no Elopement Risk Assessment Form in Resident #14's record. A review of the facility's undated elopement risk policy and procedures, conducted on , revealed on page one that staff were supposed to check and test door alarms regularly. The policy also noted on page 1 that staff were supposed to be able to identify and monitor residents at risk for elopements. There was a form entitled "Elopement Risk Assessment" attached to the elopement risk policy and procedures. There were no directions on the completion of the Elopement Risk Assessment form. During an interview with Staff B, Resident Care Aid, conducted on at 10:00am, Staff B stated that she was not sure which residents were at risk for elopements. During an interview with Staff C, Resident Care Aid, conducted on at 11:00am, Staff A stated that all twenty-two residents on the second-floor memory care unit were at risk for elopements. During an interview with Staff I and the Business Office Manager, conducted on at 01:30pm, Staff I and the Business Office Manager stated that staff were supposed to perform every two-hours checks/rounds on residents. During an interview with Staff J, Medication Technician and Resident Care Aid, conducted on at 02:39pm, Staff J stated that	A 032		

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A 032	Continued From page 4 sometime the first-floor memory care unit's doors did not close all the way. Staff J stated that staff were supposed to check and make sure that the doors latched/locked. Staff J there were a few residents that were at risk of elopement but was unable to state which residents. Staff J stated that staff were supposed to perform resident checks/rounds every two hours. Staff J stated that Residents #1 and #14 did not have identification on their person and that the front office may have their identifications. A review of the facility's elopement drills dated and , conducted on revealed that not all administration and direct care staff participated in the elopement drills. There were no other elopement drills provided. During an interview with Staff I and the Business Office Manager, conducted on at 03:14pm, Staff I and the Business Office Manager stated that Elopement Risk Assessment forms were to be filled out upon residents' admission and a re-assessment after an elopement. Staff I and the Business Office Manager agreed that Resident #1's record did not include an updated Elopement Risk Assessment Form. Staff I and the Business Office Manager agreed that Resident #14 health assessment form assessed the resident as at risk for elopement. Staff I and the Business Office Manager agreed that not all administrative staff and direct care staff had participated in the facility's elopement drill. Class III	A 032		

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AL243	Continued From page 5	AL243		
AL243 SS=D	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may	AL243		

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AL243	Continued From page 6 count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the . . . . . procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are	AL243		

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AL243	Continued From page 7 retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on recored review and interview, the facility failed to provide evidence of 6-hour limited mental health (LMH) training in 1 of 4 staff (Staff C) sampled. Findings include: Record review conducted on revealed Staff C, with date of hire , did not have evidence of 6-hour LMH training documented in their employee file. Interview conducted on at 3PM, with the Business Office Manager, confirmed there was no 6-hour LMH training in Staff C's employee file. Class III	AL243		