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
	AL11969964	A. BUILDING: _____ B. WING _____	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA PAZ I ALF INC	1200 SW 22ND TER MIAMI, FL 33145

(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 2024012876) was conducted at Villa Paz I ALF Inc on through . Deficiencies were identified at the time of the 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		

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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 record review and interview, the facility failed to follow its policy and procedures regarding elopement for one out of thirteen (Resident #1) sampled residents. Resident #1 left the facility without staff knowing her whereabouts and was found by the police three miles away from the facility.	A 032		

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A 032	Continued From page 2 Findings included: A review of the facility's elopement policy and procedures showed, "The organization will define when an unscheduled absence is considered an elopement and will outline the steps to be followed when a resident is determined to have eloped. Elopement occurs when a resident leaves the facility without following sign-out procedures and who has been determined by AHCA form #1823 not to have capacity. Capacity refers to a resident who was alert, oriented, and capable of making all decisions as stated in their AHCA #1823. All residents will be assessed for elopement risk within 72 hours of admission, and periodically if a significant change occurs." On , at 11:45 AM, Staff B stated that they monitored Resident #1 frequently and put an alarm on the exit doors. She stated that Resident #1 had a doctor's , , after the incident but was rescheduled for next month. She confirmed that the resident was not reassessed after she eloped, the facility did not have documentation of an updated health assessment, and that the resident's physician and case manager were not contacted after she eloped. . A review of the facility's adverse incident report showed that Resident #1 left the common area and proceeded to the front of the facility on . Resident #1 jumped over the facility's fence. Resident #6 witnessed Resident #1 jumping over the fence and informed Staff D at 10:00 AM. When Staff D reached the front of the facility Resident #1 was no longer in sight. Staff D contacted the administrator and the police. The administrator attempted to contact Resident #1's husband and daughter. The police arrived at the facility at 10:45 AM. They found the resident	A 032		

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A 032	Continued From page 3	A 032		

walking and safely returned her to the facility. The correction action plan indicated that "The facility has reviewed and increased the security of the fence to prevent future elopements. Resident #1 care plan will be updated to reflect this incident and additional supervision will be implemented during times of potential risk, Staff will undergo further training on monitoring residents and handling elopement situations efficiently and ongoing communication will be maintained with Resident's #1 case manager to ensure her safety and well-being."

A review of Resident #1's progress notes showed that Resident #6 told the staff that Resident #1 jumped over the fence to the property on the right side of the facility and walked to the street on at 9:10 AM. Staff D told Staff E and looked for her on the street. Staff D called the administration and the police. The police arrived and brought Resident #1 to the facility at 11:57 AM. The resident's family members were contacted.

A review of the facility's records showed that Resident #1 did not sleep all night. She kept walking and attempting to open all the facility's doors on at 1:35 AM. Resident #1 was not in her bed on at 3:31 AM. The staff searched for her and found the laundry door unlocked and the alarm disconnected. The resident was found on the second floor in Resident's #6 bed. The resident was brought to her room and stayed all night walking inside the facility. Resident #1 was walking inside the facility all night on . She opened the laundry door, activated the alarm, and walked outside the facility in the middle of the night. Resident #1 the alarm of the laundry door and went outside the facility in the middle of

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A 032	Continued From page 4 the night on . The resident slept on the sofa in the living room area on A review of Resident #1's health assessment dated showed a medical history and diagnoses of major , and degenerative Disc (,). The resident was independent with ambulation, eating, self-care, and transferring, and needed supervision with bathing, , and toileting. The physician indicated the resident was not at elopement risk. The record did not have documentation of an updated health assessment after the resident eloped from the facility. The record did not have documentation of the resident being reassessed after the eloped. Further review showed no documentation that the facility contacted the resident's physician and case manager after she eloped to seek guidance on preventing other occurrences. Class III	A 032		
A 079 SS=F	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375	A 079		

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A 079	Continued From page 5 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course	A 079		

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A 079	Continued From page 6 requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility	A 079		

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A 079	Continued From page 7 must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency.	A 079		

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A 079	Continued From page 8 (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 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 to ensure adequate qualified staff were available to meet the scheduled and unscheduled needs of 13 out of 13 (1, #2, #3, #4, #5, #7, #8, #9, #10, #11, #12,#13 and #14) sampled residents. Resident #1 eloped from the facility and was found by the police three miles away from the facility. Resident #1 was missing and the staff found her in another resident's room in the middle of the night. Findings included: 1) A review of Resident #1's health assessment dated showed a medical history and diagnoses of major , and degenerative disc (,). The resident was independent with ambulation, eating, self-care, and transferring, and needed supervision with bathing, , and toileting. The physician indicated the resident was not at elopement risk. A review of Resident #1's progress notes showed that Resident #6 told the staff that Resident #1	A 079		

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A 079	Continued From page 9 jumped over the fence to the property on the right side of the facility and walked to the street on . Staff D told Staff E that Resident #1 left the facility and looked for her on the street. Staff called the administration and the police. The police arrived and brought Resident #1 to the facility at 11:57 AM. Resident #1 family members were contacted. A review of the facility's records showed that Resident #1 did not sleep all night. She kept walking and attempting to open all the facility's doors on at 1:35 AM. Resident #1 was not in her bed on at 3:31 AM. The staff searched for her and found the laundry door unlocked and the alarm disconnected. The resident was found on the second floor in Resident's #14 bed. The resident was brought to her room and stayed all night walking inside the facility. Resident #1 was walking inside the facility all night on . She opened the laundry door, activated the alarm, and walked outside the facility in the middle of the night. Resident #1 the alarm of the laundry door and went outside the facility in the middle of the night on . The resident slept on the sofa in the living room area on A review of the facility's adverse incident report showed that Resident #1 left the common area and proceeded to the front of the facility on . Resident #1 jumped over the facility's fence. Resident #4 witnessed Resident #1 jumping the fence and informed Staff D at 10:00 AM. When Staff D reached the front of the facility Resident #1 was no longer in sight. Staff D contacted the administrator and the police. The administrator attempted to contact Resident #1's husband and daughter. The police arrived at the facility at 10:45 AM. They found the resident	A 079		

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A 079	Continued From page 10 walking and safely returned her to the facility. 2) On at 12:02 PM, Staff D stated she worked with Staff E when Resident #1 left the facility. She said that after she assisted the resident with her bath, the resident sat in the living room. A few minutes later Resident #6 told her that Resident #1 jumped over the fence to the neighbor's property on the right side of the facility and walked to the street. She called the administrator and 911. The police came immediately and looked for the resident. The police brought the resident to the facility at around noon. She did not observe the resident attempting to leave the facility again after the incident. A review of the facility's employee records showed Staff E, hired date was unknown and did not have an employee file onsite. On at 12:30 PM, the Administrator stated that Staff E only worked one day at the facility. She confirmed that the employee record for Staff E was not available for review during the visit. 3) A review of the staffing pattern for , , , and showed two staff worked in the facility, one staff worked 24 hours from 6 AM to 6 PM and the other staff worked from 7:30 AM to 4:00 PM from Monday to Friday and from 7:30 AM to 5:00 PM from Saturday to Sunday.	A 079		

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A 079	Continued From page 11 A review of the residents' records showed that six residents needed supervisor with ambulation, nine residents needed supervision with bathing, and one resident needed assistance; seven residents needed supervision with ␣ and one resident needed assistance; six residents needed supervision with eating and one resident needed assistance; seven residents needed supervision with self-care; six residents needed supervision with toileting, and 6 residents needed supervisor with transferring and one resident needed assistance. A review of Resident #1's health assessment dated showed a medical history and diagnoses of major ␣ , and degenerative disc (,). The resident was independent with ambulation, eating, self-care, and transferring, and needed supervision with bathing, ␣, and toileting. A review of Resident #2's health assessment dated showed a medical history and diagnoses of , native ␣ , unspecified protein-calorie , , , , , , , and type II. The resident needed supervision with ambulation, eating, self-care, toileting, and transferring and needed assistance with bathing, and ␣. A review of Resident #3's health assessment dated showed a medical history and diagnoses of the post- , post-right , and . The resident was independent with ambulation, bathing, ␣, eating, self-care, toileting, and	A 079		

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A 079	Continued From page 12 transferring. A review of Resident #4's health assessment dated showed a medical history and diagnoses of prostatic hyperplasia, D deficiency, seborrheic , , and a history of . The resident was independent with ambulation, eating, and toileting, and needed supervision with bathing, , self-care, and transferring. A review of Resident #5's health assessment dated showed a medical history and diagnoses of type II, , and . The resident needed supervision with ambulation, bathing, , eating, self-care, toileting, and transferring. A review of Resident #7's health assessment dated showed a medical history and diagnoses of , , , , and . The resident needed supervision with ambulation, , eating, self-care, toileting, and transferring and needed assistance with bathing. A review of Resident #8's health assessment dated showed a medical history and diagnoses of , , suspected , , , tobacco use, history of EtOH , , and lower extremity . New onset . The resident was independent with ambulation, bathing, , eating and toileting, and transferring and needed assistance with self-care.	A 079		

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A 079	Continued From page 13 A review of Resident #9's health assessment dated showed a medical history and diagnoses of type 2 / . The resident was independent with ambulation, eating, self-care, toileting, and transferring, and needed supervision with bathing and . A review of Resident #10's health assessment dated showed a medical history and diagnoses of closed left , on left , and history of COVID. The resident was independent with ambulation, bathing, , eating, self-care, toileting, and transferring. A review of Resident #11's health assessment dated showed a medical history and diagnoses of , , , , , , , and elevated . The resident was independent with ambulation, eating, self-care, toileting, and transferring, and needed supervision with bathing, and . A review of Resident #12's health assessment dated showed a medical history and diagnoses of , , , , post , and . The resident was independent with eating, needed supervision with ambulation, , self-care, toileting, and transferring, and needed assistance with bathing. A review of Resident #13's health assessment dated showed a medical history and diagnoses of , , , , , and . The resident was	A 079		

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(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 079	Continued From page 14 independent with eating, needed supervision with ambulation, bathing, _, self-care, and toileting, and needed assistance with transferring. A review of Resident #14's health assessment dated showed a medical history and diagnoses of hypertensive and _, . The resident was independent with eating and needed supervision with ambulation, bathing, _, self-care, toileting, and transferring. Class III	A 079		
A 123 SS=E	429.27( ) FS; 59A-36.013(2) FAC Fiscal - Resident Trust Funds 429.27 (3) A facility, upon mutual consent with the resident, shall provide for the safekeeping in the facility of personal effects not in excess of $500 and funds of the resident not in excess of $500 cash, and shall keep complete and accurate records of all such funds and personal effects received. If a resident is absent from a facility for 24 hours or more, the facility may provide for the safekeeping of the resident's personal effects in excess of $500. (4) Any funds or other property belonging to or due to a resident, or expendable for his or her account, which is received by a facility shall be trust funds which shall be kept separate from the funds and property of the facility and other residents or shall be specifically credited to such resident. Such trust funds shall be used or otherwise expended only for the account of the resident. At least once every 3 months, unless upon order of a court of competent jurisdiction, the facility shall furnish the resident and his or her	A 123		

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	AL11969964	A. BUILDING: _____ B. WING _____	12/10/2024

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A 123	Continued From page 15 guardian, trustee, or conservator, if any, a complete and verified statement of all funds and other property to which this subsection applies, detailing the amount and items received, together with their sources and disposition. In any event, the facility shall furnish such statement annually and upon the discharge or transfer of a resident. Any governmental agency or private charitable agency contributing funds or other property to the account of a resident shall also be entitled to receive such statement annually and upon the discharge or transfer of the resident. (5) Any personal funds available to facility residents may be used by residents as they choose to obtain clothing, personal items, leisure activities, and other supplies and services for their personal use. A facility may not demand, require, or contract for payment of all or any part of the personal funds in satisfaction of the facility rate for supplies and services beyond that amount agreed to in writing and may not levy an additional charge to the individual or the account for any supplies or services that the facility has agreed by contract to provide as part of the standard monthly rate. Any service or supplies provided by the facility which are charged separately to the individual or the account may be provided only with the specific written consent of the individual, who shall be furnished in advance of the provision of the services or supplies with an itemized written statement to be attached to the contract setting forth the charges for the services or supplies. 59A-36.013 (2) RESIDENT TRUST FUNDS. Funds or other property received by the facility belonging to or due a resident, including personal funds, must be held as trust funds and expended only for the	A 123		

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A 123	Continued From page 16 resident's account. Resident funds or property may be held in one bank account if a separate written accounting for each resident is maintained. A separate bank account is required for facility funds; co-mingling resident funds with facility funds is prohibited. Written accounting procedures for resident trust funds must include income and expense records of the trust fund, including the source and disposition of the funds. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide a statement at least once every three months required by law, detailing sources and disposition of funds with their correspondent receipts for all purchases made with the resident's , , , ( ) for two out of fourteen (Resident #3 and #9) sampled residents. Findings included: A review of Resident #3's record showed the payment for $184.40 dated . The log with the monthly amount received showed the resident received $100.00 on , $ 100.00 on , $100.00 on , and $100.00 on . The log was signed by the resident and initialed by the facility's staff. A review of Resident #9's record showed the payment for $184.40 dated . The log with the monthly amount received showed that the resident received $100.00 on , $100.00 on , and $100.00 on . The log was signed by the resident and initialed by the facility's staff. On at 12:40 PM, the Administrator	A 123		

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A 123	Continued From page 17 stated the residents were entitled to receive $160.00 monthly, but they gave them $100.00 and kept $60.00 with them to be used for their personal needs. She confirmed that the facility did not keep a log of the purchases or the receipts. Class III	A 123		
A 161 SS=E	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification,	A 161		

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A 161	Continued From page 18 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity _____, to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain documentation of background screening for one out of four (Staff E) sampled staff. The facility failed to have an attestation of compliance with background screening on file for one out of five (Staff E) sampled staff. The facility failed to maintain a copy of an employment application with references for two out of five (Staff E) sampled staff. Findings included: A review of the clearinghouse database revealed	A 161		

Agency for Health Care Administration

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A 161	Continued From page 19 that Staff E has an eligible level II background screening dated . A review of the facility's employee records showed Staff E, hired date was unknown and did not have an employee file onsite. On at 12:29 PM, the Administrator stated that Staff E only worked one day at the facility. She confirmed that Staff E's employee record was not available for review during the visit. Class III	A 161		