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
	AL11953232	A. BUILDING: _____ B. WING _____	11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER FAMILY HOME	6690 WEST 14 AVENUE HIALEAH, FL 33012

(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 (#2025014935) was conducted at Ebenezer Family Home on Deficiencies were identified at the time of survey.	A 000		
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 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		

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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 document, notify the health care provider or otherwise intervene when one of three sampled residents had a change of condition which ultimately contributed to his elopement and hospitalization (Resident #3). Findings included: A review of the adverse incident report filed on 09/2325 showed, "On at 4 PM resident was sitting in the patio Resident #1 left the facility. Staff C and D who was working had not noticed Resident #1 had exited the facility premises.	A 025		

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A 025	Continued From page 2 A review of records showed that facility elopement drills were conducted on , , , and The health assessment found completed was dated showed -Medical history and Diagnoses: , ( ), (CKD4), Prostatic Hyperplasia ( ), , , and -Physical or sensory limitations walks independently - or behavioral/ status: alert and awake, speech clear -Nursing/ treatment/ service requirements: , ( ), , ( ) & nursing for and -Special precautions: universal, -Elopement risk: no Resident #1 was independent with ambulation, bathing, eating, and transferring. He required supervision with bathing, grooming and needed assistance with self-administration. He was not a risk for elopement. A review of Resident #1's progress notes showed on Resident #1 was seated in the patio area watching television with another resident. Staff B had gone inside to make coffee and when she returned Resident #1 was gone. The inside of the facility was search and an outside search was done, and Staff B and C were unable to locate resident 31.Staff called the police and three minutes later staff received call that Resident #1 was found three blocks away and was taken to the hospital. The resident's son, the Administrator and doctor, was notified.	A 025		

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A 025	Continued From page 3 On Son informed the facility that Resident #1 would be transfer from hospital to mental health facility. On Resident was transfer to mental health hospital. On Son called to inform Resident 31 would not be coming and would be transferred to another facility. On at 9:35 AM Staff B stated, "Resident #1 was sitting in the patio when he asked for coffee. I went inside to prepare the coffee and 10 minutes later realized Resident #1 had eloped. I searched for the patio, inside and outside the assisted living facility (ALF) and didn't find him. Another employee was here with me, so she stayed with the residents while I went outside to look for him in the area. Then I called the owner to let her know and she told me to call the police and I called them. A stranger found him walking and he was disoriented and turned him in to the police. The resident looked like he jumped on the fence in the . It is not high gates. The other Staff C no longer works. Since this happened we have been trained on elopement policies again. There is always two staff presents watching and being with the residents at all times even when they are in the patio area outside. No other residents here right now are at risk of elopement. He showed no signs that he was leaving, he never complained about anything. He has never done that before." On at 11:10 AM Participant #1 stated, "Maria informed me about the incident. They contacted me immediately. The week it happened he was found and had no id. He has never done this before. We came to an agreement to transfer him to another facility. Dad's state of mind was not the same. He also	A 025		

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A 025	Continued From page 4 developed a crush on one of the ladies here and thought of her as his girlfriend. It was cute and adorable, then he seemed to become possessive of her and jealous. He did not want anyone to talk to her; he had never done that before. They moved them away from each other and he was angry and that the reason , I believe he left. He has just deteriorated since he went to hospital years agoH before he came t tjis facility. He had some removed, and , . He is , ... And he was there a long time and since then had declined. was never the same. I live in Ocala, Florida and they called me, and I came down to see him and made the trip. He was at a mental facility. They ran test. When I saw him, his mind was in another place. The place he is at now is better for him. It all men. They really took care of dad. I decided to move him to another facility where its all men. It's a better fit for him." On at 11:30 AM Staff D stated, "He had never done that before he showed no signs that he wanted to leave. We contacted the son and the staff looked for him and called the police. The staff were trained, and we have two staff at all times supervising the residents. The other staff who was there came on day and took all her records. She did not tell us she was taking them and I do not have contact with her. On at 12:03 PM attempted to interview Administrator, she was very sick with COVID and could not stay on the phone to speak. Class II	A 025		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff	A 161		

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A 161	Continued From page 5 429.275 (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, 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.	A 161		

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A 161	Continued From page 6 (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 personnel records for each staff member which contain, at a minimum, documentation of background screening, employment application, with references, and documentation compliance with all staff training and continuing education for one of three (Staff C) sampled staff. Findings included: Review of facility records showed no personnel file for Staff C had no documentation of having completed a background screening, no employment application, with references, and no documentation of compliance with staff training and continuing education of trainings in reporting major and adverse incidents, facility emergency procedures, and elopement. On at 12:50 PM Staff B and D stated, "STaff C came one day and took all her paperwork without anyone knowedge. What we have are the copies we had as extras."	A 161		

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A 161	Continued From page 7 Class III	A 161		