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
	AL11966999	A. BUILDING: _____ B. WING _____	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICKY'S HOME ALF	6402 SW 41 STREET MIAMI, FL 33155

(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 investigation (complaint number 2024002631) was conducted at Vicky's Home ALF on . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=E	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 interview and record review, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general whereabouts of one out of two (Resident #1) sampled residents. Resident #1 eloped from the facility and was found by law enforcement about 12 hours later. The facility failed to maintain a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention for one out of two (Resident #2) sampled residents. Findings included: 1)	A 025		

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A 025	Continued From page 2 Interview conducted on at 11:25 AM, Staff A stated that Staff E was working in the facility when Resident #1 eloped and called him immediately. He checked the facility's camera and saw when the resident left the facility. He went to the facility to look for the resident in the neighborhood. He called the police to report a missing person. He received a call from the police around midnight to inform him that the resident was found and was transferred to the hospital. The resident was discharged from the hospital and came . . . to the facility around 1:00 PM. He contacted the resident's psychiatrist, and she increased the dose of one of the resident's medications. Interview conducted by phone on at 1:44 PM, Staff E stated that she was working when Resident #1 eloped. The resident used to sit on the front porch. She heard a noise at the front gate and when outside the facility. She observed the resident walking in the street, and she called her. The resident kept walking and she called the owner. The owner brought the resident to the facility at around 1:00 AM. A review of Resident #1's progress notes revealed "The incident occurred the morning of , . . . The resident left the facility by the front door, going to the bus stop. Owner called 911 for reporting a missing person around 10:55 AM. Owner received a call at 12:00 AM from police to inform that the resident was found in a restaurant at around 9:36 PM. They picked her up at the restaurant and took her to the hospital. The resident was discharged from the hospital and was taken to the facility at 1:00 AM. The resident said she had gotten on a bus then she got lost."	A 025		

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A 025	Continued From page 3 A review of Resident #1's record revealed a health assessment completed on [redacted]. The resident was diagnosed with [redacted] symptoms. The physician indicated the resident was not an elopement risk and needed supervision with ambulation, eating, transferring, and assistance with bathing, [redacted], self-care, and toileting. A review of the facility's incident report revealed Resident #1 eloped on [redacted] at 9:15 AM. The owner called 911 to report a missing person. Law enforcement called the owner to inform him that the resident was found in a restaurant around 9:36 PM. The resident was transferred to the hospital and returned to the facility around 1:00 AM. A review of the facility's elopement policy and procedures showed, "The facility establish a method of assessing residents for risk of [redacted] and eloping at the time of admission and as needed." A review of Resident # 1 record revealed there was no elopement risk assessment after the resident eloped on [redacted]. 2) Interview conducted on [redacted] at 11:42 AM, Staff A stated that Resident #2 when she went to get a roll of toilet paper in the laundry room located at the backyard last Tuesday at 3:55 PM. The staff called 911 and the resident was transferred to the hospital. He contacted the	A 025		

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A 025	Continued From page 4 resident's primary physician and legal guardian. The resident's primary physician told him that the resident had a [illegible] during the [illegible], but he did not know anything else. The Administrator acknowledged that the notes were not written in the resident's file. A review of Resident #2's record revealed a health assessment completed on [illegible]. The resident was diagnosed with [illegible] atherosclerotic [illegible] of native [illegible]. The physician indicated that the resident was independent with ambulation, [illegible] eating, self-care, toileting and transferring and needed assistance with [illegible]. A review of Resident #2's progress notes revealed no documentation that the resident [illegible] on [illegible] and the resident was transferred to the hospital. There was no evidence that the facility contacted Resident # 2's healthcare provider or legal guardian when the facility sent the resident to the hospital. Class III	A 025		
A 165 SS=D	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	A 165		

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A 165	Continued From page 5 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. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 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	A 165		

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A 165	Continued From page 6 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 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	A 165		

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A 165	Continued From page 7 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 interview and record review, the facility failed to submit an adverse incident report through the agency's portal within 1 business day, after the occurrence of a resident incident, for one out of two (Resident #2) sampled residents. Findings included: On at 11:42 AM, Staff A stated that Resident #2 went to pick up a roll of toilet paper in the closet located on the patio last Tuesday at 3:55 PM. She and the staff called 911. The resident was transferred to the hospital. He contacted the resident's primary physician and legal guardian. The resident's primary physician told him that the resident had a during the , but he did not know anything else. A review of the online Adverse Incident Reporting System database showed no documentation that the facility filed a one-day report regarding Resident #2 with injury( ), and the need for the resident to require a higher level of care and was sent to the hospital. On at 11:20 AM, Staff A stated that he did not file an adverse incident report. Class III	A 165		