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
	AL11911165	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSTIC RETREAT	1120 NORTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435

(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 An unannounced licensure Complaint (2022012886, 2023004280, 2024000121) and Generator Monitoring survey was conducted on . . . . . through . . . . . at Rustic Retreat. The facility had deficiencies identificed at the time of the survey.	A 000		
A 032	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	A 032		

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A 032	Continued From page 1 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, 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 records review, observation, and interviews, it was determined that the facility failed to set in place procedures and preventive measures to reduce the risk of elopement of at least 1 of 1 sampled resident (Resident #1). The lack of intervening measures resulted in Resident #1 being exposed to severe danger after he left	A 032		

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A 032	Continued From page 2 the facility unnoticed and unsupervised. The findings included: On [redacted] at approximately 1:45 PM, Resident #1 was reported missing from the facility. After, the employee on duty (Employee F/ Resident Care Aide) assigned to care for the Resident could not locate him in his room or on the property. An interview with Employee F on [redacted] at 1:38 PM , revealed while everyone was busy providing care on [redacted] to other residents after lunch, a family member gained access to the facility through the main entrance door with the door key; without anyone being aware. After opening the door, the door's kickstand dropped to the ground and kept the door ajar facilitating an easy exit for Resident #1. The door was not secured closed after the entrance of the family member. The Administrator also affirmed on [redacted], that they saw the sequence of the events (as stated by Staff F) on the continuous video recording. However, when asked to see the video, the Administrator reported that they did not save the recording. She said that the recording is ongoing and loops around every week. Resident #1 had eloped since [redacted]. Therefore, the video footage was no longer available. Further review of the incident report completed by the facility revealed that Resident #1 was not able to make it far after he left the facility. He crossed the Northbound double lane road (near the facility) and [redacted] in the median area of the road landscaped with shrubs that are [redacted] Resident #1 [redacted] fully inside the middle of the shrubbery area and not partially on the road and	A 032		

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A 032	Continued From page 3 the median. During an interview conducted on at 1:23 PM, Resident #1 asserted that he wanted to leave the place to go to his house located not far from the facility. Resident # 1 stated that he did not like the facility. He did not utter any reasons for his dislike. He also said that when he in the middle of the road, in the landscaped area, he could not get up. He acknowledged the danger that he had exposed himself to. Review of the facility's elopement policy revealed the following. The facility's elopement policy(undated) stipulated that "a missing resident is an individual whose whereabouts is not known to staff and that the resident is not able to independently leave the facility". Review of Resident #1's file revealed the an admission to the facility around . His admitting diagnoses obtained from his health assessment (AHCA form 1823) dated included: , , , and , , ( ). The1823 revealed that Resident #1 was independent with all activities of daily living (ADLs) including, ambulation, bathing, , transferring, eating, self-care (grooming), and toileting. It was further documented that Resident #1 was not at risk for elopement, and that he was oriented x2 (not specified to what), and forgetful. Further review of the form, in section B of the health assessment, titled General Oversight, it was noted that the whereabouts and the wellbeing of Resident #1 must be observed daily. Review of a previous health assessment dated documented that Resident #1 had a history of , , , , , and	A 032		

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A 032	Continued From page 4 other health issues. It documented that Resident #1 was at risk for elopement. This information was deemed relevant and important because it coincided more with the current mental status of Resident #1. Section B of the health assessment, titled General Oversight, also documented that the whereabouts and the wellbeing of Resident #1 must be observed daily. On at 3:43 PM, in an interview conducted with Employee A(Resident Care Aide) referred to, at the facility as a universal worker, it was revealed that elopement . . . . . was a current behavior of Resident #1. Employee A described him as a resident who always sought to exit the facility (touching every doorknob) and trying to open them. Employee A also reported that Resident #1 has tried to leave the facility twice before his last successful attempt of . . . . . . Employee A stated that one time Resident #1 left the facility and walked down towards the ice cream place located approximately a mile south from the facility. One of the facility's staff found him there. Employee A said that event occurred a couple years ago; the other time was in 2021. Given the continuous manifestation of Resident #1's desire to leave the facility, the 1823 dated more accurately depicted Resident #1 tendency to elope. Despite this vivid knowledge of Resident #1's behavior of being exit seeking, his most recent AHCA form 1823 did not reflect elopement intentions. The Administrator said on at 11:53 AM, that she did not know why the Health Practitioner changed the original AHCA form 1823 from elopement risk to no elopement risk. She said that would have to discuss that with the health practitioner. The Administrator also denied having knowledge or recollection of Resident #1	A 032		

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A 032	Continued From page 5 leaving the facility multiple times. Further review of the facility's elopement policy documented that "Residents who are independently able to leave the facility but do not return by the expected time will also be considered as a "missing resident". In addition, the elopement policy outlined that: Upon admission residents will be evaluated regarding the risk potential for elopement. All staff will be made aware of these residents and their needs. The residents will be provided identification with their name, the facility's name, address, and phone number. Staff will pay increased attention to the residents identified as "at risk" and ensure daily that the identification is on the person. During observation conducted on through from 9:00 to 4:30 PM, Resident #1 was not once observed wearing an identification on his person. During , interviews conducted with multiple Employees (B, C, & D) during the survey revealed that they were not aware of anyone at the facility being at risk of elopement, even though they knew that Resident #1 had recently eloped. On at 2:10 PM, the Administrator reported that, in addition to staff ensuring the safety of the residents, they have placed cameras throughout the common areas of the facility to monitor the whereabouts of every resident. Yet, the day Resident #1 left the facility, no one saw him leaving in the monitors to alert the staff. Also, the visitation policy which allowed family members of some residents to have keys to enter the facility had not been revised during the initial investigation of Resident #1's elopement. It was after the Surveyor's questioning, that the	A 032		

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A 032	Continued From page 6 Administrator had decided on to implement a new visitation policy that would require all visitors to notify the facility's staff before access to the facility can be granted. Also, the Administrator reported that she did not conduct any staff training after Resident #1 had eloped. During the exit meeting on at 4:30 PM, the Administrator provided no additional information and agreed with the findings. Class II	A 032		
A 165	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 ;	A 165		

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A 165	Continued From page 7 4. [illegible] or [illegible] 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 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) [illegible], neglect, or [illegible] 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	A 165		

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A 165	Continued From page 8 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 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 records review, observations, and interviews, the facility failed to file an adverse incident report in cases involving 1 of 2 sampled residents (Resident #1) who had eloped from the facility. The findings included: 1) Review of an incident report revealed that on at 1510 hrs., Resident #1 left the	A 165		

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A 165	Continued From page 9 facility unknown to staff at about 1200 hours. Further review of the incident report revealed that Resident #1 was found lying on the street in the median area of the road. The report read "A short time later, ...a male matching Resident #1's description laying supine in the median along the bushes directly in front of the facility. After confirming the Resident's identity BBFR responded to the scene to treat Resident #1 for the minor cuts he sustained on his ⌄ while lying in the bushes. Resident #1 was also complaining of , . According to the Administrator, the ambulance had taken Resident #1 to the hospital for further evaluation. After his physical assessment which was negative of further complication, Resident #1 was brought to the facility, on the same day. The Administrator said that she did not file an adverse incident report or notify the regulatory agency of this incident. Employee A, an Aide reported on . . . . at 3:43 PM that there was another resident who used to live at the facility who also had eloped from the facility by jumping over the fence. Employee A said that she could not remember the exact date of that incident, but it was not recent. The Administrator provided no additional information during the exit meeting on . . . . . at 4:30 PM. Class III	A 165		
A 167	59A-36.018 FAC; 429.24 FS Resident Contracts 59A-36.018 Resident Contracts. (1) Pursuant to section 429.24, F.S., the facility	A 167		

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A 167	Continued From page 10 must offer a contract for execution by the resident or the resident's legal representative before or at the time of admission. The contract must contain the following provisions: (a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services that the resident elects to receive; (b) The daily, weekly, or monthly rate; (c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule that must be attached to the contract; (d) A provision stating that at least 30 days written notice will be given before any rate increase; (e) Any rights, duties, or ˬ of residents, other than those specified in section 429.28, F.S.; (f) The purpose of any advance payments or deposit payments, and the refund policy for such advance or deposit payments; (g) A refund policy that must conform to section 429.24(3), F.S.; (h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or ˛ ˛ ˛ facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf;	A 167		

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A 167	Continued From page 11 (i) A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility; (j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those that the facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, must be notified in writing that the resident must make arrangements for transfer to a care setting that is able to provide services needed by the resident. In the event the resident has no one to represent him or her, the facility must refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions outlined in section 429.26(8), F.S., will take effect; (k) A provision that residents must be assessed upon admission pursuant to subsection 59A-36.006(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4), of that rule; (l) The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to rule 59A-36.008, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule; and, (m) The facility's policies and procedures related to a properly executed DH Form 1896, ... (2) The resident, or the resident's representative, must be provided with a copy of the executed contract. (3) The facility may not levy an additional charge for any supplies, services, or accommodations	A 167		

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A 167	Continued From page 12 that the facility has agreed by contract to provide as part of the standard daily, weekly, or monthly rate. The resident or resident's representative must be furnished in advance with an itemized written statement setting forth additional charges for any services, supplies, or accommodations available to residents not covered under the contract. An addendum must be added to the resident contract to reflect the additional services, supplies, or accommodations not provided under the original agreement. Such addendum must be dated and signed by the facility and the resident or resident's legal representative and a copy given to the resident or resident's representative. 429.24 FS (1) The presence of each resident in a facility shall be covered by a contract, executed at the time of admission or prior thereto, between the licensee and the resident or his or her designee or legal representative. Each party to the contract shall be provided with a duplicate original thereof, and the licensee shall keep on file in the facility all such contracts. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration. (2) Each contract must contain express provisions specifically setting forth the services and accommodations to be provided by the facility; the rates or charges; provision for at least 30 days' written notice of a rate increase; the rights, duties, and [illegible] of the residents, other than those specified in s. 429.28; and other matters that the parties deem appropriate. A new service or accommodation added to, or implemented in, a resident's contract for which the resident was not previously charged does not require a 30-day written notice of a rate increase.	A 167		

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A 167	Continued From page 13 Whenever money is deposited or advanced by a resident in a contract as security for performance of the contract agreement or as advance rent for other than the next immediate rental period: (a) Such funds shall be deposited in a banking institution in this state that is located, if possible, in the same community in which the facility is located; shall be kept separate from the funds and property of the facility; may not be represented as part of the assets of the facility on financial statements; and shall be used, or otherwise expended, only for the account of the resident. (b) The licensee shall, within 30 days of receipt of advance rent or a security deposit, notify the resident or residents in writing of the manner in which the licensee is holding the advance rent or security deposit and state the name and address of the depository where the moneys are being held. The licensee shall notify residents of the facility's policy on advance deposits. (3)(a) The contract shall include a refund policy to be implemented at the time of a resident's transfer, discharge, or . . . . . . (b) If a licensee agrees to reserve a bed for a resident who is admitted to a medical facility, including, but not limited to, a nursing home, health care facility, or . . . facility, the resident or his or her responsible party shall notify the licensee of any change in status that would prevent the resident from returning to the facility. Until such notice is received, the agreed-upon daily rate may be charged by the licensee. (c) The purpose of any advance payment and a refund policy for such payment, including any advance payment for housing, meals, or personal services, shall be covered in the contract.	A 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911165	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSTIC RETREAT	1120 NORTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435

(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 167	Continued From page 14 (4) The contract shall state whether or not the facility is affiliated with any religious organization and, if so, which organization and its general responsibility to the facility. (5) Neither the contract nor any provision thereof relieves any licensee of any requirement or imposed upon it by this part or rules adopted under this part. (6) In lieu of the provisions of this section, facilities certified under chapter 651 shall comply with the requirements of s. 651.055. (7) Notwithstanding the provisions of this section, facilities which consist of 60 or more apartments may require refund policies and termination notices in accordance with the provisions of part II of chapter 83, provided that the lease is terminated automatically without financial penalty in the event of a resident's or relocation due to hospitalization or to medical reasons which necessitate services or care beyond which the facility is licensed to provide. The date of termination in such instances shall be the date the unit is fully vacated. A lease may be substituted for the contract if it meets the disclosure requirements of this section. For the purpose of this section, the term "apartment" means a room or set of rooms with a kitchen or kitchenette and lavatory located within one or more buildings containing other similar or like residential units. This Statute or Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure that 1 of 3 sampled Residents (Resident #1 & Resident #3)' records to include (Resident #3's contract) was safely	A 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911165	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSTIC RETREAT	1120 NORTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435

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A 167	Continued From page 15 kept for a period of five years. The findings included: Review of a complaint allegation revealed that Resident #3 was admitted to the facility with [illegible]. The complaint also documented, at the time the Resident was admitted to the facility, the Administrator obtained a check in the amount of $8000 dollars written by Resident #3 to the order of the facility. The Complaint outlined that when discussing the Resident's outstanding [illegible] to the facility, after Resident #3 left the facility, this check written to the facility was never mentioned. In addition, it was noted that Resident #3 was a recipient of Medicaid coverage for long term care which would imply that Resident #3 to the facility would have been minimal. Resident #3 was admitted to the facility on . The Administrator reported on 1/82024 at 2:01 PM, she did not remember collecting $8000.00 from Resident #3. She said that she did go the bank with Resident #3, but she only received $6000.00 dollars from Resident #3. The Administrator said that the Resident was placed to her facility by the Adult Protective Services (APS), and she was not sure who was going to pay for the facility. She said that when she got the money, APS had not given her any money. The Administrator reported that she did assist the resident in obtaining pest control for his abandoned Condominium and had charged him for those services. The Administrator was asked to provide a detailed accounting of Resident #3's financial [illegible] and the total amount that Resident #3 and other agencies might have paid. The	A 167		

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 167	Continued From page 16 Administrator provided three copies of the accounting that detailed the amount that was due, the amount paid by Resident # 3, and the amount subsidized by another agency. However, the Administrator could not provide evidence of the total amount she received as check from Resident#3, she could not provide proof of the Resident's contract and his , and she could not show evidence of other transactions completed for the Resident that were not legally abiding as per review of the facility's contractual agreement given to all residents (e.g. Exterminated condo fees; sold car + 4 cans fix a flat; oversee exterminating; Professional exterminator fees; Exterminated Condo fees; 2nd person fee; Transportation and assistance to VA fees). Finally, the Administrator could not provide an accurate accounting of Resident #3. During the Exit with the Administrator on , at 4:30 PM, she provided no additional information, she said that she could not find the requested records. Class III	A 167		