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
	AL11968421	A. BUILDING: _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLOUD HAVEN ALF	907 N TAYLOR RD BRANDON, FL 33510

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A 000	Initial Comments A complaint survey (complaint # 2023010567) in conjunction with a generator monitoring were conducted at St. Cloud Haven ALF on and . Deficiencies were identified at the time of survey.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice,	A 010		

AHCA Form 3020-0001

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

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A 010	Continued From page 1 and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and,	A 010		

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A 010	Continued From page 3 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are	A 010		

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A 010	Continued From page 4 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Owner determined appropriateness of a resident that was admitted to the facility by ensuring it had a plan to meet the needs of the resident for one (Resident #1) of the two sampled residents. Furthermore, the facility failed to ensure that that a new health assessment was completed for residents every 3-years for one (Resident # 2) of the two sampled residents. Findings included: An interview with Staff A, Resident Aide, conducted on at 9:20AM, revealed that she was not given any paperwork to show what Resident #1's care needs were until , after the resident had eloped. She went on to say that the information given to her at the resident's admission only revealed identification cards and the admission agreement. A record review of Resident #1's file, conducted on showed that the resident admitted on and that no health care information regarding the resident's needs were in the resident's file. A record review of Resident #2's file, conducted on revealed that the resident had admitted on . The file contained an undated health assessment that had a faxed date stamp for and was on the form that was last revised in 2017 which was greater than three years ago. During an interview with the Owner conducted on	A 010		

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A 010	Continued From page 5 . . . . . at 11:20AM, the Owner stated that the health information for Resident #1 was not in the record because it was too hard to read, and he wasn't sure what was going on. During a further interview with the Owner, conducted on . . . . . at 12:00PM, the Owner agreed that Resident #2's health assessment needed to be updated. Class III	A 010		
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	A 025		

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A 025	Continued From page 6 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. (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 provide care, services, and supervision appropriate to the needs of the residents accepted for admission including awareness of the resident's general health and whereabouts which directly , the health and safety of one (Resident #1) of the six sampled staff. The lack of admission process and awareness of	A 025		

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A 025	Continued From page 7 Resident #1 places all current and future residents at risk of potential harm and exacerbation of health concerns. Findings included: A record review of the facility's adverse incident reports, conducted on revealed that on , Resident #1 had eloped from the facility and was later located by the police department at the mall. The facility failed to retrieve the resident before he went missing again. The resident's whereabout were unknown to the facility. A record review of Resident #1's file, conducted on revealed that the resident was admitted on with no health care documentation in place to identify the resident's risks or needs. An interview with Staff A, Resident Aide, conducted on at 9:20AM, revealed that the care staff had no record of Resident #1's health information until after the resident had eloped on . Staff A stated that if she had known Resident #1's history that the elopement could have been prevented. A record review of Resident #1's health assessment which was dated for , conducted on revealed that Resident #1 had a diagnosis of , , , and . An interview with Staff A, conducted on at 9:20AM revealed that as Staff A was trying to locate the resident the day he eloped on , she mentioned that she later found out that he had come from a secured	A 025		

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A 025	Continued From page 8 facility. She went on to say that she is unsure of the resident's current location. An interview with the Administrator of Resident #1's previous facility, conducted on [redacted] at 10:54AM, the Administrator stated that he explained to the Owner that Resident #1 could not leave the facility alone and needed someone to accompany him when leaving. He went on to say that the resident's family informed him that Resident #1 had [redacted], in the hospital after the elopement due to [redacted]. A record review of the previous facility of Resident #1, conducted on [redacted] revealed that the resident's previous facility advertised services including [redacted] and [redacted] care. It also advertised memory care services. An interview with the Owner on [redacted] at 11:20AM, revealed that the Owner was aware that the resident's previous facility was a secured facility. The Owner went on to reveal that neither he nor the Administrator assisted in searching for the resident as they were out of state. The Owner stated that he agreed that ultimately this was his responsibility and he stated that this was an unfortunate situation. He also stated that he is unaware of the resident's current location. A record review of Resident #1's hospital records, conducted on [redacted] revealed that Resident #1 arrived to the hospital on [redacted] with increased [redacted] and [redacted] following an elopement from his assisted living facility. Resident #1 was admitted to the hospital unkempt and smelling of feces and [redacted] per the notes. The hospital noted the resident's diagnosis's included [redacted], and [redacted].	A 025		

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A 025	Continued From page 9 The emergency notes stated that resident was in need of further care. The hospital history and physical stated that resident resided in a memory care facility but moved to a different assisted living due to cost of care. The hospital discharge notes revealed that resident , , on at 10:11AM from . The hospital notes also stated that resident had suffered from rhabdomyolysis with acute , injury likely caused by being on the street exposed to sun and . An interview with Resident #1's family member via telephone, conducted on at 12:16PM revealed that the resident , on . The family stated the facility was made aware of Resident #1's and risk for leaving the facility when he admitted. Resident #1's family member stated the facility was not treating him well which likely contributed to him leaving. She stated that she had brought in a television that was never set up for the resident and it was really just the family looking out for the resident. She stated the police could not assist with returning the resident to the facility because the facility had no paperwork to give the police stating his condition of . The family also stated that the facility was aware of his condition as he wore a necklace that stated his . She stated that she feels his elopement contributed to his passing and that the facility still remains unaware of Resident #1's location due to them never following up with her and contacting her. Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards	A 032		

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A 032	Continued From page 10 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 resident's representative. (b) Facility Resident Elopement Response	A 032		

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A 032	Continued From page 11 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 conduct at least two elopement drills annually. Findings included: A record review of the facility's elopement policy, conducted on revealed that "Elopement drills are preformed twice a year." A record review of the facility's elopement drills, conducted on revealed that the facility had completed one elopement drill in the last year which was dated for . An interview with the facility Owner, conducted on	A 032		

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A 032	Continued From page 12 [redacted] at 11:19AM revealed that the Owner was unsure where the elopement drills were located. Class III	A 032		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. 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 [redacted]; 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,	A 160		

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A 160	Continued From page 13 F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (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 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 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years.	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968421	A. BUILDING: _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLOUD HAVEN ALF	907 N TAYLOR RD BRANDON, FL 33510

(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 160	Continued From page 14 (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. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) 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 record review and interview, the facility failed ensure that the admission and discharge log were up-to-date for one (Resident #1) of the two residents sampled. Findings included: A record review of the facility's admission and discharge log, conducted on revealed that Resident #1 was not listed as admitted or	A 160		

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
	AL11968421	A. BUILDING: _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 160	Continued From page 15 discharged on the log. A record review of Resident #1's file, conducted on revealed that the resident admitted on . During an interview with the Owner, conducted on at 11:53AM, the Owner confirmed that Resident #1 was not listed on the log. Class III	A 160		